NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

QUALITY REPORT
2017-18

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 2018-19 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 and to achieve this we strive to do all we can to treat and care for people in a high quality, safe environment which protects them from avoidable harm.

Our drive for continual improvement is embodied within the Trust's Corporate Strategy 'Making a Difference' 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 Quality Objectives, and places a new Quality Board at the centre of these processes.

These are 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 underpin 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 also have robust processes in place across the Trust from Board 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 and this informs and drives decision making and retains our focus on delivering safe high quality care.

Our mortality rates and infection prevention metrics continue to be good. In the last two years we have also seen a continued reduction in the number of falls and pressure ulcers as a result of Trust wide initiatives such as 'React to Red' and safety huddles.

A number of innovations and developments by our teams, such as point of care patient testing for flu, the Sheffield Safer 10 Principles and the Safer Nursing Care Tool have also been shared wider across the NHS as good practice.

End of life care has been a particular focus across the Trust during 2017-18 and the development of a new strategy, guidance, care plans and training has been the result of genuine co-production and engagement across staff, patients and carers. We promote the culture that care of the dying is everyone's responsibility, and are providing the skills and tools to enable our staff to consistently and compassionately undertake this.

Personalised, responsive and timely care is also important to those patients who are being referred for care which is why we have continued to sustain a strong performance against the 18 week referral to treatment time standards with our national performance in the top quartile over the last two years. 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 improve efficiency of care. One particularly successful area has been across the Seamless Surgery programme which aims to create best practice and truly patient centred experience of elective surgery where the referral to recovery process for every patient is seamless.

As well as timeliness and efficiency of care, ensuring services take account of the particular needs and choices of different people is integral to our service improvement work. We are caring for an increasing number of patients with one or more long term conditions and in particular a significant number of people living with dementia. Dementia training is high on the agenda across our organisation for all levels of staff. Many wards have been upgraded using the design principles from the Kings Fund 'Enhancing the Healing Environment' guidance.

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

We have also signed up to 'Johns Campaign' offering carers passports for use outside of visiting hours and extended visiting hours to encourage relatives and carers to be involved in assessment and care planning.

Privacy and dignity of patients is inherent in everything we do and the importance we place on this was demonstrated in January 2018 when we refused to relax our zero tolerance stance on mixed sex accommodation despite the national standard being relaxed due to Winter pressures.

We also ensure that patient privacy and dignity and compassion and kindness are fundamental considerations in all developments including capital schemes, changes to practice, efficiency programmes, infection prevention and control considerations, training and education. It was therefore pleasing to note that in the most recent NHS national inpatient survey nine out of ten inpatients said they were treated with respect and dignity during their stay.

We have invested heavily in new facilities with the emphasis on design and care pathways which meet the personal needs of the patients being care for. For example at Weston Park we have embarked on an exciting multi million pound ward transformation programme which will include more single rooms for privacy and a dementia friendly environment.

A new Frailty Unit at the Northern General Hospital is enabling frail older patients to be assessed in an environment which has been designed specifically for their needs. The Unit has ambulatory assessment bays with recliner chairs rather than beds. This is easier for patients who are frail as they can stay in their own clothes. Other features include a dementia friendly design. The new unit is staffed by an integrated multi-disciplinary team who have received dedicated training to work together in a unique way to provide tailored assessment and treatment. The unit aims to enable patients to return home the same day wherever appropriate.

The last two years have seen some fantastic partnership work between health, social care and voluntary teams to make real differences to the lives of people living with physical or mental illnesses in our city. It is the beginning of a journey which has already started to prevent older people or those individuals living with long term conditions having to be admitted to hospital.

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. 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. The 'Why not Home, why not today' initiative focuses on expediting discharges and removing inpatient days which add no value.

A commitment to adopt and work with shared and trusted data has been fundamental to the early success of new ways of working across the transfer of care pathways. We are at the start of this journey but good progress was made during 2017 with a significant reduction in delayed transfers of care. There have been further challenges over the winter period which continue to be addressed by all the partners with a particular emphasis on the underlying causes.

On a system-wide level we are excited by the potential changes we can explore for health and social care as part of the South Yorkshire and Bassetlaw Integrated Care System (ICS). This new approach will outline how health and care services are planned by place or location, rather than around individual Trusts and care providers. The Sheffield Place Based Plan will be one of the ways we deliver the shared ambitions outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) at a local level.

Within the plan there are eight priority areas:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective care and diagnostics
- Maternity and children's services
- Cancer
- Non clinical support functions

Over the next few years we look forward to this increased collaboration fostering further quality improvements for our patients.

Further information about this and other developments during 2017-18 can also be found in the Annual Report and on our website: www.sth.nhs.uk/news.

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Of course none of these improvements are possible without the support of all 17,000 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 2017-18 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 Friends and Family Test for patients and staff gives 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 2018-19 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 continual improvement we will provide our patients with the safe, high quality care and experience they deserve.

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

Sir Andrew Cash OBE
Chief Executive

22 May 2018

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 2017-18

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

A new Quality Board oversees the production of the Quality Report. The membership includes Trust managers, clinicians, governors, and representatives from Healthwatch Sheffield and the local Voluntary and Community Sector. The remit of the Quality Board is to agree the content of the Quality Report along with the Trust's quality improvement priorities whilst ensuring it meets the regulatory standards set out by the Department of Health and NHS Improvement.

As a Trust, we have considered carefully which quality improvement priorities we should adopt for 2018-19. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with Trust governors and with representatives from NHS Sheffield Clinical Commissioning Group (CCG), Healthwatch Sheffield and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

In developing this year's Quality Report we have taken into account the comments and opinions of internal and external parties on the 2016-17 Report. The proposed quality improvement priorities for 2018-19 were agreed by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, on 26 February 2018 The final draft of the Quality Report was sent to external partner organisations for comments in April 2018 in readiness for the publishing deadline of the 31 May 2018.

Dr David Throssell
Medical Director

2.0 Priorities for Improvement

This section describes progress against the three priorities for improvement during 2017-18 and provides an update on progress in relation to improvement priorities from previous years. In addition, priorities for 2018-19 are outlined, along with an explanation of the process for their selection.

2.1 Priorities for improvement 2017-18

Priority

To further improve the safety and quality of care provided to our patients through initiatives such as the Patient Safety Zone and Safety Huddles.

Background

To build on the Trust's focus on patient safety within inpatient areas, a structured process to improve the transfer of time-critical patient information, Safety Huddles, continued to be implemented throughout the Trust to aid communication. Safety Huddles were initiated in healthcare by the Yorkshire and Humber Academic Health Sciences Network Improvement Academy. From initial testing in three pilot sites (Leeds, Scarborough and Barnsley), The Health Foundation funded a three year programme to roll out Safety Huddles on a wider scale across the region in a programme called 'Huddle Up for Safer Healthcare'.

Objective

To continue to roll out Safety Huddles, a meeting focused on reducing the risk of patient harm. The use of Safety Huddles is an opportunity to improve multidisciplinary team working, communication, and proactively managing risks to avoid incidents. Aim to have 30% of all inpatient areas using Safety Huddles by March 2018. Alongside this continue to roll out and embed the Patient Safety Zone across the Trust.

Achievements against objective

At the end of March 2018, a total of 29/75 (38.6%) inpatient teams had introduced Safety Huddles. A further 25 inpatient teams have expressed an interest in starting Safety Huddles in 2018.

In addition to inpatient areas, Portering Services held their first huddle on 27 February and invited Infection Control to discuss personal protective equipment. The Radiology Team at the Northern General site started huddles during summer 2017 and have seen a reduction in the number of reported incidents. There has also been interest from Charles Clifford Dental Hospital who aim to implement changes to prevent sharps injuries.

Many of these teams have achieved a stepped reduction in the number of patient falls since introducing Safety Huddles and are having longer periods of time between new pressure ulcers. All of these successes have been shared on Twitter and Facebook and staff engagement in safety is increasing.

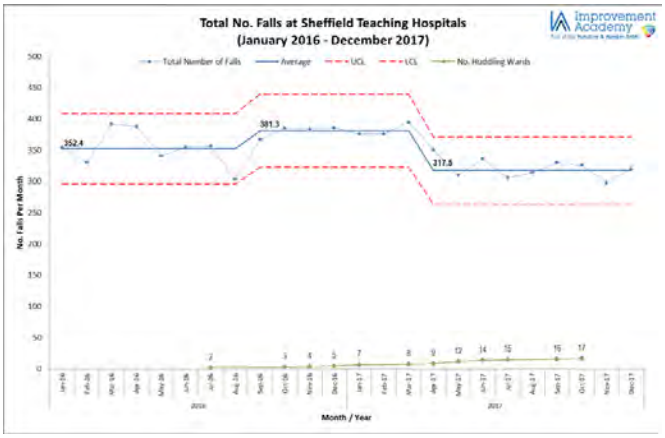
Over the last two years (January 2016 – December 2017), the number of falls across the Trust has reduced from 352.4 per month to 317.5 per month, an overall reduction of 10%. This means that a total of 315 falls were avoided (Chart one). NHS Improvement has calculated the cost of a fall (based on 'no/low harm') at £2,600. Based on the assumption that all 315 avoided falls were 'no/low harm', the cost saving to the Trust to date is around £819,000. The cost saving may be significantly higher however, as during this time period, 26% of falls in the Trust were categorised as 'moderate harm or above'. As at January 2018 when this analysis was completed, a total of 17 inpatient areas were focusing on reducing falls. As this number increases, we would expect the number of falls to continue decreasing.

Most areas have undertaken a Teamwork and Safety Climate Survey and these will be completed again to identify any improvements in teamwork and safety culture since the commencement of Safety Huddles.

The NHS Improvement 90 day Falls Improvement Collaborative recognised the work within the Trust as 'The Initiative that is most easily transferred between organisations'. The development of this intervention is also being shared with other external partners including providers of intermediate care beds, with an aim of reducing readmissions.

Work is ongoing to increase the number of Safety Huddles across the Trust, with a trial to be developed for virtual huddles to be introduced in the community setting.

Chart One



This work is now becoming embedded into practice. To support this Safety Huddle Coaches are now established in Medicines and Pharmacy Services (MAPS) and in South Yorkshire Regional Services (SYRS).

Work is underway within Hearing Services to embed the Patient Safety Zone (PSZ). The PSZ is now embedded in all areas that have received Physiological Services accreditation across the Trust. These are:

- Neurophysiology
- Gastrointestinal Physiology
- Audiological Science

On ward areas, the principles of the PSZ are being incorporated into structured processes for effective ward rounds. This includes staff introducing themselves and confirming the patient's identity. This approach continues to be piloted in two areas as part of the 10 Safer Sheffield Principles.

Priority

To further improve End of Life Care

Background

There has been a significant change in the way end of life care is delivered in hospitals. Nationally this has included the removal of the Liverpool Care Pathway (2014) and locally the Sheffield End of Life Care Pathway, in line with Department of Health policy following the Neuberger Review (More Care, Less Pathway).

Local guidance focusing on looking after patients who may die in the next few hours or days of life was implemented in October 2015 and subsequently evaluated through a notes audit across three wards. The purpose of the audit was to assess the impact of the new guidance on documentation around the Five Priorities of Care for end of life care for Trust patients. The evaluation examined documentation pre and post guidance implementation.

Although the audit did show a small number of improvements, it was concluded that overall there were no significant changes after the guidance was introduced.

Following the CQC inspection in December 2015, the Trust received 'Requires Improvement' for End of Life Care at the Royal Hallamshire, Northern General and Weston Park Hospitals. End of Life Care in the Community received a rating of 'Good'.

The following actions were identified for the Trust by CQC:

- The Trust must ensure there is a clear strategy for end of life care, which is implemented and monitored.
- The Trust must ensure that staff implement individualised, evidence based care for patients at the end of life.
- The Trust must ensure that DNACPR records are fully completed.
- The Trust should develop a system for monitoring whether patients died in their preferred place of care.
- The Trust should monitor preferred place of care for patients at the end of life.

Objectives

To develop an implementation plan, with staff, to operationalise the End of Life Care Strategy across the Trust. To have the implementation plan rolled out by March 2019.

Achievements against objectives

During March and April 2017 staff were consulted on the End of Life Care Strategy and from this an implementation plan for how this strategy would be operationalised in the Trust was developed. The clinical leads are now leading on the roll out of the implementation plan supported by the End of Life Care Project Working Group. The key objective was to implement all five work streams of the implementation plan. The five workstreams are;

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

The following progress has been made across the five workstreams.

The core nursing care plan in Lorenzo (with section 12 for End of Life Care) continues to be rolled out across the Trust, the plan includes recording of preferred place of care and death. The use of section 12 of this plan is being monitored by the project team. Accompanying support and information to encourage its use has been developed in conjunction with nursing staff. Roll out commenced in June 2017 and is planned to complete at the end of August 2018.

The guidance review has concluded and new 'guidance for the care of the person who may be in the last hours to days of life' was launched in December 2017. The new 'Individualised Care Plan for the last days of life' has been developed and approved. This is currently being piloted on three wards and will then be rolled out across the Trust once an evaluation has taken place and any changes from the pilot have been made.

The new End of Life Care intranet page is currently being developed and will be launched in early 2018. This will act as a central hub for staff to access all relevant End of Life Care information. An End of Life Care education and training subgroup has been set up to review and move forward with aspects of education and training to support the implementation of these new resources.

An end of life care survey was run for 12 months from May 2016 in order to seek feedback from bereaved family and carers in relation to the care of their loved one during the last days and hours of their life. The results of the survey have been reviewed and key themes for improvement have been established.

The key themes are:

- care received.
- the environment.
- communication.
- pain control.

There were also many positive comments in these areas as well.

These results and themes will be used as a baseline against which we can compare the results of future surveys to identify if improvements have been made

Work to improve End of Life Care will continue during 2018-19. Details of the objective for 2018-19 can be found on page 89.

Priority

Introduce Electronic Care Planning across the Trust to improve the quality of care planning.

Background

In 2015-16 it was identified by Nurse Directors and the CQC that care planning across the Trust does not always fully reflect the individual needs of patients. To improve this, an extensive scoping and consultation exercise was undertaken to develop a way forward for care planning in the Trust. Feedback from the consultation overwhelmingly pointed towards a return to a well-established nursing model of care planning. This is aimed to improve individual care plans, sharing of information and interaction with patients/carers.

An electronic version of this model has been built in the Trust electronic patient record, Lorenzo and debated at various forums for approval. This was then piloted on three wards for a six-week period from the week commencing 31 October 2016, on wards E1/2, RHH and Firth 9, NGH.

The Department of Health defines care planning as:

"…a process which offers people active involvement in deciding, agreeing and owning how their condition will be managed. It is underpinned by the principles of patient-centeredness and partnership working. It is an on-going process of two-way communication, negotiation and joint decision-making in which both the person and the health care professionals make an equal contribution to the consultation."

The intended outcomes of the care planning pilot were:

- To have fully individualised care plans for patients.
- To improve the quality of documentation.
- To enable evaluation of the care to be done at the bedside in collaboration with the patients (using laptops on wheels).
- To facilitate contemporaneous documentation using laptops on wheels.

Following agreement with the Chief Nurse and Nurse Directors, the model was approved to roll out Trust-wide.

Objective

To roll out previously agreed e-care planning model using Lorenzo as a platform to all 72 wards at STH. Providing bespoke e-care plans as required for different specialities.

Achievements against objective

E-care planning is currently rolled out to 47 wards. The project is scheduled to finish at the end August 2018.

Initially there were some concerns regarding hardware and connectivity, however these have been resolved through partnership working with key IT colleagues.

Staff views and feedback have been used throughout the development process for example; the format of the care plan has changed in response to staff feedback. It now appears as a "one pager" scrollable document which has reduced the amount of clicks required to evaluate the care plan. A "Lorenzo extension" has been introduced, this enables staff to see the entire evaluated care plan at a single click of a button from Lorenzo.

The project has developed numerous bespoke care plans for different specialties, including cardio-thoracic, PVDU,

lines and access devices, diabetes, delirium, vascular, advanced respiratory care, post-operative surgery, drug and alcohol abuse.

Throughout the project a number of incidental achievements have been achieved, including the standardisation of the content and completion of the discharge checklist.

The care plan now prompts staff to ask for the passports for patients with Learning Disability passports, which meets the requirements of the accessible information standard about communication needs of patients. It has also provided the opportunity for several specialities to review any existing care plans and bring them up to date with current requirements. As a result, any paper care plans have been transposed into Lorenzo.

Work is currently underway with the Nurse Directors on amendments to the Nursing Contact Assessment admission documentation to mandate certain fields such as Next of Kin. The Deputy Nurse Directors and Tissue Viability colleagues are working to undertake a Trust-wide review of pressure ulcer documentation in line with NHS Improvement requirements.

The project is on track to be completed by June 2018. Progress of this project will continue to be monitored by the Nursing Executive Group.

2.2 Update On Progress Against Previous Priorities For Improvement

Priority

To improve how complaints are managed and learned from.

There have been key changes in the management and structure of the Patient Partnership Department during the past year. The Complaints and Patient Services teams now sit managerially within the Patient and Healthcare Governance Department and within the Medical Director Directorate, providing the opportunity to more closely align complaints, incidents and inquests/claims. A new Complaints Manager was appointed in January 2018.

A number of further quality initiatives have been implemented over the past 12 months as follows:

Medicine and Pharmacy Services (MAPS) and Acute and Emergency Medicine (AEM) transferred the coordination of complaints to the central complaints team during 2017-18. This has been a positive move, with response times to complaints improving significantly as a result.

The revised tiered response time targets continue to provide a framework and benchmark, with the target remaining as responding to 85% complaints within the agreed timescale. The performance this year (April 2017 to February 2018) was 93%, achieving the target (85%) for the third consecutive year.

The Concerns and Complaints Policy was reviewed and updated in late 2017. This will be supported by easy to follow flow charts summarising the complaints process, which will be produced during 2018.

The complainant satisfaction survey continues to be undertaken with surveys being sent to complainants, by either post or email, three weeks after the response to their complaint.

Between April and December 2017, 177 complainants responded to the survey, a response rate of 24%. The highest scoring area was in relation to how easy the responses were to understand. The lowest scoring area was in relation to complainants having confidence that improvements had been made as a result of their complaint. Work is underway to address this issue through improving the robustness of action plans Trust-wide, including within complaints.

In addition to the survey, a sample of complainants who chose to provide their contact details through the survey are interviewed either by telephone or face to face. Additionally, the associated complaint files are audited against the outcome of the survey, with interviews and audits then being analysed and compared. There will be a review of the complainant satisfaction survey during 2018 in order to ensure robust and meaningful information is obtained.

A comprehensive programme of complaints training has been running since September 2015. The training is underpinned by an ethos of welcoming and acting on feedback. During 2017-18, 45 training sessions have been held, attended by 670 staff across three different sessions, Complaints are Like Medicine, Investigation Skills and Getting it Write. 526 staff provided evaluations of the training, with over 98% stating that they would be extremely likely or likely to recommend the training.

The programme is planned to undergo a review in 2018. The Patient Experience Committee will continue to oversee the programme of work.

Priority

To improve staff engagement by using the tools and principles of Listening into Action (LIA).

2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

Background

LIA was introduced in the Trust in the Autumn of 2014 as way of introducing changes that will make a positive impact for patients and for staff through high engagement strategies.

Since the launch there have been 85 schemes delivered by 52 teams. In 2017 we had 43 schemes in eight clinical directorates, five schemes with Trust-wide reach and six corporate schemes. 20 LIA schemes were focussed directly on improving patient experience, 23 of which focussed on improvements for patients through high engagement practices. Some of these were comprehensive programmes of work spanning a minimum of 12 months and a wider Organisational Development approach and therefore feature in more than one phase. The schemes progressed in 2017 are detailed in table one.

Table One

Phase 4	
Frontline	
Developing a Protected Clinical Assessment Area for Vascular Ambulatory Care	Improving Patient Choice for Pain Management for Minor Procedures in Obstetrics & Gynaecology
Creating a Safe, Efficient and Timely Cardiac Surgery Pathway & Positive Patient Experience	Patient Safety Zone – Developing Safer Medicines Management in Critical Care
Introducing a Pelvic Pain Pathway in Obstetrics & Gynaecology	Improving Patient Experience and Reducing Waiting Time Prior to Induction of Labour
Collaboration Between Front Door Response Team & Active Recovery to Support Winter Pressures	Review of Working Practices to Allow More Time for Patient Care Over a 7 Day Week in Therapy Services
Review of Clinical Operations & Discharge Process	
Enabling Our People	
Reducing the Backlog in Clinical Coding at Month End	Diversity: Networking for disabled and BME staff
Improving Staff Engagement in Informatics	Staff Engagement: Improving the Junior Doctor Experience
Improving ENT Medical Engagement	Improving Staff Engagement in Vascular Services
Shared Care Planning in Spinal Injuries	Improving Health & Wellbeing in Operating Services, Critical Care & Anaesthesia
Improving Team Working in Charles Clifford Dental Hospital	Improving Team Working in Laboratory Medicine
Perfecting Physiotherapy Placements for Physiotherapy Students and Clinical Educators	

2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

Phase 5	
Frontline	
Reconciling the Needs of Patients, Relatives and Staff in Critical Care	Introducing Family Centred Care in Neonatology
Improving the Pathway for Women Having Planned Caesarean Sections	Improving the Continuity of Care for Women Antenatally and Postnatally
Improving Patient Preparation for Oesophageal and Gastric Surgery	Development of a Therapy Instructor Role in Medicine
Implementation of Virtual Yearly Follow Up of Primary Hip Replacements	Improving Patient Choice for Pain Management for Minor Procedures in Obstetrics & Gynaecology
Collaboration Between Front Door Response Team & Active Recovery to Support Winter Pressures	
Enabling Our People	
Improving Staff Engagement in Operating Services, Critical Care & Anaesthesia	Improving Staff Engagement in Informatics
Improving the Junior Doctor Experience	Improving Staff Experience and Use of Lorenzo Across STH
Improving Health & Wellbeing in Operating Services, Critical Care & Anaesthesia	Improving Communication in Charles Clifford Dental Hospital
Perfecting Physiotherapy Placements for Physiotherapy Students and Clinical Educators	Embedding Governance into Day-to-Day Culture of Obstetrics, Gynaecology and Neonatology
Reducing the Backlog in Clinical Coding at Month End	
Phase 6	
Frontline	
Reconciling the Needs of Patients, Relatives and Staff in Critical Care	Improving the Process of Discharge from Transitional Care in the Neonatal Unit
Delivering an Effective Handover for the Labour Ward Multi-disciplinary Team	Improving Attendance Rate at Charles Clifford Dental Hospital
Optimising Nutritional Status Following Hip Trauma Surgery on Vickers 4	Implementation of Virtual Yearly Follow Up of Primary Hip Replacements
Optimising Surgical Listing through a Visual Medium in Orthopaedics	
Enabling Our People	
Improving Staff Morale in ENT	Improving Staff Engagement in Informatics
Improving the Junior Doctor Experience	Improving Staff Experience with and Use of Lorenzo Across STH
Improving Staff Engagement in EPRS	

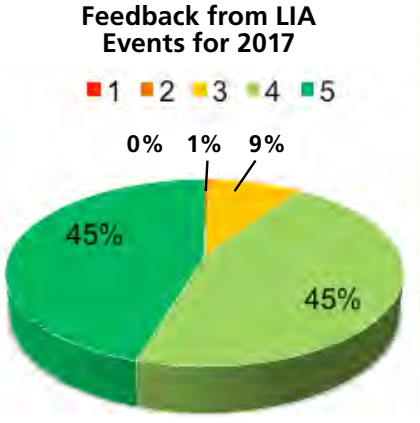
Measuring the difference

We can measure the impact of LIA in the following ways:

Outcomes: Each scheme develops targets and desired outcomes at the start and these are revisited at the end. Examples of outcomes includes:

- The Front Door Response Team & Active Recovery team have proven by a trial in A&E of Active Recovery intervention that there is a need for the service within A&E. This trial showed that the patient's length of stay can be reduced by one night with this support. As a result the team are looking for funding to secure this service on a permanent basis.
- The protocol for starving elective C-section patients has been revised as a result of an audit, which will mean that patients are able to drink freely prior to surgery rather than the lengthy time of starvation that was the case previously (often more than 12 hours).
- A re-audit has shown that Sheffield is meeting the national requirements, with an average of a woman seeing a maximum of two members of staff antenatally and three postnatally.
- Informatics Directorate have developed, with staff, a comprehensive staff experience plan and are implementing this. Staff involvement is now embedded in how the leadership team manage day to day business and changes that are planned have staff experience weaved in throughout.
- LIA was used to engage all staff in South Yorkshire Regional Services on Lorenzo and identify how we could make improvements could be made that would benefit patients and improve staff experience and usage. Changes have been made to the system, bespoke training provided and computers have been changed where needed to improve the speed.

Chart 2



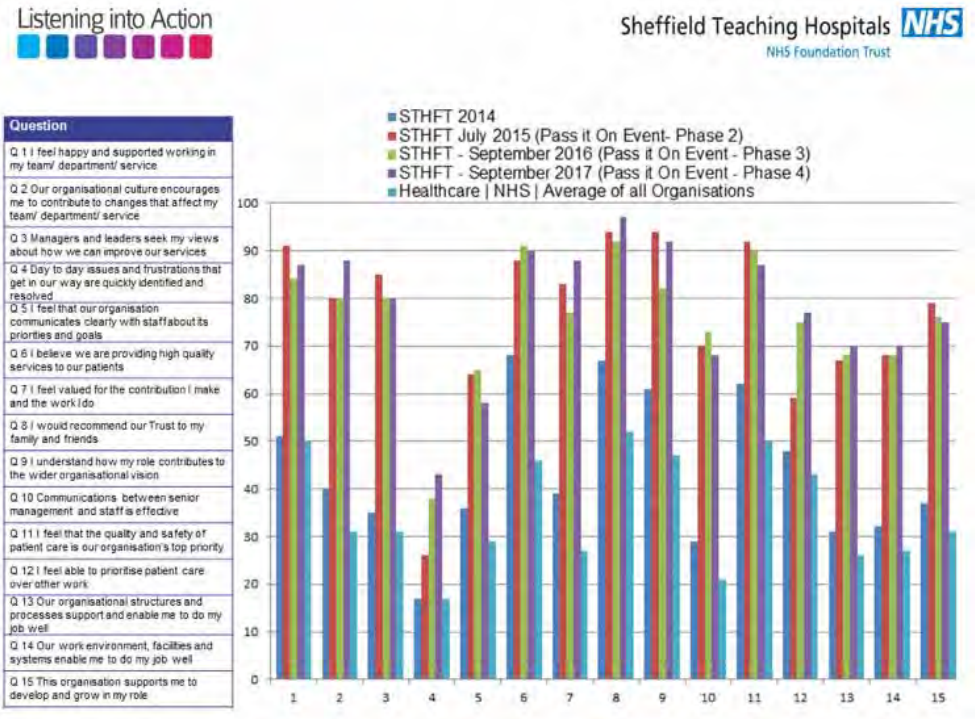
At every event staff are asked to provide feedback on how motivated the session has made them feel in connection with the LiA. Chart two shows accumulated data from teams who attended the launch, Compass Check and Pass It On Events since LIA's introduction. A total of 366 respondents, with 1,006 responses replied to the following three questions:

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

The impact of LIA is also being measured by a Pulse Check. This consists of 15 questions focussing on how staff feel they are engaged and supported to do their job, which link to the key areas of the staff survey. It is simple and quick to complete and administer. To date 478 people have completed a Pulse Check. Results in chart three show the scores benchmarked against the average score for all other trusts that have adopted LIA. The Trust has better results than any other organisation. This shows overwhelmingly that people who get involved in LIA feel better led, more involved, motivated and positive about their work and the Trust.

Work has already started on increasing the evaluation of scheme outcomes with the aim of taking these into other areas as appropriate.

Chart 3



2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

Priority

In July 2014 the Trust committed to a three year 'Sign up to Safety' campaign. The Trust's overall aim was to further improve the reliability and responsiveness of care given to patients, which in turn aims to achieve a 50% reduction in harm.

Progress against the five goals which underpin the campaign is outlined below:

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

The Trust has introduced bespoke training packages in Human Factors, providing staff with the skills to undertake simulation exercises and to improve the investigation of and learning from serious incidents. During 2017-18 there have been two training days including a bespoke session for Executive Directors and senior colleagues.

Training has also been ongoing to promote Human Factors awareness across the Trust with information being provided through nurse education, F1 'away days', Acute Care of the Medical Emergency course and presentations at medical governance meetings to enable all staff to understand the implications of Human Factors for practice.

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

An audit of patients' pre-cardiac arrest SHEWS was undertaken. This provides assurance that the Management of the Deteriorating Patient Policy is being adhered to. The audit ensures that where any learning is identified this is discussed with local governance teams and reviewed through local governance processes. The Trust has also developed a plan for the introduction of a Track and Trigger system which will provide early alerts when patients start to deteriorate. This is an objective for 2018-19. Details can be found on page 97.

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

Care bundles for Red Flag Sepsis and AKI have continued to be rolled out and developed throughout 2017-18 and a joint education package for newly qualified nurses has been developed which links the management of sepsis, AKI and the deteriorating patient into one teaching session. The sepsis tool has been implemented in all areas and 80 champions have been trained to undertake the train the trainers role.

The AKI team have been continuing with delivering education across the Trust and have been piloting a revised fluid balance chart prior to evaluation and launch across the Trust. A small number of wards have also been trialling the use of weighing scales to accurately measure fluid output for incontinent patients.

Sepsis and AKI are now standalone objectives for 2018-19. Details of the sepsis objective can be found on page 96. Details of the AKI objective can be found on page 98

Absolute reduction in the cardiac arrest rate

The Trust continues to maintain a reduction in the cardiac arrest rate. Audits following every cardiac arrest have provided the Trust with quality data, which is submitted to the National Cardiac Arrest Database . Following a review of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms further work has commenced and is being evaluated into the use of a treatment options form to be used alongside the DNACPR form. The purpose of this form is to establish the most appropriate care for the patient and to ensure that plans are fully communicated to the patient, their family or carer, and other staff.

Improved communication in the introduction of structured processes to improve the transfer of patient information.

This was embedded into the 2017-18 objective to further improve the safety and quality of care provided to our patients through initiatives such as the Safety Huddles. Details can be found on page 74.

Priority

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

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

In July 2015, the Trust introduced a mix of tent boards and wall mounted boards at patients' bedside which captures each patient's named nurse and consultant. The type of board used was dependent on the different locations and patients' needs. Between October and December 2016 a Trust wide evaluation of the use of the boards commenced. A total of 140 staff and 140 patients took part in the evaluation. The results showed that the majority of staff and patients across the Trust were completing the tent boards. The Nurse Executive Group have determined that the tent boards/whiteboards at the back of beds should continue to be used as an aide to good communication practice and identification of the consultant and nurse responsible for care.

Following the evaluation, education packs have been produced and circulated to educators through the Nurse Directors. These, along with posters, have been used to re-launch/promote the use of the tent boards within their care groups. The evaluation found that there were issues with the availability of pens to complete the tent boards. In order to improve this, the order codes for pens have been re-circulated. Ward Managers now ensure that pens are on regular order and are readily available.

All the actions following the evaluation have been completed and will be monitored going forward. As such, this will now be routine practice and will no longer be reported in the Quality Report.

Priority

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

The Trust has continued to review mortality by day of the week during 2017-18. Findings show that our Hospital Standardised Mortality Ratio for all admissions (and for non-elective admissions only) for each day of the week, including Saturdays and Sundays, is 'as expected' when compared to the national average.

The Trust continues to be involved in the national High-Intensity Specialist-Led Acute Care (HiSLAC) project. This HiSLAC project is a three year rolling programme and the Trust has an active role in the research with the Principle Investigator residing within the Medical Director's office. The initial output from this work has yet to be published but it suggests that there is no material effect on mortality from differential staffing by consultants at the weekends.

To ensure, as a Trust, we learn from all deaths we have been implementing the National Quality Board guidance on Learning from Deaths during 2017-18, full details can be found on page 108.

Priority

Cancelled Operations

On day cancellations of elective surgical procedures can create problems for patients and staff. When an avoidable cancellation occurs, this can often lead to delays to patient treatment, and extensive re-work for administrative and clinical staff to prepare the patient for surgery again.

The on-day cancellation rate for elective surgery has reduced during 2017-18 to around 5.7%, from over 6% in the past two years, which is a significant improvement and represents a full year reduction of around 300 avoidable on-day cancellations. This improvement has resulted from coordinated and targeted efforts in multiple directorates, through the Seamless Surgery Improvement Programme, to identify and address the root causes of on day cancellations.

Examples of work that has taken place to enable this improvement are as follows:

- An expansion of reminder calls for patients at four days prior to surgery to ensure they are fit, ready, willing and able to attend as planned.
- Improved planning and scheduling processes in directorates to ensure appropriate equipment and staffing can be planned well in advance to reduce potential on day problems.
- Development and implementation of a Standard Operating Procedure for elective scheduling, to enable better communication with patients and clinical teams, reducing the chances of list and patient cancellations .
- Rigorous implementation of a Policy for Management of On-Day Cancellations, which when followed, ensures all steps are taken to avoid an on day cancellation.
- Introduction of new guidelines for high blood pressure in Ophthalmology, meaning patients who may previously have been cancelled on the day are now having their procedure as planned.

During 2017-18 the main reasons for patients being cancelled on the day of surgery have been as follows:

- Patient unfit – For example patients arriving with an infection, or having results of standard tests outside of the expected ranges (e .g . high blood pressure) .
- Patient did not attend - The patient did not arrive for the scheduled procedure.
- Operation not required - Symptoms that have improved or disappeared or the patient may have changed their mind about having the surgery.
- Lack of theatre time - Previous patients on the list taking longer than expected; changes to the order of a list resulting in (or as a result of) delays .

These reasons account for around 70% of all on-day cancellations so work continues to be undertaken to address these challenges to ensure that elective operations go ahead as planned wherever possible. The Seamless Surgery Programme is about creating a best practice elective pathway where the referral to recovery process is right first time and work is taking place in all surgical directorates to address the principles of seamless surgery. As we move into 2018-19 work will continue to focus on reducing the on-day cancellation rate further and this will be overseen by the Seamless Surgery Board,

chaired by the Medical Director. Examples of additional planned improvements to help a further reduction in cancellations are as follows:

- Text message reminders to patients seven days prior to elective surgery reminding of the date, time, location and the cost to the NHS of not attending for surgery.
- Further improvements to advance theatre list planning in all specialties.
- Full adherence to the Management of On-Day Cancellations Policy in all cases.
- Standardisation and spread of the weekly root cause analysis at directorate level.
- Collate the outcomes from the directorate analysis centrally, to support organisational learning and improved processes.

The challenge of reducing the volume of on-day cancellations is critical to providing the best elective surgical pathway, so the focus will continue to remain on this during the next year. This work will be overseen by the Seamless Surgery Board and will no longer be reported in the Quality Report.

Priority

Pressure Ulcer Prevention

Monthly survey data for the period	2015-16 Oct 15-Mar 16	2016-17 Oct 16-Mar 17	2017-18 Oct 17-Mar 18
Proportion with pressure ulcers acquired whilst receiving care from the Trust	1.81%	1 .57%	1.78%
Proportion with pressure ulcers prior to receiving care from the Trust (Inherited)	5.03%	4.38%	4.39%
Overall proportion	6.84%	5 .94%	6.17%

As shown in table two the overall proportion of pressure ulcers has increased to 6.17% during 2017-18. Previously, work reporting on pressure ulcers has been focused on using the data obtained through the Safety Thermometer. The Safety Thermometer data are collected on a single day in the month and then validated prior to uploading to the national system. For 2018-19 onwards STHFT plan to use actual numbers of reported pressure ulcers by grade in order to more accurately reflect the pressure ulcer numbers being reported. These data will be reported via the nursing and midwifery quality dashboard. An ambitious plan for improvement has been set for 2018/19.

During 2017 the Trust Executive Group (TEG) formally approved the integration of the acute and community tissue viability teams. Both teams have worked collaboratively over the course of the year and have been proactive in implementing strategies to reduce the incidence of acquired pressure damage through a number of different initiatives. This work has also considered improved outcomes of existing pressure ulcers. It is anticipated the integration of the acute and community tissue viability teams, planned for completion in April 2018, will positively influence the pressure ulcer preventative work further.

Following the community pressure ulcer prevention audit in 2016 several areas of concern were identified and an action plan was developed. The aim of this was increasing the number of risk assessments completed at first visit, increasing the number of risk assessments reviewed, updating and improving the pressure ulcer prevention care plan and increasing the number of patients receiving a Malnutrition Screening Tool (MUST) assessment. All of these actions have now been implemented. A re-audit was undertaken in November/ December 2017, the results are currently being analysed and an improvement plan will be developed if required.

The community are currently engaged in the wound care CQUIN and this has resulted in an audit of the completion of the wound template and use of photography in wound care on SystmOne. Actions arising from this audit have already been implemented and a further audit is planned for March 2018.

Due to the increasing demand for pressure relieving equipment in the community, an audit was undertaken to ensure that clinicians are requesting individual items from the British Red Cross in line with current clinical guidelines. The audit provided the required assurances that requesting is appropriate and changes have been implemented when required.

The Trust was successful in joining the NHS Improvement pressure ulcer collaborative, launched in October 2017.

2.2 UPDATE ON PROGRESS AGAINST PREVIOUS PRIORITIES FOR IMPROVEMENT

This collaborative focuses on 'Stop the Pressure' initiatives to reduce patient harm in the acute setting. The focus is on using quality improvement methods and knowledge to develop pressure ulcer prevention strategies across the multi professional team. The strategies developed include using a Nightingale style handover (this is a project to improve consistency and standardised approaches to delivery of care), body mapping and bedside education. The number of pressure ulcer free days since starting the initiative is recorded daily on both wards and the final session with NHS Improvement is due to take place in April 2018. So far the results have been promising and the learning from this initiative will be communicated Trust wide at the 2018 Sharing Good Practice Festival.

Across the Trust wards are implementing and embedding Safety Huddles with the support of the Improvement Academy framework, a proportion are focussing on pressure ulcer prevention. The Safety Huddles, led by clinicians and with a multidisciplinary focus, support the team to identify those patients most at risk of developing a pressure ulcer and a plan for prevention.

The Tissue Viability Team have delivered bi-monthly study days for Health Care Assistants and Registered Nurses that focused on pressure ulcer prevention and management, with over 140 staff attending these days since April 2017. The Acute Team also provide teaching sessions on pressure ulcer prevention and management to all new Registered Nurses, Healthcare Assistants undertaking the 'Prepare to Care' course, Medical Students, Apprentices, Therapy Assistants and Operating Department Practitioners. Educational projects have also been developed including 1:1 ward based 'Tissue Viability Champion' training (piloted and evaluated), bed and mattress champion training and a moisture versus pressure damage educational tool used by ward staff.

In community further roll out of the 'React to Red' training programme, which is a pressure ulcer prevention training initiative, has been delivered to community nursing, intermediate care, active recovery, stroke services and therapy mental health services. By October 2017, 578 staff members had accessed and undertaken the React to Red e-learning programme, which is currently being evaluated using a post training and implementation to practice questionnaire.

Following the success of the 'React to Red' implementation in community settings, there are plans to roll out to home care providers in Sheffield community and also across the acute hospital sites. The e-learning package has now been adapted for use in the acute setting. It is hoped that the e-learning package will also be available as a phone application in the near future.

During the past year the Tissue Viability Team has been involved in the Total Bed Management Project. This has incorporated an in-depth review of beds, specialist beds and foam mattresses, to ensure clinical and cost effective products only are included in the tender. Off-loading heel devices have also been trialled. Two city wide joint study days have been held during 2017-18, covering aspects of pressure ulcer prevention. The Trust also held a 'Stop the Pressure' day to coincide with the national programme.

Electronic care records are being rolled out across the acute site. A workshop was held in February 2018 to fully review the current documentation in use and a plan is being developed to ensure that the documentation in use focuses on pressure ulcer prevention. The Tissue Viability Team has worked with the technology team to develop an electronic referral system, so that ward staff can refer appropriate patients into the service. This has improved documentation and communication.

A triage protocol, which is awaiting implementation, has been developed to ensure patients are prioritised effectively. Electronic records for nursing staff relating to wound assessment and care planning for pressure ulcer prevention are being developed. The wound template has been refined to meet the national minimum data set for wound assessment and created so information can be collected electronically to inform practice and allow some consideration of wound healing rates and outcomes.

The Tissue Viability team have also been involved in working with the Nursing and Midwifery Quality Dashboard group and pressure ulcers are a key indicator included in this work. This continues to be a priority for the Trust for 2018-19. Details of the priority for 2018-19 are outlined on page 95.

Priority

Optimise Length of Stay

The Trust has been continuing to develop its arrangements to optimise patient flow and reduce length of stay. The strategic direction for this work is provided by the Excellent Emergency Care workstream, part of the Trust Transformation Programme, 'Making it Better'. Work during 2017-18 has included:

Development of the Sheffield SAFER Flow 10 principles based on national best practice and local learning from wards at STHFT. The underlying principles of this work are informed by the NHS England guidance Safer, Faster, Better: good practice in delivering urgent and emergency care. The aim of these principles is to ensure that all patients have a plan and they receive the care they need

in a timely way. 'Give It A Go Week' this year (June 2017) was all about launching the Sheffield SAFER Flow 10 principles across the Trust and creating a momentum for improvement.

Learning from 'Give It a Go Week' and established improvement work with a number of wards is that the Board Round is the most important phase of good discharge planning. 70% of base wards currently have a daily board round. Service Improvement will be working with directorates and wards teams to help them agree plans to ensure all patients receive a senior review and plan every day on all wards and that these board rounds meet a local gold standard.

The Trust is a partner in the Sheffield Delayed Transfer of Care Programme (why not home, why not today?), aiming to enable more people to leave hospital immediately on the day that they no longer need hospital treatment and enable a greater proportion of people to be able to return safely to their own home. Routes out of hospital have been simplified to three main routes and four wards are involved in piloting these along with earlier discharge planning. A ward metrics dashboard has been created with the Trust's Information Services Department to enable the impact of these changes to be assessed.

2.3 Priorities for Improvement 2018-19

The priorities for improvement 2018-19 have been agreed by the Quality Board in conjunction with patients, clinicians, governors and Healthwatch Sheffield. These were approved by the Healthcare Governance Committee, on behalf of the Trust's Board of Directors, in February 2018.

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

A total of 13 priorities for improvement, these span the domains of patient safety, clinical effectiveness and patient experience. The priorities for improvement 2018-19 are as follows:

Safety:

- Reduce inpatient falls during 2018-19 by 10%.
- Develop a human factors plan which will have practical application and lead to tangible improvements in safety culture.
- Demonstrate a 30% improvement in the early recognition and management of sepsis within the Trust.
- Ensure a Trust wide reduction by 10% of all avoidable patient harm associated with pressure ulcer prevention and management.
- Improve recognition and timely management of deteriorating patients leading to improved care- Implement an electronic system for tracking patients' observations.
- Reduce preventable Acute Kidney Injuries (AKIs) across the Trust (three year plan).

Patient Experience:

- Implement and evaluate at least one major co-production project and develop a plan for embedding this approach more widely.
- Ensure that End of Life Care is individualised and meets the needs of both patients and those who are important to them.
- Ensure out-patient and in-patient letters are fit for purpose, are clear and understandable, and meet the needs of both patients and national good practice guidelines.
- Significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard. These people are often those who need our services most but with whom we engage the least.
- Increase the availability of high quality refreshment facilities in outpatients including hot drinks.

Effectiveness:

- Improve the process and quality of consenting with a focus on ensuring patients are provided with individualised information.
- Ensure that the Sheffield Teaching Hospitals Procedure Safety Checklist is embedded into practice, aiming to reduce errors and adverse events, and increase teamwork and communication.

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve consenting

Improvement Goal: Improve the process and quality of consenting with a focus on ensuring patients are provided with individualised information

Quality Domain	Effectiveness
Senior Lead	Associate Medical Director, Safety
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Two years

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Contact each Care Group to confirm which procedures and treatment require written consent. In addition identify which procedures and treatments requiring written consent are appropriate for delegated consent. • 40% of specialities will engage in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to develop the combined procedural/ treatment specific patient information leaflet and consent form. • Review existing Trust written consent forms.	• Work with Medical Education to map delegated consent education and training package currently available or identifying any packages that need updating or developing. • 60% of specialities will engage in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to review and approve the combined procedural/treatment specific patient information leaflet and consent form. • Consult with Trust solicitor and clinicians on proposed revisions to the existing Trust written consent forms.	• Update and develop delegated consent education and training packages. • 80% of specialities will engage in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to implement the combined procedural/treatment specific patient information leaflet and consent form. • Trust to approve final version the revised Trust written consent forms.	• Re-launch the delegated consent process and education and training packages. • All specialities engaged in monitoring compliance and effectiveness with the STH Consent to Examinations and Treatment Policy. • Pilot sites to audit the combined procedural/ treatment specific patient information leaflet and consent form. • Re-launch revised Trust written consent forms.

Outcome Measures

- Increase compliance rates in the consenting process.
- 100% of Clinical Directorates are engaged with the Clinical Effectiveness Unit to develop/implement processes to undertake the Trustwide Consent Audit.
- 100% of pilot sites have embedded the new combined patient information leaflet / procedure specific consent form.

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduce errors and adverse events in interventional procedures

Improvement goal: Ensure that the Sheffield Teaching Hospitals Procedure Safety Checklist is embedded into practice aiming to reduce errors and adverse events, and increase teamwork and communication

Quality Domain	Effectiveness
Senior Lead	Associate Medical Director, Safety
Operational Lead	Nurse Director
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Review and update STH Safer Procedure Policy including standardisation of the Procedure Safety Checklist and audit tool. • Develop local induction programme for relevant new starters that participate in defined invasive procedures including competency development. • Upload on PALMS an online learning programme for the WHO Safer Surgery Checklist for all relevant staff to demonstrate an understanding of and compliance with the 5 steps to safer surgery/ procedure according to the World Health Organisation's (WHO) guidelines, procedural checklists and supporting documentation.	• Ratify and issue STH Safer Procedure Policy. • Implement local induction programme for relevant new starters including issue of competency to staff. • Ensure that the PALMS online learning programme is built into job specific training.	• All relevant areas engage in monitoring compliance and effectiveness with the STH Safer Procedure Policy. • Monitor compliance of local induction programme for new starters. • Monitor the compliance of completing the PALMS online learning programme.	• All relevant areas implement local action plans. • Evaluate local induction programme and competency for new starters. • Review and act upon levels of compliance with completing the PALMS online learning programme.

Outcome Measures

- Increase compliance in the procedural safety checklist audit across all areas.
- Reduce the number of errors and adverse events reflected in the incident data on Datix
- Reduce the level of risk associated with the audit outcomes as registered on Datix
- Access PALMS online learning programme to monitor compliance of staff completion of packages

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve working in partnership with our patients, their families and carers towards shared goals.

Improvement Goal: We will build on our experience of co-production, working in partnership with our patients, their families and carers towards shared goals. We will implement and evaluate at least one major co-production project and will develop a plan for embedding this approach more widely. We will use NHS England's recognised 'Always Event' methodology to support co-production work.

Quality Domain	Patient Experience
Senior Lead	Head of Patient and Healthcare Governance
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Two years

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Planning • Identify an oversight committee (PEC) • Select a pilot unit (Spinal Injuries) • Identify staff to be part of the Always Event • Identify possible opportunities for improvement • Create over-arching plan including schedule of meetings and timeline of key actions to ensure project delivery • Establish ground rules to ensure patients are equal partners throughout the process • Plan 'kick start' event involving patients and staff	Co-design • Hold 'kick start' event to help understand what matters most to patients. From this event, identify patients who want to be involved on an ongoing basis. • Convene working group to include patients and staff • Identify priorities for change • Collaborate with staff, patients family members and carers to co-design a meaningful improvement • Develop an Aim Statement • Define how the improvement will address what matters to patients • Ensure the improvement meets the four criteria outlined in the NHS England Always Event tool kit which are: Important, Evidence-based, Measurable, and Affordable and Sustainable	Implementation • Implement improvement • Define measures (key indicators) to demonstrate improvement • Observe and redesign processes as needed, to increase reliability • Create a system to ensure improvement happens for every patient, every time • Ensure systems are sustainable	Evaluate • Use measures and assess progress/ success • Create summary of the Always Event methodology • Measure experience of involvement with the Always Event (patients and staff) • Measure experience following changes to service (patients and staff)

Outcome Measures Year 1

- Completed and evaluated an Always Event in selected areas
- Positive experience following changes made to service (patient and staff)
- Increased patient and staff satisfaction across key indicators
- Positive experience of being involved with the Always Event (patient and staff)

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: To further improve End of Life Care

Improvement goal: To ensure that End of Life Care is individualised and meets the needs of both patients and those who are important to them.

Quality Domain	Patient Experience
Senior Lead	Clinical Leads
Operational Lead	Service Improvement Lead
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Continue roll out of Core Nursing care plan, including Section 12 for End of Life Care, in Lorenzo • Evaluate the pilot of the 'Individualised plan of care for the last days of life' • Introduce E-learning programme for End of Life Care Undertake a review of end of life care-related complaints • Carry out surveys via End of Life Care feedback cards • Continue engagement with the DNACPR Committee regarding respect form and future developments • Disseminate findings of clinical audit report evaluating the completion of the DNACPR form	• Complete roll out of Core Nursing care plan, including Section 12 for End of Life Care, in Lorenzo across the Trust • Develop education and training to support launch of the 'Individualised plan of care for the last days of life' and Section 12 • Continue surveys via End of Life Care feedback cards and evaluate results • Continue engagement with the DNACPR Committee regarding respect form and future developments	• Launch the 'Individualised plan of care for the last days of life' to all staff • Provide Education and training for the 'Individualised plan of care for the last days of life' and section 12 • Monitor use of and evaluate success of Section 12 (including preferred place of care and death) • Continue to develop education and training resources to support 'Individualised plan of care for the last days of life' and section 12 and additional learning as identified by evaluation • Continue engagement with the DNACPR Committee regarding respect form and future developments	• Undertake review of notes and clinicians survey 'how was it for them?' • Amend Section 12 based on evaluation and target further education and training in areas requiring this • Continue to develop education and training resources to support 'Individualised plan of care for the last days of life' and section 12 and additional learning as identified by evaluation • Continue engagement with the DNACPR Committee regarding respect form and future developments • Re-launch full bereavement survey

Outcome Measures

- Suite of education and training and the 'Individualised plan of care for the last days of life' launched to all staff
- Results of complaints review
- Results of the End of Life Care survey feedback card

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve communication with patients

Improvement Goal: To ensure out-patient and in-patient letters are fit for purpose, are clear and understandable, meet the needs of both patients and national good practice guidelines

Quality Domain	Patient Experience
Senior Lead	Performance and Information Director
Operational Lead	Deputy Transformational Lead
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Complete review of current letters held within Lorenzo • Understand the system configuration potential for amendment and presentation of letters • Produce a list of standard letter templates • Undertake a cull of all unused letters, as agreed at the Lorenzo User Group • Produce a sample letter, in a format suitable for post, email and Xerox hybrid mail • Consult patient views on the new format	• Amend sample letter, taking account of patient views • Test new format and content • Amend all outpatient letters to comply with new format and content • Produce a Standard Operating Procedure (SOP) for the use of the new letters, and for any future amendments • Roll out new letters across all services • New outpatient letters in use	• Evaluate impact of new letters – patient views, service views etc. • Begin to review content of in-patient letters • Undertake a cull of all unused I/P letters, as agreed at the Lorenzo User Group • Produce a sample letter, in a format suitable for post, email and Xerox hybrid mail • Consult patient views on the new inpatient letter format	• Amend sample letter, taking account of patient views • Test new format and content • Amend all inpatient letters to comply with new format and content • Produce a SOP for the use of the new letters, and for any future amendments • Roll out new letters across all services • New inpatient letters in use • Undertake patient survey to evaluation the new letters

Outcome Measures

- All new out-patient and in-patient letters changed to new, agreed format
- SOP for the use of the new letters, and for any future amendments, developed and communicated to staff
- Evidence of patient involvement
- Completed evaluation of the new letters

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard. These people are often those who need our services most but with whom we engage the least.

Improvement goals:

Year 1: Establish an engagement network database which provides quick and easy access to large numbers of people and groups, including seldom heard groups.

Year 2: Pilot this new model focussing on one seldom heard group, evaluate the model and publicise for wider use across the Trust.

Quality Domain	Patient Experience
Senior Lead	Head of Patient and Healthcare Governance
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Two years

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Research • Research best practice in engagement with seldom heard groups. • Liaise with Healthwatch Sheffield to understand their programme of work in this area and their engagement database. • Review existing databases of networks including the Sheffield Citizen Portal • Review Trust support groups such as SHOC (cardiac surgery) and epilepsy support group • Liaise with the Foundation Trust Manager to explore increased engagement with Foundation Trust members	Proposal • Consider IT issues/ solutions, maintenance of network database, consent and other Information Governance issues • Prepare options appraisal for engagement model, consult and agree final proposal.	Set up • Build, develop and populate engagement database • Develop Standard Operating Procedure for its use	Pilot • Liaise with relevant organisations such as Healthwatch and Public Health to understand local demographics and priority groups • Analyse Trust patient demographics including DNAs to understand specific groups who are not engaging with the Trust • Agree a pilot of the new model with one topic

Outcome Measures

- Engagement database set up and operational
- Positive feedback from voluntary and community sector, Healthwatch and Foundation Trust members about the model

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improve patient experience of outpatient areas

Improvement Goal: Increase the availability of high quality refreshment facilities in outpatients including hot drinks

Quality Domain	Patient Experience
Senior Lead	Head of Patient and Healthcare Governance
Operational Lead	Patient Experience Coordinator
Objective timescale	1 year

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
• Survey outpatient areas to understand current patient, family and carer requirements and views • Review the current market for options to offer additional refreshment facilities in outpatient areas	• Select a method for offering refreshment facilities to pilot in two to four outpatient areas across the Trust • Put new refreshment facilities in place in pilot areas	• Undertake a survey within pilot areas to seek patient, family and carer (along with staff) feedback to evaluate the new facility	• If successful embed the new refreshment facilities in the two pilot sites. • Undertake a Trust-wide scoping exercise in relation to the various possible refreshment solutions in different outpatient areas and prepare a proposal for rollout.
Outcome Measures			
• Completed outpatient survey demonstrating an improvement in access to refreshments • Improved patient, family and carer satisfaction with outpatient refreshment facilities			

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduce inpatient falls

Improvement goal: Reduce inpatient falls during 2018-19 by 10%

Quality Domain	Patient Experience
Senior Lead	Consultant Geriatricians
Operational Lead	Consultant Geriatrician
Objective timescale	12 months and then ongoing

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Agree changes to current version of falls documentation within Lorenzo • Draw up Trust response to results of Second National Audit of Inpatient Falls (NAIF2) • Pilot changes to improve weekly updating of falls risk for inpatients (in response to first audit of bedrail use). • Increase wards participating in Safety/ Falls Huddles in GSM and MAPS through identification of Safety Huddle coaches to increase engagement and provide on-going support for frontline teams.	• Begin Service Improvement process to improve implementation and recording of actions to address falls risk factors (from NAIF2) • Share Yorkshire evaluation report. Share data for previous two-year period to demonstrate improvements to date.	• Continue Service Improvement process to improve implementation and recording of actions to address falls risk factors (from NAIF2) • Re-audit of bedrail use and updating of falls risk assessment	• Review falls documentation within Lorenzo to ensure they are still appropriate • Review results of actions to improve implementation and actions from NAIF2 • All wards in MAPS and GSM engaged in Safety/ Falls Huddles

Outcome Measures

- Reduce inpatient falls by 10% compared with 2016-17 (Maximum limit of 4000 in 2018-19)
- Reduce inpatient hip fractures by 10% compared with 2016-17 (Maximum limit of 39 in 2018-19)

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Further develop the safety culture across the Trust

Improvement goal: Develop a human factors plan which will have practical application and lead to tangible improvements in safety culture

Quality Domain	Safety
Senior Lead	Head of Patient and Healthcare Governance and Associate Medical Director, Safety
Operational Lead	Patient Safety Manager
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Work with an appointed consultancy to undertake a review of human factors with a focus on action planning from incident investigations • Research trusts who have developed a human factors approach and draw learning from them • Research literature in relation to human factors • Scope the current provision of human factors training within the Trust • Undertake a skills assessment of trainers providing human factors training • Review any previous culture study work undertaken within the Trust • Agree measures of success and impact measures	• Identify any potential areas for immediate gains • Identify priority areas for human factors development and the practical application of human factors principles and techniques • Develop a human factors plan based on recommendations from the review and on learning from literature and from other trusts • Obtain examples of good practice in human factors training from within the Trust and share • Assess capacity to provide human factors training across the Trust • Undertake focussed work with risk/ governance leads to question elements of human factors when undertaking investigations and agreeing action plans • Determine options on how best the Trust can provide human factors expert knowledge (eg buy in, or employ 'expertise)	• Implement any immediate gains/quick wins • Develop a human factors implementation plan with timescales and commence implementation • Undertake baseline safety culture surveys in departments where human factors developments are going to take place • Commence work with departments were no human factors training is currently taking place	• Demonstrate initial changes, including examples of practical changes, as a result of the human factors plan • Human factors to be considered and recorded in all moderate or above incidents

Outcome Measures

- Human factors plan completed with clear, practical applications
- Success/impact measures are agreed and include practical measures

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduce overall harm from avoidable pressure ulcers

Improvement Goal: To ensure a Trust wide reduction by 10% of all avoidable patient harm associated with pressure ulcer prevention and management.

Quality Domain	Safety
Senior Lead	Deputy Chief Nurse
Operational Lead	Lead Clinical Nurse Specialist Tissue Viability
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Agree annual work plan for 2018/2019 • Reset goals for pressure ulcer reduction with each ND to be incorporated into the Nursing Quality Dashboard • Change reporting to reflect actual numbers of pressure ulcers and patient harm • Revise Pressure ulcer prevention policy to ensure it is fit for purpose. • Roll out agreed documentation strategy via e care planning when in use. • Develop a plan for implementation of react to red across the home care sector • Review the pilot of combined P1&P2 documentation. • Refocus the tissue viability workload into provision of specialist advice • Complete work relating to NHSI pressure ulcer collaborative and establish plan for organisational spread of learning • Establish Share point site for all educational materials in relation to pressure ulcer prevention and management • Complete the integration of acute and community tissue viability teams, to ensure seamless reviews throughout the health community. • Agree an educational strategy for Pressure ulcer prevention and management • Review Incident reporting processes to embed Root cause analysis tools within the system • Pressure Ulcer Prevention and Management Group (PUPMG) to formalise case study reviews to aid learning	• Review and establish with PUPMG a process for a "learning review" or "check and challenge" of patient harm in relation to hospital acquired pressure ulcers. • Continue educational roll out plan to embed in directorates • Establish a regular method of auditing pressure ulcer prevention and management within the acute directorates (linked to accreditation) • Ensure investigation of pressure ulcers is completed within a timely fashion • Reduce timescales for completion of all root cause analysis (RCAs) from 6 weeks to 28 days. • Establish a process of RCAs including an embedded form in Datix for Grade 2 pressure ulcers trust wide, led by ward sister's charge nurses. • Embed agreed documentation strategy • Establish a plan for implementation of photography in pressure ulcer prevention, management and wound care within STH.	• Launch process of clinical accreditation to include all aspects of pressure ulcer prevention and management • Contribute specialist tissue viability advice to the review of specialist mattresses trust wide. • Ensure that the process for ordering specialist equipment is robust and timely. • In conjunction with the Trust wound group and procurement agree a trust standard formulary for wound management products trust wide • Complete embedding of learning from NHSI pressure ulcer collaborative. • Review goals for pressure ulcer reduction with each ND. • Agree a method with acute and community for ensuring that data collection around trust attributable pressure ulcers is robust to inform future decisions.	• Evaluate e care planning of tissue viability interventions to ensure that new processes are embedded and effective • Evaluate effectiveness of educational strategy • Agree formal work plan priorities for 2019/2020 • Set goals for pressure ulcer reduction with each ND. • Submit proposal to Nurse Executive Group to consider a Zero tolerance approach for 2019/2020. • Complete implementation of react to red across the care home sector

Outcome Measures

- Development of pressure ulcer prevention annual work plan and education strategy
- 10% reduction in all avoidable patient harm associated with pressure ulcer prevention and management.
- Sustained reduction in avoidable harm related to pressure ulcers across STH

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Reduction in sepsis

Improvement goal: Demonstrate a 30% improvement in the early recognition and management of sepsis within the Trust

Quality Domain	Safety
Senior Lead	Associate Medical Director, Safety
Operational Lead	Lead Nurse, Sepsis
Objective timescale	One year

Work plan

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• On-going patient identification and data collection. • Feedback on current screening tool. • Examine an electronic feedback mechanism for the Trust on compliance to screening and care delivery. • Develop multimedia educational tools to maintain resilience	• Promote effective use of current electronic systems within the Trust to identify patients as having sepsis. • Re develop the screening tool to ensure compliance in its use. • Develop a dashboard will need support from the Trust and extract data from current spreadsheets. • Consider mandatory element of sepsis education.	• Expand sharing of data with deteriorating patient and AKI leads. • Re launch new deteriorating patient tool and changes • Develop the dashboard and provide training for wards. • Develop educational material and enter on PALMS	• Ensure data collected demonstrates change. • Continue to examine compliance through data collection. • Continue feedback mechanisms to ward areas. • Maintain registration of education through PALMS.

Outcome Measures

- 90% of identified patients who deteriorate with an infection will have been screened for sepsis and will have received appropriate treatment within one hour.
- An electronic feedback system for wards to monitor compliance with the deteriorating patient and sepsis will have been developed
- 80% of clinical staff will have received education on sepsis and an update to maintain resilience.
- 30% improvement in the early recognition and management of sepsis within the Trust

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Improved recognition and timely management of deteriorating patients

Improvement goal: Improved recognition and timely management of deteriorating patients leading to improved care- Implement an electronic system for tracking patients' observations

Quality Domain	Safety
Senior Lead	Associate Medical Director, Safety
Operational Lead	Patient Safety Manager
Objective timescale	One year

Work plan			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
• Convene a project working group with representation from Informatics, Operational Change, Strategy & Planning, Safety, Nursing and Medical • Identify inter-depencies of Trust systems including Mobile Devices • Scope the capabilities of the Lorenzo system	• Commence discussions with Lorenzo developer • Establish a 'first of type' case to facilitate the access to further potential external funding stream • Understand the impact of a Track and Trigger System • Convene a project working group for the implementation of NEWS 2	• Determine the requirements of the system and compare this with the current infrastructure within the Trust • Clarify the role out strategy for NEWS 2 • Roll out the New Vital Signs monitors	• Begin trials of the new system in a selected area • Implement NEWS 2
Outcome Measures			
• Improved recognition of deteriorating patients and timeliness of intervention			

2.4 DETAILED OBJECTIVES LINKED TO IMPROVEMENT PRIORITIES FOR 2018-19

Priority: Achieve an absolute reduction in the prevalence of preventable Acute Kidney Injury (AKI) in the Trust

Improvement Goal: Three year plan set as a reduction in preventable acute kidney injuries (AKIs) across the Trust

Quality Domain	Safety
Senior Lead	Associate Medical Director, Safety
Operational Lead	Clinical Effectiveness Manager
Objective timescale	Three years

Work plan

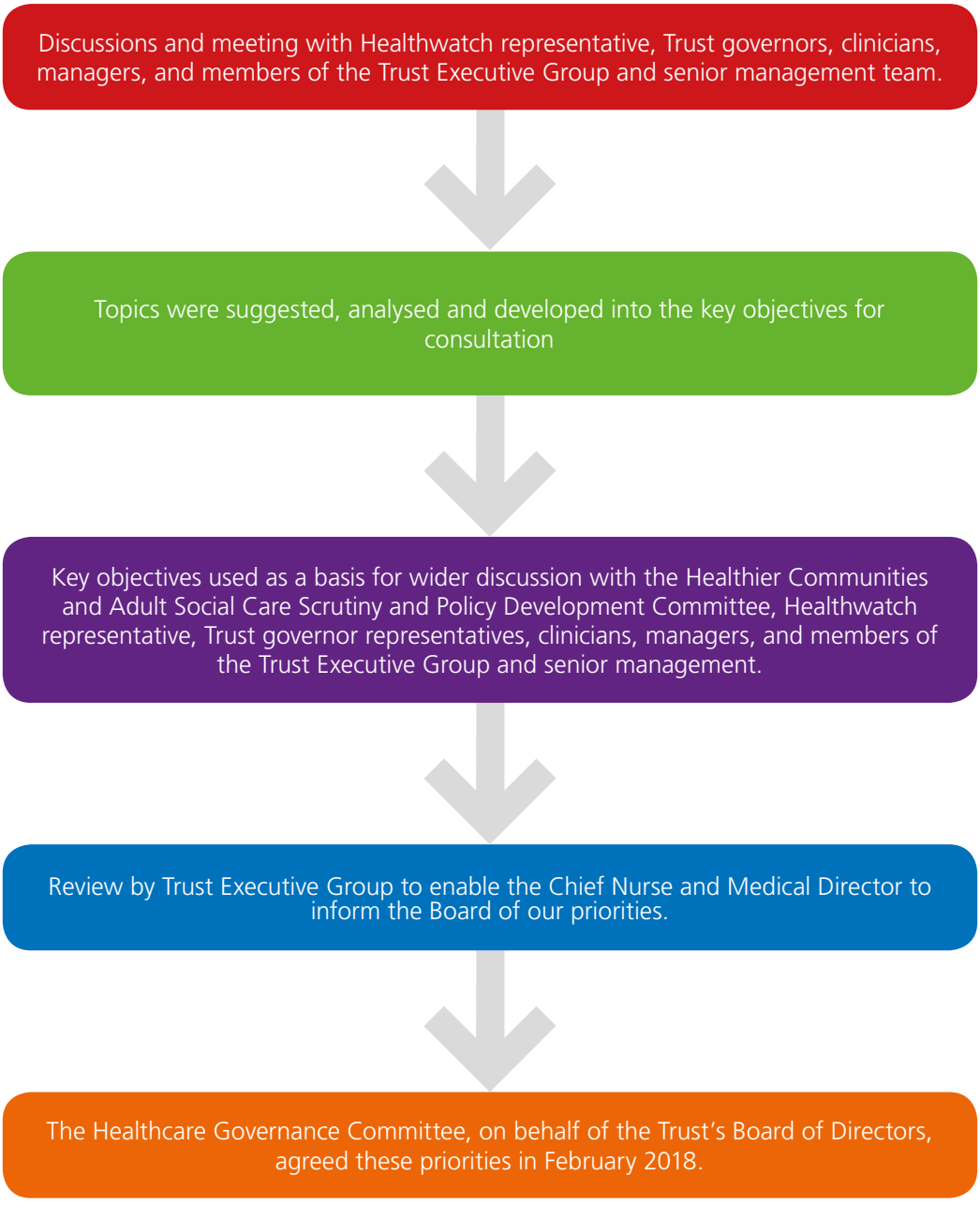
This objective spans the lifetime of the Quality Strategy. In 2018-2019 a reliable baseline measure of the prevalence of preventable AKI will be defined which will provide a springboard for improvement targets to be set. This will involve review of patients referred to the renal physicians with AKI followed by a retrospective case note review on the management of these patients. It will also include the determination of the number of elective patients flagged as being at risk of developing AKI and those who then go on to develop AKI during their inpatient stay.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Plan and register a project with the Trust Clinical Effectiveness Unit to obtain a baseline of preventable AKI. • Pull together a steering group to oversee the project. • Create and pilot a data collection tool. Pilot to the tool on renal referrals for AKI.	• Data collection for project - Undertake retrospective case note review on the management of patients referred to renal physicians with AKI, to include; • Retrospective case note review of management prior to referral • Auditing of whether management was in line with Acute Kidney Injury Policy • Assessment of current staff engagement with AKI care bundle checklist, extrapolating if this improves compliance with AKI policy treatment protocols	• Identify ward/wards with highest referral rate for quality improvement project (QIP) • Identify junior Dr/nurse on selected wards for QIP data collection • Design QIP. • Carry out two quality improvement cycles to identify which improvements are most effective	• Implementation and monitoring of change • QIP to continue and complete. • Action planning for year two, including setting improvement targets.

Outcome Measures

- Established baseline of the prevalence of preventable AKI.
- Completed quality improvement project
- Plan, included improvement targets, for 2019-20.

2.5 HOW DID WE CHOOSE THESE PRIORITIES?



2.6 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) Learning from Deaths
h) Patient Safety Alerts
i) Staff Engagement
j) Annual Patient Surveys
k) Complaints
l) Friends and Family Test
m)Mixed Sex Accommodation
n) Coroners Regulation 28 (Prevention of Future Death) Reports
o) Never Events
p) Duty of Candour
q) Safeguarding Adults
r) Seven Day Service

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

a. Services Provided

During 2017-18, the Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 50 relevant health services. The Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 50 of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services by the Sheffield Teaching Hospitals NHS Foundation Trust for 2017-18.

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

b. Clinical Audit

During 2017-18, 58 national clinical audits and four national confidential enquiries covered relevant health services that Sheffield Teaching Hospital NHS Foundation Trust provides.

During that period Sheffield Teaching Hospital NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Sheffield Teaching Hospital NHS Foundation Trust was eligible to participate in during 2017-18 are documented in table three.

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2017-18, 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.

Table Three

Audits and Confidential Enquires	Participation N/A = Not applicable	% Cases Submitted
Acute Care		
Case Mix Programme (CMP)	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Major Trauma Audit	Yes	100%*
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD):		
Heart Failure	Yes	100%
Young People's Mental Health	Yes	100%
Chronic Neurodisability	Yes	93%
National Emergency Laparotomy Audit (NELA)	Yes	46%* See supporting statement
National Joint Registry (NJR)	Yes	82.6%*
National Neurosurgery Audit Programme	Yes	100%
National Ophthalmology Audit	Yes	100%
Nephrectomy audit	Yes	92%
Percutaneous Nephrolithotomy (PCNL)	Yes	100%
Cystectomy Audit	Yes	100%
National Bariatric Surgery (NBSR)	Yes	100%
Female Stress Urinary Incontinence Audit	Yes	100%*
Urethroplasty Audit	Yes	100%*
Radical Prostatectomy Audit	Yes	76%
Fracture Neck of Femur	Yes	100%
Procedural Sedation in Adults (care in emergency departments)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme:		
Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	100%
Blood and Transplant		
Bowel Cancer (NBOCAP)	Yes	90*
Head and Neck Cancer Audit HANA	Yes	100%*
National Lung Cancer Audit (NLCA)	Yes	100%*
National Prostate Cancer Audit	Yes	91%*
Oesophago-gastric Cancer (NAOGC)	Yes	70%* See supporting statement
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Audits and Confidential Enquires	Participation N/A = Not applicable	% Cases Submitted
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%*
Adult Cardiac Surgery	Yes	100%*
Cardiac Rhythm Management (CRM)	Yes	100%*
Congenital Heart Disease (CHD)	Yes	100%*
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%*
National Cardiac Arrest Audit (NCAA)	Yes	94%
National Heart Failure Audit	Yes	82%*
National Vascular Registry:		
National Carotid Interventions Audit	Yes	98%
Abdominal Aortic Aneurysm (AAA)	Yes	81%
Peripheral Vascular Surgery – Lower limb angioplasty/stenting	Yes	55%
Peripheral Vascular Surgery – Lower limb bypass	Yes	90%
Peripheral Vascular Surgery – Lower limb amputation	Yes	41%
Pulmonary Hypertension Audit	Yes	100%
Long Term Conditions		
Chronic Kidney Disease in primary care	N/A	N/A
Inflammatory Bowel Disease (IBD) programme	No	See supporting statement
National Audit of Dementia	Yes	100%
National Diabetes Audits:		
National Diabetes Audit :Insulin Pump	Yes	100%
National Diabetes Foot care Audit	Yes	50%*
National Diabetes Inpatient Audit	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Audit - Adults	Yes	100%
Renal Replacement Therapy (Renal Registry)	Yes	100%*
UK Cystic Fibrosis Registry	Yes	100%
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)Secondary Care	Yes	100%*
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) Pulmonary Rehab	Yes	83%
UK Parkinson's Audit	Yes	100%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

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

Older people		
Falls and Fragility Fractures Audit programme (FFFAP):		
National Hip Fracture Database	Yes	100%
National In Patient Falls	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	90%**
National Audit of Intermediate Care (NAIC)	Yes	79%

Other		
Elective Surgery (National PROMs Programme)	Yes	89.5%*
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%

Women's and Children's Health		
Child Health Clinical Outcome Review Programme	N/A	N/A
Diabetes (Paediatric) (NPDA)	N/A	N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Paediatric Intensive Care (PICA Net)	N/A	N/A
Paediatric Pneumonia	N/A	N/A
Pain in Children	N/A	N/A

Please note the following

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

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

Supporting statements

National Emergency Laparotomy Audit (NELA):

Case ascertainment is increasing. The clinical team continue to address challenges with data upload. This should increase data submission to the NELA in 2018-19.

There are a number of issues in relation to case ascertainment for this audit. Reasons for this include web access issues at time of procedure for all surgeons likely to perform an emergency laparotomy, the number of surgeons involved in delivering emergency surgery, and the complexity of data requirements from surgeons and anaesthetists across the full pathway of care. Also the high volume of surgical procedures carried out at the Trust means that the associated audit workload is high within the directorates concerned. The Clinical Effectiveness Unit has maintained a continuous dialogue with the directorates and has provided administrative support, however much of the data collection requires clinical interpretation and consequently the audit continues to fall below expected case submission numbers. Examples where trusts have achieved good case ascertainment include those who have appointed a data co-ordinator with clinical expertise to assist with data collection / follow-up and to ensure each patient is entered onto the database as they present.

Oesophago-gastric Cancer (NAOGC):

Case ascertainment is lower than 100%. Patients diagnosed in District General Hospitals and treated at STHFT, are included in the DGH submission figures to NAOGC, as opposed to STHFT. This is directed by the National Audit.

IBD Registry:

Resource to upload information to the IBD registry has been limited in 2017-18. The Directorate continue to look at ways to engage effectively with the IBD Registry. This has included appointment of additional IBD specialist nurses and additional administrative time. This should increase data submission to the Registry in 2018-19.

The reports of 32 national clinical audits were reviewed by the provider in 2017-18 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided in the examples included below:

The National Pregnancy in Diabetes (NPID) audit

The National Pregnancy in Diabetes audit is a continuous data collection measuring the quality of care and outcomes for women with pre-gestational diabetes when they become pregnant. The audit measures against national standards set out in the NICE (National Institute for Health and Care Excellence) guideline NG3, previously NICE Care Guideline CG63. The audit seeks to address three key questions:

- Were women adequately prepared for pregnancy?
- Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother?
- Did any adverse outcomes occur?

The results of the audit found that 69% (95/137) of mothers with type 1 and type 2 diabetes became pregnant with a HbA1c higher than 48 mmol/L and therefore had an increased risk of miscarriage, pre-term labour, congenital malformation, stillbirth and neonatal death. The audit also found that 58% (80/139) of women with diabetes who are pregnant did not receive immediate contact with a joint diabetes and antenatal clinic (<10 weeks gestation). Due to this they missed out on one or more of the following - early medication review; ensuring 5mg folic acid was being taken daily; early Ultra Sound Scan; HbA1c; advice on good diabetes control.

Women with diabetes have an increased risk of having a pregnancy affected by a neural tube defect (NTD). The audit found 50% (69/137) of patients did not start folic acid prior to pregnancy and therefore had a further increased risk of having a pregnancy affected by NTD.

The Trust, in collaboration with Sheffield CCG, is taking the following actions to make improvements:

- Produce E-bulletins to:

  Advise GP's to use Diabetes Anti Natal Clinic referral via the CCG web site for referring women with pre-existing diabetes

  Publicise the pathway
- Introducing an information prescription in SystmOne – this will be designed by the diabetes team and implemented by the CCG and Primary Care Diabetes Leads
- Display Safer Campaign posters in all GP practices
- Ensure a Safer Campaign patient information leaflet is available in all GP practices
- Design preconception cards with contact numbers for the diabetes team and for preconception advice. These will be designed by the diabetes team, funded by the CCG and will be available in all GP practices.

The Trust continues to work with Primary Care to ensure type 1 and type 2 diabetic women:

- Start 5mg of folic acid daily before becoming pregnant
- Keep HbA1c below 48 mmol/mol
- Stop oral glucose-lowering medications apart from Metformin before becoming pregnant and stop statins and ACE inhibitors/ARBs before becoming pregnant
- Are offered immediate contact with a joint diabetes and antenatal clinic (<10 weeks gestation)

STHFT has been successful with an application to join the National Diabetes in Pregnancy Quality Improvement Collaborative.

National Diabetes Insulin Pump Audit

The Insulin Pump Audit is part of the National Diabetes Audit programme, and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit programme. The National Diabetes Audit is managed by NHS Digital in partnership with Diabetes UK and is supported by Public Health England.

The Insulin Pump Audit collects information on the number and characteristics of people with diabetes using an insulin pump, the reason for going on an insulin pump and the outcomes achieved since starting the pump.

National standards for the use of insulin pumps were set out in NICE guidance - Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus (NICE technology appraisal guidance [TA151] Published date: July 2008).

45.4% of STHFT pump patients received all eight diabetes care processes in 2015, compared to 39.9% nationally (the standard is 100%). STHFT are performing above the national average however, 54.6% of STHFT pump patients failed to receive one or more of the eight care processes. This means that one or more modifiable risk factors of long-term diabetes-related conditions cannot have been assessed.

STHFT are taking the following actions to make improvements:

- As part of ongoing improvements for the STH Diabetes department as a whole, the template used in SystmOne has been updated so that any missing care processes are immediately apparent when a doctor or Diabetic Specialist Nurse goes into a patient record to record any data.
- Outpatient support staff are routinely completing the smoking status form, and know which patients require a urine sample for ACR measurement.
- Analysis of local data as some patients do not consent for inclusion within the National Audit data set. The national data set may not be considered a true reflection of the overall outcomes for the Trust patients.
- Trial of Drop-In Clinics for Under 25 year olds.
- Increasing administrative support.

The Trust expects to see an improvement in outcomes in the next round of the published National Audit.

UK Registry of Endocrine and Thyroid Surgery (UKRETS)

It is a requirement of the HQIP that all thyroid operations are entered onto UKRETS as thyroid surgery has been chosen by the Chief Medical Officer to be one of 13 specialties where consultant level outcomes should be openly available for public viewing.

The outcomes for surgeons at the Trust are better than the national average. A number of local audits looking at subgroups of patients within this larger cohort have been carried out where we have examined a number of specific outcomes including nerve damage rates and hypoparathyroidism in much greater detail than the national audit.

On the basis of local audits, the Trust has implemented several changes to local practice including establishing and validating protocols for post-thyroidectomy hypocalcaemia and practice around perioperative laryngoscopy. These changes have helped in reducing adverse events and length of stay in hospital.

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

Local Clinical Audits

The reports of 428 local clinical audits were reviewed by the provider in 2017-18 and Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit of security of medicines in clinical areas

During their inspection in December 2015, the CQC identified that 'Intravenous fluids were not always stored safely and securely' and issued a 'MUST DO' action for the Trust to ensure the safe storage of intravenous fluids. This prompted the requirement to obtain a comprehensive understanding of the scale of the issue across the Trust.

An audit to determine whether the storage of medicines at ward level complies with the national standards was undertaken. A member of the pharmacy governance team and the Trust Security Manager carried out unannounced visits to 90 ward areas. One area was excluded as it was due to close for full refurbishment in the near future. A standard pro forma was used to assess compliance. Information was also gathered about the type of security mechanisms in use (e.g. key, proximity reader, PIN code), and whether non-medicines were also stored in rooms containing medicines on open shelving.

This audit has demonstrated that whilst the majority of areas have a mechanism for securing all medicines, a significant number of areas do not keep the facilities locked. Where proximity card readers have been installed compliance with locking the medicine rooms is 95%, compared with 33% where other security mechanisms are used. The Medicine Safety Committee has therefore recommended that proximity card readers be installed to all medicine room doors, and a business case has been approved to take this forward.

Audit of Surgical Safety Checklist

As an organisation the Trust has implemented the World Health Organisation's Surgical Safety Checklist (SSC) as a

mechanism to reduce patient adverse events and improve patient safety in the perioperative setting.

In 2008, the World Health Organisation (WHO) launched the "Safe Surgery Saves Lives" campaign as a drive to reduce the number of surgical deaths across the globe; the Surgical Safety Checklist was part of this initiative. The checklist consists of five steps which are: - "Team brief," which occurs prior to the commencement of surgery and facilitates the transfer of crucial information to all multi-disciplinary team members. The "Sign-in" then provides a verbal check of patient details prior to induction of anaesthesia. The "Time-out" is where all members of the team confirm together the planned procedure prior to surgical incision. Following surgery the "Sign-out" is completed, where the team verbally check that the correct procedure has been recorded. The final step is the "debrief", where all aspects of the operating day can be discussed in detail.

The efficacy of the Surgical Safety Checklist is dependent upon a number of factors such as optimal communication, effective team working and the participation of the surgical team working collaboratively to minimise risks and harm associated with surgical procedures.

The aim of the audit was to measure the compliance to the STHFT Safer Procedure Policy and identify and address any problems with compliance. A rapid cycle audit was undertaken from May 2017–December 2017 through three cycles of data collection. The first cycle highlighted shortfalls in compliance with the audit standards. When the risk was identified and investigated it was highlighted that:

- Team brief and debrief were not used effectively
- Cases were not discussed on an individualised basis.

A comprehensive action plan was implemented to address the highlighted issues and a further two cycles of data collection were undertaken.

From the third cycle results, it is evident that there have been significant improvements in the Sign In, Time Out and Sign Out steps of the surgical safety checklist. Overall compliance has improved from 90.3% in cycle 1 to 97.3% in cycle 2 and 99.4% in cycle 3.

A notable improvement has been seen in the compliance rate of no distractions/interruptions during all steps of the surgical safety checklist: this includes Sign in, Time out and Sign out. The most recent audit results demonstrate 100% compliance with this standard which is an improvement from 64% for sign in, 88% for time out and 84% for sign out in cycle 1.

The Safer Surgery Checklist Audit continues to be measured to assure sustained improvements in practice.

Audit of Written Consent for Examination and Treatment

Consent must be obtained before any examination or treatment. It may be non-verbal (e.g. offering a wrist for taking a pulse), oral or written. Not all consent needs to be written, but written consent can provide evidence that consent has been discussed with the patient.

Consent is a continuous process rather than a one-off decision. It is important that patients are given continuing opportunities to ask further questions and to review decisions about their health care.

To reflect recent changes in legislation and the findings of an audit of consent which was completed by the Trust's internal auditors in 2016, the Consent to Examination or Treatment Policy was updated and ratified at the Trust Executive Group in January 2017.

A Trust wide rolling programme of audit was commenced following the policy update. The aim of the audit was to measure compliance with the STHFT Consent to Examination or Treatment Policy and to identify and address any problems with compliance. The first areas to commence auditing have now undertaken a second audit cycle and have in place agreed action plans for improvements. It was agreed at the Trust Clinical Management Board that the introduction of a combined patient information leaflet and procedure specific consent form would be piloted and five pilot sites within the Trust have been identified. The Trust has funded changes to the system used to produce the Patient Information Leaflets that will enable the leaflets to be combined with the procedure specific consent form. A combined form will provide consistency in relation to the minimum information given to patients though there is still the requirement to individualise this for each patient based upon material risks. Furthermore, the combined forms are not intended to replace the discussions that should take place with the patient. When signing the consent form the patient is agreeing to the procedure/treatment, to accepting the risks and benefits of the treatment and to having understood the alternative treatments and no treatment options. These will therefore be clearly outlined in the procedure/treatment specific patient information leaflet and further discussed with the patient. Further data collection for the audit should demonstrate improvements in compliance with the revised Trust policy.

c. Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Teaching Hospital NHS Foundation Trust in 2017-18 that were recruited during that period to participate in National Institute of Health Research (NIHR) Portfolio research trials was 11,908. This is 131% of our end of year target. We have made excellent progress in continuing to improve our performance.

During 2017, STH has had significant success in attracting major awards of research funds from National Institute of Health Research (NIHR), including:

- Biomedical Research Centre in Translational Neurosciences. £4.0 million over five years.
- Clinical Research Facility for Early Translational (Experimental Medicine) Research. £3.1 million over 5 years.
- Experimental Cancer Medicine Centre (ECMC). Awarded £1.0 million over five years.
- Devices for Dignity MedTech Co-operative. Awarded £1.4 million over five years.
- The Department of Health has agreed that the current contract for STH to host the National Institute of Health Research (NIHR) Clinical Research Network for Yorkshire and Humber will be extended to the end of March 2022.

During 2017, to increase the awareness of research that takes place, and to highlight how people can get involved, the Trust organised several successful events for patients and the public, and for local researchers.

- In February, we held a Research Event aimed at educating patients and the public about the benefits that research can bring. Approximately 90 patients in attendance were present to learn from leaders in their fields talk about a variety of diseases such as dementia and cancer, and the innovations and breakthroughs that are driving forward current healthcare.
- International Clinical Trials Day is held annually to celebrate the anniversary that James Lind began the first ever clinical trial. The day provides an opportunity to raise awareness of clinical research, what it means, and highlights the myriad of ways that the public can be involved in contributing to ground-breaking medical discoveries. Additionally, it highlights the breadth of research taking place Trust-wide.

In 2017, approximately 80 delegates attended our International Clinical Trials Day event where everyone had the opportunity to see how they could get involved in health research, and took part in discussions about topical research studies being conducted at STH regarding challenges faced by the NHS. To showcase the infrastructure available for conducting high quality research at STH, delegates were taken on a tour of our dedicated National Institute for Health Research funded Clinical Research Facilities.

- For our staff, we held a "Valuing Patients in Research" Workshop to educate them about Public and Patient Involvement (PPI) and to give them an opportunity to hear from patients/researchers about their experiences in PPI. Feedback from attendees was extremely positive and highlighted the benefits of holding such an event.
- In December, we welcomed over 70 patients, members of the public and staff to the public launch event of our National Institute of Health Research Biomedical Research Centre for Translational Neuroscience. This event provided an ideal platform for introducing researchers to Patient and Public Involvement representatives, and for the public to learn about the cutting-edge research that will be conducted over the coming years with the aim of improving the lives of people with chronic neurological diseases.

Following the successes of the last year, in 2018 the Trust will again hold a variety of events including one to celebrate International Clinical Trials Day where key priorities will be attracting people from Sheffield with little or no knowledge of clinical research. To further our engagement with Trust staff, we will be organising our first local Research Conference in 2018 which we hope to make an annual event.

d. Commissioning for Quality and Improvement (CQUIN Framework)

A proportion of Sheffield Teaching Hospitals NHS Foundation Trust income in 2017-18 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 2017-18 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ and https://www.england.nhs.uk/nhs-standard-contract/cquin/pres-cquin-17-19/.

In 2017-18, £17,626,537 of our contractual income was conditional on achieving the Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield CCG / NHS England. Of the 2.5% of contract income associated with the National

(CCG commissioned) CQUIN schemes, 0.5% was linked to engagement with Sustainability and Transformation Plans and 0.5% was linked to achievement of the Trust's control total. The remaining 1.5% 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 well-being 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 2016-17 the Trust secured £14,187k.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 has not taken enforcement action against Sheffield Teaching Hospitals NHS Foundation Trust during 2017-18.

Sheffield Teaching Hospitals NHS Foundation Trust has participated in the Care Quality Commission Local System Review during 2017-18.

This review relates to Sheffield health and social care systems. It asks an overarching question: 'How well do people move through the health and social care system, with a particular focus on the interface, and what improvements could be made?' Sheffield health and social care systems were reviewed on 5-9 March 2018. The final report following the review is yet to be published.

f. Data Quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2017-18 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%	For admitted patient care
99.9%	For outpatient care
97.4%	Accident and Emergency Care

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

100%	For admitted patient care
100%	For outpatient care
100%	Accident and Emergency Care

Sheffield Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit process during 2017-18.

Sheffield Teaching Hospitals NHS Foundation Trust continues with the following programmes to improve its data quality:

- The new team (the EPR and DQ Team), created to support and drive forward a coordinated Data Quality agenda across the organisation is now well established.
- The development of reporting dashboards to support improvement to Data Quality , including the Administrative Patient Safety Dashboard.
- The Data Quality Steering Group, chaired by the Assistant Chief Executive, is well established, and is supporting data quality improvement across the organisation .
- The IT Trainers have integrated with the Performance and Information function, to support users in learning from errors, and improve training to focus on data quality.
- The Administrative Profession Programme has been launched with a view to ensure all those undertaking administrative functions are suitably trained and supported. This includes standardisation of procedures, and availability of standard operating procedures for all tasks.

Sheffield Teaching Hospitals NHS Foundation Trust Information Governance Toolkit v.14.1 Assessment final score for 2017-18 was 71% and was graded as green and satisfactory.

g. Learning from Deaths

The National Quality Board published its guidance on Learning from Deaths in March 2017 and updated this guidance in June 2017.

The Trust Executive Group has approved a governance process for the management of the review of acute hospital deaths which involves the Medical Examiner and the Mortality Governance Committee, and requires the appointment and funding of specially trained case note reviewers. A Non-Executive Director has been appointed with the remit of Mortality Governance. These actions are all in line with national guidance.

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

The Trust reports the mandated data to the Public Board on a quarterly basis.

The Trust continues to work collaboratively with the regional group to identify mortality related issues on a local and regional basis and has increased the number of individuals who are trained in case note review.

The proposed structure for learning from deaths within the Trust will ensure that all deaths are reviewed by the Medical Examiner's Office and members of the review teams on a daily basis. This information will be collated weekly, and any reviews that raise potential concerns about an individual patient's care will undergo a second review by a different reviewer, and, where necessary, the Directorate responsible for the patient's care.

On a monthly basis the Trust's Serious Incident Group will receive information on the total number of deaths per month, including details of any where review of the patient record raised concerns about possible lapses in care. The Serious Incident Group will also receive information on the status of any investigation needed. On a quarterly basis, total deaths, total numbers of reviews and the total number of deaths in which poor or very poor care is identified will be discussed at the Trust Executive Group, the Healthcare Governance Committee and the Board of Directors. In addition, any deaths in which lapses in care were thought to have contributed to the patient's death will be identified and reported publically as per the guidance within the national framework.

At present we have trialled this process within the Medical Examiner's Office and used our expert reviewers to review those cases flagged up by the Medical Examiner's Office. Those cases which have been referred to and accepted by the coroner have not been subject to a Structured Judgement Review at this stage as per our published policy.

During 2017-18, 2,919 of Sheffield Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 667 in the first quarter; 655 in the second quarter; 742 in the third quarter; 855 in the fourth quarter.

By 31st March 2018, 1,713 case record reviews (Medical Examiner review / Structured Judgement Review) and six serious incident investigations had been undertaken in relation to the deaths included in data contained within the above paragraph. Deaths in the fourth quarter are still to be reviewed.

In six cases a death was subject to both a case record review (Medical Examiner review / Structured Judgement Review) and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

533 in the first quarter
546 in the second quarter
634 in the third quarter

Deaths in the fourth quarter are still to be reviewed.

There were no cases reviewed in quarter one that were judged to be more likely than not to have been due to problems in the care provided to the patient. Analysis of data for quarter two, three and four is ongoing.

The Trust has been instrumental in contributing to regional and national initiatives concerned with mortality issues. As a result the Trust has trained a number of hospital staff to participate in Structured Judgement Review and this review methodology is endorsed by the Trust in respect of Morbidity and Mortality meetings. A significant proportion of the Trust's Morbidity and Mortality meetings use the review method to conduct their regular meetings. The Structured Judgement Review method has been used widely within the Trust, and the future use of the RCP web-platform will allow greater clarity of the use of Morbidity and Mortality. The Trust has used this method to analyse deaths in patients with fractured neck of femur from the 2015-16 cohort.

Of the reviews of the identified deaths above, one of the key learning points has been with regard to oxygen therapy and its administration. This death remains under consideration by the coroner but key improvement work within the Trust has taken place pending the coronial inquest. This includes asking the Healthcare Safety Investigation Branch (HSIB) for assistance in addressing identified concerns. This has resulted in the HSIB taking forward a national investigation in relation to this issue. Consistent themes have also been identified and continue to inform ongoing improvement work in such areas as Sepsis, Acute Kidney Injury, End of Life Care and Patient Deterioration.

The Trust is also involved in a ScHARR research project that aims to correlate the Medical Examiner assessment of the delivery of health care in deceased patients with the output of Structured Judgement Reviews.

h. Patient Safety Alerts

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

Table four below details the Alerts and Rapid Response Reports which have been responded to during the year 2017-18.

Table Four

Reference	Title	Issued	Deadline (action complete)	Closed
NHS/PSA/RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	6/4/2017	6/10/17	6/10/17
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	5/7/17	16/8/17	16/8/17
NHS/PSA/RE/2017/004	Resources to support safe transition from the luer connector to nrfit for intrathecal and epidural procedures, and delivery of regional blocks	11/8/17	11/12/17	11/12/17
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	27/9/17	8/11/17	6/10/17
NHS/PSA/D/2017/006	Confirming removal or flushing of lines and cannulae after procedures	9/11/17	9/8/18	Open
NHS/PSA/W/2018/001	Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders	9/1/18	20/2/18	20/2/18
NHS/PSA/D/2016/009	Reducing the risk of oxygen tubing being connected to air flowmeters	4/10/2016	04/07/2017	Open
NHS/PSA/W/2016/010	Central Alerting System: Risk Of Death And Severe Harm From Error With Injectable Phenytoin	9/11/2016	21/12/2016	21/12/2016
NHS/PSA/W/2016/011	Risk Of Severe Harm And Death Due To Withdrawing Insulin From Pen Devices	16/11/2016	11/01/2017	11/01/2017

i. Staff Engagement

The dedication, ongoing commitment and skill of our employees are what makes our hospitals and our community services successful and we continue to appreciate the hard work that they do. We place a high priority on the health and wellbeing of our staff.

Our PROUD values and behaviours will continue to underpin the way we lead and deliver our services in the next five years. If we are to flourish as an organisation we will need to rely on these values and ensure they guide us to work compassionately and efficiently to deliver our services.

We recognise the importance of positive staff engagement and good leadership to ensure good quality patient care so we were pleased to be shortlisted for the HSJ Staff Engagement Award in November 2017 in recognition of the work we have done on staff engagement.

During 2017 we began to consult with staff and patients about our People Strategy and we approved this at the start of 2018.

Staff Engagement and Wellbeing

The Trust is committed to developing good leaders and ensuring good staff engagement and wellbeing, as it recognises the importance of these for quality patient care and as such engaging leadership is an integral to the Trust ILM management programmes which continue to be very successful. A staff engagement session is also included on induction for all newly qualified nurses. This year a staff benefits and wellbeing site on the Trust intranet has been further developed to provide staff with easy access to information on staff engagement, rewards and benefits and health and wellbeing initiatives.

During 2017 the implementation of the Trust Staff Engagement Strategy and the Trust Health and Wellbeing Strategy have provided a particular focus on improving staff involvement, motivation and wellbeing for all staff. We continue to look at new ways of supporting our staff and this year with the help of the chaplaincy department we have introduced more mindfulness sessions for staff and managers together with health and wellbeing training for line managers which were well received. We have provided more personal resilience sessions for teams of staff and over 2,500 staff have accessed the Headspace mindfulness and meditation app. The introduction of Health checks for staff over 40 years of age as well as our continued referrals to staff physiotherapy and our new Employee Psychological Services demonstrated our commitment to caring for our staff.

Our Directorate Staff Engagement plans had a particular focus on actions to improve staff motivation through increased recognition and appreciation of staff at departmental level e.g. local recognition schemes, usage of 'Give a little thanks' our electronic recognition system as well as via our Thank You Awards and improving staff involvement through our Microsystems academy systems coaching, Give it a Go Work and the ongoing Listening into Action programme.

Staff Involvement

The Trust participated in the staff Friends and Family Test in quarter one, two and four, as well as undertaking a full census staff survey in quarter three. Engagement events have been held across the Trust during 2017-18, particularly in clinical areas to discuss the findings of the staff Friends and Family Test results. These events have resulted in staff making suggestions, leading to improvements for both staff and patients. It is pleasing to note that the Trust is now recognised as a centre of good practice in its approach, and use of the staff Friends and Family Test data, leading to improvements in both staff and patient experience. The Trust Staff Engagement Lead and Staff Surveys coordinator continue to be invited to share good practice at several NHS Employers events and this year the Trust was asked to write a case study to share practice across the NHS which was published by NHS Employers in October, 'Staff Engagement for Quality Improvement'.

The Trust Executive Group continue to spend time in clinical and non-clinical departments regularly as part of Back to the Floor to take the opportunity to meet with staff and listen to their feedback which has recently been extended to include some Non-Executive Board members. The Chairman meets regularly with the Staff Governors to seek feedback and the Board of Directors meet staff and recognise their efforts.

NHS Staff Survey

Staff engagement is measured every year via the annual NHS Staff Survey, which includes an overall score for staff engagement. This year a full census staff survey was undertaken with over 7,242 responses received with the vast majority of staff completing the survey online.

The Trust staff engagement score for 2017 increased to 3.83 which means the Trust is above average in comparison to other combined acute and community trusts.

It is encouraging to note that 81% of our staff would recommend the Trust to family and friends for treatment, this is well above the NHS average for combined acute and community trusts of 69%. Additionally 68% of our staff would recommend the Trust as a place to work, this again is above the NHS average for combined acute and community trusts of 59%.

Response Rates

2016		2017	
Trust	National Average	Trust	National Average
46%	40%	44%	43%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Top five ranking scores

Key Finding	2015-16		2016-17		Trust Improvement/ Deterioration
	Trust	National Combined Acute & Community Average	Trust	National Combined Acute & Community Average	
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20%	23%	20%	24%	Same as 2016
KF6 Percentage of of staff reporting good communication between senior management and staff	39%	32%	39%	33%	Same as 2016
KF20 Percentage of of staff experiencing discrimination at work in the last 12 months	9%	10%	8%	10%	improvement
KF1 Staff recommendation of the organisation as a place to work or receive treatment	3.91	3.71	3.92	3.75	improvement
KF16 Percentage of staff working extra unpaid hours	68%	71%	66%	71%	improvement

N.B Please note in 2017 Sheffield Teaching Hospital NHS Foundation Trust was benchmarked in the Combined Acute & Community Group as in previous years.

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

Bottom five ranking scores

Key Finding	2015-16		2016-17		Trust Improvement/ Deterioration
	Trust	National Combined Acute & Community Average	Trust	National Combined Acute & Community Average	
KF27 Percentage of staff/ colleagues reporting the most recent experience of harassment bullying or abuse	45%	45%	43%	47%	deterioration
KF24 Percentage of staff/ colleagues reporting the most recent experience of violence	63%	67%	62%	67%	improvement
KF7 Percentage of staff able to contribute towards improvements at work	68%	71%	68%	70%	improvement
KF4 Staff motivation at work	3.86	3.94	3.87	3.91	improvement
KF15 Percentage of staff satisfied with the opportunities for flexible working	52%	51%	51%	51%	Same as 2016

Biggest Improvements since 2016

	Trust 2016	National Combined	Trust	National Combined Acute & Community Average
KF16 Percentage of staff working extra hours	68%	71%	66%	71%
KF9 Effective team working	3.71	3.78	3.74	3.74
KF14 Staff satisfaction with resourcing and support	3.35	3.28	3.39	3.27
KF19 Organisation and management interest in action on health and wellbeing	3.65	3.61	3.68	3.63
KF15 Percentage of staff satisfied with the opportunities for flexible working	51%	51%	51%	51%

2.6 STATEMENTS OF ASSURANCE FROM THE BOARD

There were no statistically significant deteriorations in any of the 32 key findings .

The Trust has a Staff Engagement Lead and a Staff Engagement Coordinator who work with staff in Directorates to promote the sharing of good practice in both staff engagement and wellbeing across the Trust.

We will continue to work to involve our staff in making improvements at work through a variety of methods. As well as discussions about staff FFT results we hold a variety of events staff to encourage staff involvement and promote the sharing of good practice such as departmental timeouts, the Sharing of Good Practice Festival, Leadership forums, Give It a Go, LIA Pass it on events and the Microsystems Academy Expo to name a few.

We are looking at different ways to motivate and reward our staff during 2018 with the introduction of more local recognition schemes and increased staff benefits as well as introducing new communication methods to ensure more staff are aware of them. We are also looking at what more we can do to support staff and will be introducing Schwartz rounds.

An overall Trust staff engagement action plan has been drawn up to address the areas for improvement that is further supported by individual Directorate staff engagement action plans. These also address the Staff Friends and Family Test findings.

Undertaking a full census staff survey enables a staff engagement score to be calculated for every Directorate so these together with the action plans and Directorate staff Friends and Family Test scores are monitored via the Trust Executive Group/directorate performance review process and the Staff Engagement Executive.

Work Race Equality Standard (WRES)

Key Finding			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	20%	28%	22%
		BME	21%	26%	28%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19%	24%	20%
		BME	23%	26%	24%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	90%	89%	93%
		BME	71%	74%	61%
Q17b	In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	5%	5%
		BME	15%	13%	19%

The Trust has established a diversity post which will focus on workforce matters. The Trust continues to have a LIA scheme focusing on diversity and inclusion focusing on both staff with a disability and BME staff. It is pleasing to note the improvement in the percentage of BME staff believing the Trust provides equal opportunities in career progression following the work of the WRES QI group who have ensured more BME representation on nursing recruitment panels. The 2017 staff survey results show that at 3.96, staff engagement is higher amongst BME staff compared to the Trust average.

We are launching a Reverse Mentoring scheme with the support of Stacey Johnson, Associate Professor, University of Nottingham. We hope that this will improve our WRES statistics, as well as help us learn about new ways of being more inclusive and adaptable in our organisation. We have a member of our Workforce Information team working with the Director of the Workforce race equality programme at NHS England, so we can make more progressive step changes during 2018.

Leadership and Management Development

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

The PROUD values are:

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

Values Based Recruitment

We have continued using the PROUD values to recruit in the assessment centre process and having seen the benefits of this will be rolling it out to all staff. To enable us to do this we have purchased a system that enables us to screen all candidates on application to ensure we have staff with the right caring compassionate values working at STHFT

j. 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 2017-18 included participation in the National Survey Programme for inpatient, cancer and maternity services. National results, including comparative scores, will be available during 2018.

Throughout 2017, a series of local satisfaction surveys have been undertaken covering inpatient, outpatient and community patients, as well as a specific End of Life Care Survey. The Trust has scored well on questions relating to cleanliness; being treated with respect and dignity; communication; and confidence in clinical staff. During 2018, a survey of the experience of carers has commenced.

During 2017-18, the Care Quality Commission published results from the 2016 National Inpatient Survey, 2016 National A&E Survey, 2016 National Cancer Survey and the 2017 National Maternity Survey.

National Inpatient Survey 2016

The National Inpatient Survey 2016 was carried out across 149 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 2016, were eligible to be surveyed. 1,180 eligible patients from this Trust were sent a survey, and 505 were returned, giving a response rate of 43%. This is compared to the national response rate of 44%.

Compared to 2015, the Trust did not score significantly better on any questions, and scored significantly worse on one question.

Questions where the Trust scored significantly worse in 2016:

Question	2015	2016
Planned admission: admission date changed by hospital	9.5/10	9.2/10

Compared to other trusts participating in the National Inpatient Survey, the Trust scored similar to most other trusts on all questions. This is a slight improvement on 2015 where the Trust scored 'about the same' as other

trusts on all questions except one, where we scored worse, this question is presented below:

Question	All trusts 2016	STH 2015	STH 2016
The hospital and ward: Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.1/10	7.7/10	8.1/10

In response to this result, the requirements in relation to single sex facilities allow for bathrooms to be shared where they contain specialist equipment. The need for specialist equipment is not captured in the survey and this could explain the results. It is noted that this is the same for all trusts nationally. Following the 2015 survey, further work was undertaken to improve signage regarding this issue and this may be the reason behind the improved score during 2016.

In terms of the question relating to overall experience, the Trust scored the same (8 .1) as the national average (8.1). Overall, this Trust saw an improvement in 24 out 65 questions in 2016 compared with 2015, the same score was achieved on 11 questions, and scores deteriorated on 30 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 Survey 2016

The National Cancer Survey 2016 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 2016. 2,529 eligible patients from the Trust were sent a survey, and 1,513 were returned, giving a response rate of 66%. This is compared to the national response rate of 66%.

The Trust scored within the expected range on 43 questions, above the expected range on six questions and below the expected range on two questions. Areas where the Trust scored above the expected range include: patients feeling that treatment options were completely explained, possible side effects explained in an understandable way, being given information about support groups, being told who to contact if worried post discharge, being given all the information needed prior to radiotherapy treatment and being given all the information needed prior to chemotherapy treatment.

Areas where the Trust scored below the expected range were: being given easy to understand written information about the type of cancer they had, and the GP given enough information about the patient's condition and treatment.

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 and all Cancer Clinical Nurse Specialists to review patient information. Information packs at initial diagnosis have being streamlined and teams have been encouraged to support written information with a verbal discussion.

Increase awareness amongst nursing staff in relation to signposting to financial advisors. Area specific information packs developed to cover services across the whole of South Yorkshire.

Develop posters and make available to all areas illustrating how to access free prescriptions.

2016 National A&E Survey

The National A&E Survey 2016 was carried out across 137 acute and specialised hospital NHS trusts with a Type 1 (department is a major, consultant led A&E Department with full resuscitation facilities operating 24 hours a day, seven days a week) or Type 3 (department is an A&E/ minor injury unit with designated accommodation for the reception of accident and emergency patients) accident and emergency department.

Patients were eligible for the survey if they were aged 16 years or older, had attended an emergency department during September 2016, and were not staying in hospital during the sampling period. 1,182 eligible patients from the Trust were sent a survey, and 287 were returned, giving a response rate of 24%. This is compared to the national response rate of 27%.

Due to the change in sampling month, results from 2016 are not comparable with previous years. Compared to other trusts participating in the National A&E Survey, the Trust scored similar to other trusts on most questions, significantly better on one question and significantly worse on two questions.

Questions where the Trust scored better in 2016:

Question	All Trusts	STH 2016
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.3/10	8.2/10

Questions where the Trust scored worse in 2016:

Question	All Trusts	STH 2016
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.2/10	5.0/10
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.2/10	9.1/10

Survey results and comments were shared with the A&E directorate who have agreed an action plan.

National Maternity Survey 2017

The 2017 survey of women's experiences of maternity services involved 130 NHS acute trusts in England. More than 18,000 service users responded giving a national response rate of 37%. Women were eligible for the survey if they had a live birth during February 2017, were aged 16 years or older, and gave birth in a hospital, birth centre, maternity unit, or at home.

Antenatal

- The Trust scored 'about the same' as other trusts in all questions for antenatal
- The Trust did not score significantly worse in any question from the 2015 scores
- The Trust scored significantly higher than 2015 on one question.

Question	2015	2017
During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?	7.3/10	8.2/10

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 2015 in any question.

Postnatal Care

- The Trust scored 'about the same' as other trusts in most questions, except the below question where the Trust scored worse than most other trusts.

Question	STH	Lowest Score	Highest Score
Were you given enough information about any emotional changes you might experience after birth?	6.8/10	6.4/10	8.5/10

- The Trust scored significantly higher than 2015 on 5 questions

Question	2015	2017
Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	7.3/10	8.8/10
Did you feel that the midwife or midwives that you saw always listened to you?	8.4/10	9.1/10
Did the midwife or midwives that you saw take your personal circumstances into account when giving you advice?	7.9/10	8.7/10
Were you given enough information about your own physical recovery after the birth?	6.2/10	7.4/10
Were you told who you could contact if you needed advice about any emotional changes you might experience after the birth?	6.0/10	7.3/10

k. 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 days and where possible, we aim to take a proactive working approach to solving problems as they arise.

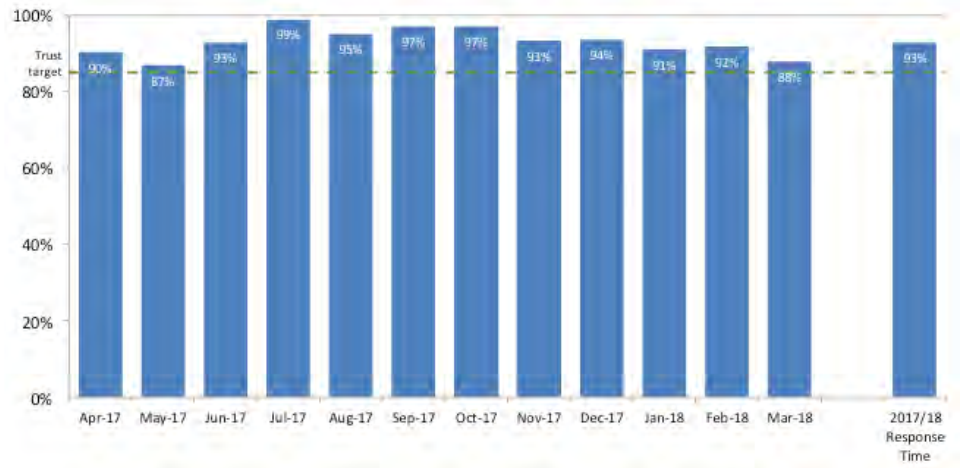
During 2017-18, we received 1,718 informal concerns which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Services Team (PST) and if staff feel they can be dealt with quickly by taking direct action, or by putting the enquirer in touch with an appropriate member of staff, such as a Matron or Service Manager, contacts are made and the enquiry is recorded on the complaints database as an informal concern.

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

During 2017-18 1,451 complaints requiring a more detailed and in-depth investigation were received. Table five provides a monthly breakdown of formal complaints and informal concerns received. Of the complaints closed during 2017-18, 41% (578/1,402) were upheld by the Trust. The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints made regarding government departments and other public sector organisations and the NHS in England. They are the final step of the complaints process, giving complainants an independent and last resort to have their complaint reviewed. During 2017-18 the PHSO closed 10 cases regarding the Trust 30% (3/10) of which were either fully or partially upheld.

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New informal concerns received	152	166	151	137	139	145	149	133	127	132	144	143	1718
New formal complaints received	102	120	100	111	132	111	143	128	85	142	124	153	1451
All concerns combined	254	286	251	248	271	256	292	261	212	274	268	296	3169

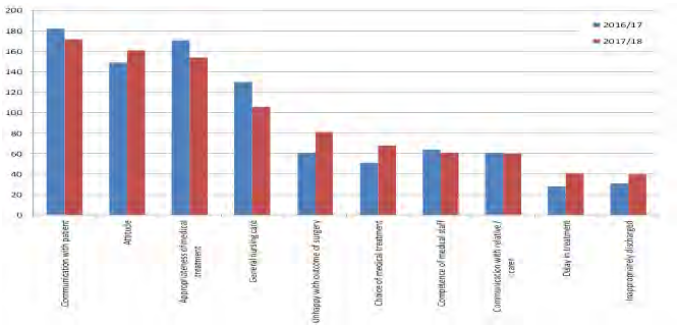
Chart 4 - Chart four - Trust Complaints Response Times



Regular complaints and feedback reports are produced for the Board of Directors, Patient Experience Committee, care groups and directorates showing the number of complaints received in each area and illustrating the issues raised by complainants. A monthly dashboard report focuses on key performance indicators for complaints handling and other feedback, supported by a more detailed quarterly report. The reporting process ensures that at all levels the Trust is continually reviewing information, so that any potentially serious issues, themes or areas where there is a notable increase in the numbers of complaints received can be thoroughly investigated and reviewed by senior staff.

Chart five shows the breakdown of complaints by theme. The findings show that the top four themes are the same as those identified last year. When presented as a percentage, complaints relating to 'communication with patient' are 1% lower this year, while complaints relating to 'attitude' are 0.5% higher. The rest of the themes identified are the about the same as last year, with a variation of just a 1% or less.

Chart Five - Subject raised in formal complaints



There continues to be an ongoing programme of work across the Trust to improve staff attitude and communication, with initiatives such as customer care training and the implementation of the PROUD values.

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

I. 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 with a six point scale, ranging from 'extremely likely' to 'extremely unlikely'. During 2017-18, the total percentage of patients who scored 'extremely likely' and 'likely' across all five elements of the FFT was 94%.

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 (IVM) and Text Messages (SMS) are the main methods of carrying out FFT in A&E, outpatients and community.

To aim to increase response rates in the Inpatient FFT, for wards who did not meet the 30% response rate target, SMS/IVM was trialled on 10 wards in 2016-2017. Following a review of response rates, scores and methods, most wards have continued to use postcards with the exception of two wards. 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 changed and it is no longer reported within the Community FFT but is now reported under the A&E element of the FFT. There was concern that this may have an impact on response rates as the GP Collaborative accounted for approximately 15% of all eligible patients within Community. The impact will be monitored.

Activity in outpatients increased during 2017-18 and it was agreed through the Patient Experience Committee to set an 80% cap on outpatients FFT, meaning that 80% of outpatients receive the survey. This ensures that high numbers of responses are received whilst managing the FFT cost effectively. The cap started in September 2017 with a view to trial the cap for three months and assess any impact on the response rate. It was estimated that the response rate would drop to between 6% and 7%. There was an initial 3.7% drop in September to (7.4%), which then maintained through October (8.3%) and November (7.1%). The response rate did not drop lower than estimated and is still above the national response rate. As it has maintained at an average of 7.6% over three months, it was agreed by the Trust's Patient Experience Committee that the cap would continue and the internal response rate target was therefore lowered from 9% to 7%.

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%, and A&E and maternity services of 20%, outpatient 9% and community 17%. These response rate targets were based on previous performances to ensure existing standards are maintained. It was agreed that the original response rate target of 17% for community was no longer achievable and therefore a new response rate of 12.5% was agreed at the Patient Experience Committee.

Over the last 12 months, 150059 FFT responses were received across all areas of FFT. Inpatients (30%), A&E (21%), maternity (28%), and outpatients (9%) all achieved their locally set response rate target during this time. Over the last 12 months the response rate for Community was 12%, this is below target response rate, although Trust performance was considerably better than the national response rate for community which was 4% for 2017-2018.

FFT results are monitored through monthly reports that present response rates, positive and negative scores and links to patient comments for all wards and departments.

Table six outlines the scores and response rates across all areas of FFT comparing 2016-2017 with 2017-2018.

	2016/2017				2017/2018			
FFT Area	Positive Score	Negative Score	Response Rate	No of Response	Positive Score	Negative Score	Response Rate	No of Response
Inpatient	95.7%	1.7%	29.8%	35855	96%	2%	30%	37204
Outpatient	93.9%	2.6%	8.9%	97125	94%	2%	9%	80138
Maternity	95.6%	1.3%	31.2%	5402	95%	1%	28%	5065
Community	88.4%	3.7%	15.5%	13256	89%	3%	12%	9422
A&E	86%	8.1%	24%	15943	87%	7%	21%	18230
Trust Total	93.2%	3%	12.1%	167581	94%	3%	12%	150059

When the Trust's response rate targets are not being met, the relevant areas are highlighted in the monthly reports.

In October 2017 the Trust's internal auditors, 360 Assurance, undertook an audit of FFT. The audit made the following recommendations.

- The Trust to record the reasons for discrepancies in FFT postcards on the tracking spread sheet to confirm that these have been investigated and to facilitate the identification of error patterns.

Amendments were made straight away to capture the reasons for discrepancies.

m. 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. There have been no breaches of this standard during 2017-18.

n. Coroners' Regulation 28 (Prevention of Future Death) Reports

When reviewing a death the Coroner has a duty to consider whether a person or an organisation should be taking steps to prevent similar deaths under Regulation 28 of the Coroner's (Investigations) Regulations 2013. A Coroner will issue a Prevention of Future Death report when there is a concern that the circumstances creating a risk of further deaths could recur or continue to exist. The person or organisation must then respond in detail regarding the action taken or to be taken, or must explain why no action is proposed. The Trust has not received any Prevention of Future Death reports during 2017-18.

o. 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 2017-18 three Never Events occurred at the Trust. These were in relation to the following:

- Misplaced naso-gastric Tube
- Wrong level neck surgery
- Wrong site surgery (this incident occurred in 2013 and was fully investigated at the time but was not escalated and reported as a Never Event)

Learning from serious incidents and Never Events is shared through different forums within the Trust. Three of the Never Events highlighted in this report involve processes undertaken within operating services and these reports have been reviewed at the Safer Surgery Steering Group. Actions taken as a result include the following:

- The minor operations checklist will be used for similar procedures and will be checked alongside the consent form
- The Procedural Marking Policy is to be incorporated into all procedures.
- Procurement of line placement imaging software
- Increased radiology consultant presence at weekends

- Taking steps to ensure that the operating team are aware of objects within the surgical field which may lead to confusion on an x-ray image
- To source an appropriate 'marking needle' produced commercially

The third never event occurred during 2013 and, whilst the incident was managed appropriately and relevant actions were taken within the directorate at the time, it was not escalated and reported as a never event. Assurances have been provided that, since 2013, a number of changes have been put in place to ensure that this would not happen again. These include increased staff awareness of incident reporting.

All the incidents are shared at the Trust's Safety & Risk Committees to ensure that wider learning and actions are developed and implemented.

p. Duty of Candour

In 2017-18 the Patient and Healthcare Governance team continued to roll out training for staff on the statutory Duty of Candour requirements, which form part of the regulatory compliance of the Trust. A 360 Assurance audit undertaken in 2016 found that the knowledge of staff about Duty of Candour, including being open and transparent, was good throughout the Trust.

The 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. During this period 345 incidents were identified as being both 'patient safety' and graded as moderate, major or catastrophic. Of these, 203 were highlighted as requiring the statutory duty to be implemented, only seven incident records did not state who was to lead the process.128 incidents highlighted that Duty of Candour did not apply despite reaching the appropriate severity code.

A further analysis of the 'did not apply' incidents was undertaken, and it was found that 50 incidents were linked to pressure ulcers which were present on the patient's admission and a further 33 were easily identifiable as being no harm incidents.

Summary compliance 'spot check' audits take place every quarter to provide assurance that directorates are complying with the Duty of Candour and these are reported to the Safety & Risk Committees.

An e-learning package on Duty of Candour was developed during the year and this is now available on PALMS.

q. Safeguarding Adults

The Trust is part of a wider network of agencies including the Sheffield Local Authority, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Children's Hospital, South Yorkshire Police, South Yorkshire Fire and Rescue, and NHS Sheffield CCG, who make up the Sheffield Adult Safeguarding Partnership (SASP). The SASP Executive Board leads and holds these individual agencies to account, to ensure the safety and well-being of adults at risk of abuse and neglect who are living in or accessing services or amenities in Sheffield.

The Trust has training, 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 Adults team works in close collaboration with the Trust's Safeguarding Children's team, the maternity services Vulnerabilities team, Emergency Department (ED) and Human Resources to identify and support adults at risk who are subject to domestic violence and abuse.

r. Seven Day Service

A national Seven Day Services Forum was established by Professor Sir Bruce Keogh, NHS England 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. NHS England's Board agreed to all of the Forum's recommendations, including full implementation of the clinical standards.

The ten standards are as follows:

Standard 1: Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital

Standard 3: All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the

responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

Standard 4: Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services. Consultant directed diagnostic tests and completed reporting will be available seven days a week:

- Within one hour for critical patients
- Within 12 hours for urgent patients

Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant directed interventions that meet relevant speciality guidelines, either on-site or through formally agreed networked arrangements with clear protocols. This includes critical care, interventional radiology, interventional endoscopy, emergency general surgery, urgent radiotherapy, PCI, cardiac pacing, renal replacement therapy.

Standard 7: Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

Standard 8: All patients on Acute Medical Units, Acute Surgical units, Intensive therapy units and all high dependency areas are seen by a consultant twice daily. All patients on general wards should be reviewed during a consultant delivered ward round at least once in every 24 hours seven days a week unless it has been determined that this would not affect the patients care pathway.

Standard 9: Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Standard 10: All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

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 1st Consultant Review
- Clinical Standard 5: Consultant Directed Diagnostics
- Clinical Standard 6: Consultant Directed Interventions
- Clinical standard 8 Ongoing Review

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).

3.1 Quality performance information 2017-18

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

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

Prescribed Information	2015-16	2016-17	2017-18
The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period National Average: 1 .00 Highest performing trust score: 0 .73 Lowest performing trust score: 1.25 (Figures for October 16- September 17)	0 .96 Banding: as expected	0.98* Banding: as expected	Oct 16-Sept 17 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. National average:31.5% Highest trust score: 59.8% Lowest trust score: 11.5% (Figures for October 16- September 17)	27 .3%	29.0%	29.1%
The 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. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this rate, and so the quality of its services, by: Performing quarterly analysis of the data underpinning the SHMI to provide a detailed understanding of the metric. SHMI diagnosis groups with a higher than expected O/E** ratio are scrutinised. This may involve any or all of the following steps; analysis of the data using variation analysis benchmarking tools, review by coding auditor, review by clinician / Clinical Director (via Structured Judgement Review method or alternative). Responses / actions are discussed at the Mortality Governance Committee and reported in a quarterly Trust Mortality Report to the Healthcare Governance Committee.			

Prescribed Information	2015-16	2016-17	2017-18
In addition, following publication in June 2017 of the updated guidance on Learning from Deaths by the National Quality Board, a governance process for the management of acute hospital deaths has been approved that will ensure that all deaths are reviewed by the Medical Examiner's Office and members of the review teams on a daily basis (See section on Learning from Deaths page 108). *The SHMI reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12month period i.e. Oct 2015 - Sept 2016. SHMI results are published five months and three weeks in arrears because of the need to validate the data nationally. The value for April 2016 - March 2017 was released on 21 September 2017 and reported as 0.98. This can be validated via the NHS Choices website. ** O/E ratio is the ratio of observed deaths divided by expected deaths			

Prescribed Information	2015-16 Finalised	2016-17 Provisional	2017-18 Provisional
Patient Report Outcome Measures (PROMs) The Trust's EQ5D patient reported outcome measures scores for:			
Groin hernia surgery			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.080 0.088 0.157 0.021	0.077 0.089 0.140 0.000	0.077 0.089 0.122 0.000
Varicose vein surgery			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.102 0.096 0.150 0.018	* 0.096 0.134 0.000	* 0.096 0.134 0.000
Hip replacement surgery primary			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.418 0.438 0.512 0.320	0.417 0.445 0.537 0.310	
Hip replacement surgery revision			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	* 0.283 0.374 0.224	0.291 0.292 0.362 0.239	
Knee replacement surgery primary			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.304 0.320 0.398 0.198	0.317 0.324 0.404 0.242	
Knee replacement surgery revision			
Sheffield Teaching Hospitals' score: National average: Highest score: Lowest score:	0.282 0.258 0.335 0.19	0.249 0.273 0.297 0.000	

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 as improved the patient's quality of life more than a lower score.

Due to the length of time before post-operative questionnaires are sent out NHS Digital have limited data for Hip and Knee replacements. The next publication is due to be released on 14th June.

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

* Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been received .The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the NHS Digital PROMs data set. The Sheffield Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its

services, by reviewing;

- Adherence to Antibiotic Policy in Elective THRs
- Length of post-operative inpatient stay following elective primary hip and knee arthoplasty
- Review of post-operative pain management for patients undergoing hip and knee replacement
- Trust level analysis of data
- Review and comparison of patient feedback, expectations and outcomes

Prescribed Information	2015-16	2016-17	2017-18
Readmissions The percentage of patients aged: 0 to 15; and 16 or over, readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period. Comparative data is not available The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the Trust's Patient Administration System up to October 2015 and then from Lorenzo. The Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, continuing to enhance assessment areas with the recent opening of a new 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. Trials in Geriatric Medicine including the development of 'Okay to Stay' plans, closer working with Care Homes and the 'Red Bag Project' have also shown some encouraging signs and we are looking to expand these further. Expanding our ambulatory care offering is also a priority in the coming months.	0% 14.3%	0% 14.7%	0% 14.88%
Responsiveness to personal needs of patients The Trust's responsiveness to the personal needs of its patients during the reporting period. National average: 72% (this is based on the average scores across all NHS trusts who are contracted with Picker Europe, the CQC's national surveys contractor) The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by National CQC Survey Contractor. The Sheffield Teaching Hospital NHS Foundation Trust continues to take action to improve this rate, and so the quality of its services, by implementing a new local inpatient survey during 2016-17. The new survey is sent to 2000 inpatients one month in each quarter. Each quarter, patients from the sample are asked six core questions, including one on privacy and dignity and follow-up questions which are themed and change each quarter, as follows: • April 2017 – Noise, food, and staff. • July 2017 – Discharge. • October 2017 – Communication. • January 2018 – Environment. Local inpatient survey results to questions relating to responsiveness to personal needs of patients during 2017-18 are as follows: • Did you always feel safe while on the ward? – 88% • Did hospital staff treat you with respect and dignity? – 91% • Did you always get the help you needed to eat? – 87%	76.9%	74.7%	80.4%

3.1 QUALITY PERFORMANCE INFORMATION

Prescribed Information	2015-16	2016-17	2017-18
Friends and Family Test - Staff who would recommend the Trust (from Staff Survey) The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: Combined acute & community trusts – 68% All trusts – 69% Highest performing trust score:(Combined acute & community trusts): 91% Lowest performing trust score: (Combined acute & community trusts): 48% The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the national CQC survey contractor. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by seeking staff views and involving them in improving the quality of patient services via Listening into Action, Microsystems Academy, Staff Friends and Family Test and our ongoing staff engagement work.	76%	81%	81%
Friends and Family Test - Patients who would recommend the Trust The percentage of patients who attended the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. The Friends and Family Test scores are now recorded taking the percentage of respondents who 'would recommend' our service which is taken from ratings 1 (Extremely Likely) and 2 (Likely). The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Healthcare Communications, verified by UNIFY and reported by NHS England. The Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and so the quality of its services: • A monthly report is circulated across the Trust enabling staff to keep on top of scores and response rates, as well as review the comments that patients have left about their experience. • The Patient Experience Committee monitors FFT scores for all elements of the FFT each month and takes the necessary action should the positive score fall in any particular area of the Trust. • Monthly FFT scores are compared with the 12 month Trust score as well as the 12 month National score to monitor performance.	All areas 92% Inpatient 96% A&E 83% Maternity 96% Outpatient 94% Community 86%	All areas 93% Inpatient 96% A&E 86% Maternity 96% Outpatient 94% Community 88%	All areas 94% Inpatient 96% A&E 88% Maternity 95% Outpatient 94% Community 89%

3.1 QUALITY PERFORMANCE INFORMATION

Prescribed Information	2015-16	2016-17	2017-18
Patients risk assessed for venous thromboembolism (VTE) The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. Comparative data is not available The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and so the quality of its services, by having established processes in place that check if a patients has had a VTE risk assessment. Where this has not been completed this is followed up and completed.	95.18%	95.2%	95.29%
Rate of Clostridium Difficile The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period. Comparative data is not available *The rate shown is provisional until the Public Health England denominator rates are published. The denominator used is the 2016-17 figure as this is unlikely to change significantly. During 2017-18 there have been 83 cases of C.difficile infection attributable to the Trust. The national threshold for 2017-18 was 87 Trust attributed cases. All Trust attributable cases now have a root cause analysis to identify if there has been any lapse in care. At publication 14 cases have been highlighted as possibly having a lapse in care. Quarter 4 cases are still being reviewed. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by the Public Health England. The Sheffield Teaching Hospitals NHS Foundation Trust continues to take the a range of actions to improve this rate, and so the quality of its services, by having a dedicated plan as part of its Infection Prevention and Control Programme to continue to reduce the rate of C.difficile experienced by patients admitted to the Trust.	14.4	20.3	15.5*

3.1 QUALITY PERFORMANCE INFORMATION

Prescribed Information	2015-16	2016-17	2017-18
Rate of patient safety incidents			(April- Sept 2017)
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	17,714	20,089*	10,070**
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 2016 **Cluster average: 40.21 Highest performing Trust score: 70.23 Lowest performing Trust score: 22.24	33.4	37.15*	37.6**
The number and percentage of patient safety incidents that resulted in severe harm or death. **Cluster reporting data: 38 (0.3%) Highest reporting Trust: 1908 (1.3%) Lowest reporting Trust: 3 (<0.1%)	23 (0.1%)	18* (0.1%)	23** (0.2%)
* The figures for 2016-17 are different to those documented in last year's Quality Report as they have now been validated. **Full information for the financial year 2017-18 is not available from the National Reporting and Learning System (NRLS) until November 2018. The Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the National Reporting and Learning System (NRLS). The Sheffield Teaching Hospitals NHS Foundation Trust intends to increase the incident reporting rate. To note: As this indicator is expressed as a ratio, the denominator (all incidents reported) implies an assurance over the reporting of all incidents, whatever the level of severity. There is also clinical judgement required in grading incidents as 'severe harm' which is moderated at both a Trust and national level. This clinical judgement means that there is an inherent uncertainty in the presentation of the indicator which cannot at this stage be audited.			

3.1 QUALITY PERFORMANCE INFORMATION

Mandated Indicators in the Risk Assessment Framework and the Single Oversight Framework

Measures of Quality Performance	2015-16	2016-17	2017-18
Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer			Q1, Q2 and Q3 data used
Urgent GP referral for suspected cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	83%	83%	78.32%
National Standard	85%	85%	85%
Urgent GP referral for suspected cancer			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	96.31%	96.31%	94.82%
National Standard	90%	90%	90%
Data Source: Open Exeter National Cancer Waiting Times Database			
Accident and Emergency maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	*	86.77%	88.64%
National Standard	95%	95%	95%
*At the end of September 2015, the Trust introduced a new Accident and Emergency tracking system, as part of the move to a new Electronic Patient Record. This has presented various technical difficulties and challenges to accurately did capture data on patients wait in A&E. Due to this we did not report our A&E waiting time data nationally during 2015-16.			
MRSA blood stream infections			
Trust attributable cases in Sheffield Teaching Hospitals NHS Foundation Trust	0	2	3
Trust assigned cases in Sheffield Teaching Hospital NHS Foundation Trust	0	2	3
Sheffield Teaching Hospitals NHS Foundation Trust threshold	0	0	0
Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	87.3%	85.4%	88.21%
National Standard	90%	90%	90%

3.1 QUALITY PERFORMANCE INFORMATION

Measures of Quality Performance	2015-16	2016-17	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	95.9%	93.16%	94.44%
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%	93.5%	95.70%
National Standard	92%	92%	92%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability			
Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	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
Never Events (Count)			
Sheffield Teaching Hospital NHS Foundation Trust Performance	4	6	3

3.1 QUALITY PERFORMANCE INFORMATION

Measures of Quality Performance	2015-16	2016-17	2017-18
Hospital Standardised Mortality Ratio (HSMR)			(Feb 17-Jan 18)
Sheffield Teaching Hospital NHS Foundation Trust Performance	103%	105%**	102%
National Benchmark	100%	100%	100%
Data source: Dr Foster			
**This figure is different from last year as it represents the whole year (April 2016 – March 2017) rather than Jan 2016-Dec 2016 as reported in last year's Quality Report.			
Data Completeness for Community Services			
Referral to treatment information:	62%	65%	62%
Sheffield Teaching Hospitals NHS Foundation Trust achievement	50%	50%	50%
National Standard			
Referral information:	100%	100%	100%
Sheffield Teaching Hospitals NHS Foundation Trust achievement	50%	50%	50%
National Standard			
Treatment activity information:	100%	100%	100%
Sheffield Teaching Hospitals NHS Foundation Trust achievement	50%	50%	50%
National Standard			
Maximum 6-week wait for diagnostic procedures			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	97.34%	98.93%	92.95%
National Standard	99%	99%	99%

Governor Involvement in the Quality Report Steering Group

January 2018 saw the commencement of the new overarching Quality Board. The Quality Board has taken over the work of the Quality Report Steering Group which concentrated on fewer priorities while the new Board will focus on many more quality objectives and will oversee delivery of the Trust's annual quality improvement priorities.

Attention is continuing to focus on patient safety and the patient experience. All objectives will be relevant and meaningful and while some will be achievable in the short term there will be many longer term aims.

As previously there are governors on the Board and our contribution is welcomed and valued. We are looking forward to participating in new developments, as well as assisting with longer term aims.

Kath Parker
Patient Governor 20th April 2018

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 2017/18 the Trust has achieved a number of key Constitutional standards and key quality performance measures with particularly high achievement in the incomplete 18ww target. However, the Trust has continued to experience challenges in the delivery of the 95% A&E target, a number of the cancer wait targets and more recently in diagnostic waits during the year.

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 2017/18. 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 2018/19 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 2018

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

The Healthier Communities and Adult Social Care Scrutiny Committee would like to thank the Trust for this opportunity to comment on the draft 2017/18 Quality Account.

The Trust engaged with the Committee early on in the Quality Account process, and commends the Trust on the robust process put in place in to identify Quality Priorities for this year. We are pleased to see clear outcome measures against each priority, and clear plans for how they will be achieved.

During our work this year, we have considered the issue of transfers of care. We are pleased to see that the Statement on Quality notes the progress that has been made in this area, particularly around partnership working; and more importantly, that challenges remain. The Committee will be looking for further improvements in this area next year. Beyond this, the Committee has not been made aware of any concerns over the Trust's performance or service delivery.

The Committee is concerned to see that 3 'Never events' have been recorded this year. The Committee notes that the learning from these events is shared through Trust forums and will be seeking assurance that these are not repeated.

The Committee's comments are put together in a period when the full and final performance information is not available. We are therefore unable to take a comprehensive overview of performance, but note with some concern that urgent suspected cancer GP referral to treatment times are below the National Standard.

We recognise that these are challenging times for the NHS, and would like to take this opportunity to thank all the staff at the Teaching Hospitals who work so hard to deliver vital services across the city.

1st May 2018

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 welcome your new approach to the management of your quality objectives within the Quality Board and we are pleased to participate in this Board.

We are satisfied with the progress made against 2017/18's quality priorities and are pleased to see that they will continue to be built on in 2018/19. We are particularly pleased that you plan to roll out safety huddles to all wards in Medicines and Pharmacy Services (MAPS) and Geriatric and Stroke Medicine (GSM) in 2018/19.

We welcome the new quality priorities for 2018/19 and the clear outlining of quarterly objectives for each one. Priorities with timescales of longer than one year would benefit from clarity about what you plan to achieve in year two, to help us to see the long term plan. We strongly support two priorities in particular, to 'improve working in partnership with our patients, their families and carers towards shared goals' and 'significantly increase the scale of patient engagement with those who may be harder to reach or seldom heard'. We look forward to supporting the implementation of these quality objectives during 2018/19.

During this year we have highlighted the duty on all providers of NHS care to properly implement the Accessible Information Standard, and we have shared with you the experiences of Deaf people using STHFT services that have often fallen short of expectations. We welcomed the action plan you have put in place in response to these problems and note that the implementation of the Standard is particularly relevant to your quality priorities for 2018/19, to 'improve the process and quality of consenting within STHFT with a focus on ensuring patients are provided with individualised information' and 'ensure out-patient and in-patient letters are fit for purpose, are clear and understandable, and meet the needs of both patients and national good practice guidelines'.

We are pleased to note that the proportion of patients who would recommend the trust to friends and family slightly increased last year, with community and A&E seeing the largest increases in this measure of patient satisfaction.

We feel that your account generally reflects the experiences shared with us by services users and their families about Sheffield Teaching Hospitals. We have been happy with the way the quality board is utilising patient experience to develop quality objects and we look forward to working with the trust on this over the coming year.

30th April 2018

4.2 STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

Statement of Directors' Responsibilities for the Quality Report

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

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 2017-18 and supporting guidance.

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period April 2017 to March 2018
- papers relating to quality reported to the board over the period April 2017 to March 2018
- feedback from commissioners dated 3rd May 2018
- feedback from governors dated 20th April 2018
- feedback from local Healthwatch organisations dated 30th April 2018
- feedback from Overview and Scrutiny Committee dated 1st May 2018
- the trust's draft complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
- the latest national patient surveys, dated May 2017 (Inpatients), October 2017 (Emergency Department), January 2018 (Maternity) and July 2017 (Cancer)
- the latest national staff survey published March 2018
- the Head of Internal Audit's annual opinion of the Trust's control environment discussed at the Audit committee of 21 May 2018.
- CQC inspection report dated 9 June 2016

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

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

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

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

The Quality Report has been prepared in accordance with 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

Tony Pedder OBE
Chairman

22 May 2018

Sir Andrew Cash OBE
Chief Executive

22 May 2018

4.3 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 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients at the end of the reporting period; 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 2017/18; 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 2017/18.

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 2017 to April 2018;
- Papers relating to quality reported to the Board over the period April 2017 to April 2018;
- Feedback from NHS Sheffield Clinical Commissioning Group, dated 3 May 2018;
- Feedback from governors, dated 20 April 2018;
- Feedback from the Healthwatch Sheffield, dated 30 April 2018;
- Feedback from Sheffield City Council Healthier Communities and Adult Social Care Scrutiny Policy Development Committee, dated 1 May 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for the year April 2017 to March 2018 (draft version 1);
- The latest national patient surveys;
- The latest national NHS staff survey;
- Care Quality Commission inspection report, dated June 2016;
- The Head of Internal Audit's annual opinion over the Trust's control environment for the period April 2017 to March 2018; 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. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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.

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

We permit the disclosure of this report within the annual report for the year ended 31 March 2018, 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.

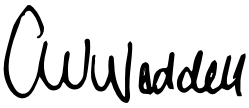
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, 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 2018:

- 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 2017/18; 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
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham DH1 5TS

24 May 2018

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

Opinion

We have audited the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of the audit report

This report is made solely to the Council of Governors of Sheffield Teaching Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue Recognition There is a risk of fraud in the financial reporting relating to revenue recognition due to the potential to inappropriately record revenue in the wrong period. Due to there being a risk of fraud in revenue recognition we consider it to be a significant risk on all audits. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting such that we consider revenue recognition to be a Key Audit Matter at the Trust. We identified specific risks in relation to revenue recognition to be in the following areas: • Recognition of income and receivables around the year end; • Recognition of Sustainability and Transformation Fund (STF) income during the year. **Valuation of Land and Buildings** Land and buildings are the Trust's highest value assets. In 2017/18 the Trust moved to an alternative site valuation method. This reduced the value of these assets significantly and was subject to a significant degree of estimation and judgement. Management engaged the Valuation Office Agency (VOA) as an expert to assist in determining the fair value of these assets to be included in the financial statements. Changes in the value of land and buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Group Accounting Manual	Our approach involved a range of substantive procedures including: • testing of material income and material year-end receivables; • testing receipts in the pre and post year-end period to ensure they have been recognised in the right financial year; • reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care and, if necessary, seeking direct confirmation from third parties or their external auditors; and • testing of STF income and agreeing the consistency of the returns made to NHS Improvement during the year and in-year financial reporting. There were no significant findings arising from our work on revenue recognition. Our approach involved: • assessing the scope and terms of engagement with the VOA; • assessing how management used the VOA's report to value land and buildings in the financial statements; • assessing and challenging the VOA's methodology and their procedures to ensure independence, objectivity and quality (including consulted our own expert to assess the VOA's work); and • considering regional valuation trends (provided by our valuation expert) to assess the reasonableness of the movement in valuations. In addition, we: • assessed the Trust's approach to the alternative site valuation; and • tested the reasonableness of the data used to derive the model for the alternative site valuation. There were no significant findings arising from our work on the valuation of land and buildings.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements.

Based on our professional judgement, we determined materiality for Sheffield Teaching Hospitals NHS Foundation Trust for the financial statements as a whole as follows:

Overall materiality	£15m
Basis for determining materiality	Approximately 1.5% of operating expenses from continuing operations
Rationale for benchmark applied	Operating expenses from continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.25m, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

An overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the Accounting Officer and the overall presentation of the financial statements. The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed in the "Key audit matters" section of this report. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Other information

The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2017/18 ; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.
Use of resources	
We are required to report to you if the Trust has not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.	We have nothing to report in respect of this matter.
Other information	
We are required to read the other information and report to you if the other information is: • materially inconsistent with the audited financial statements or our knowledge obtained in the course of performing our audit; or • otherwise appears to be materially misstated. We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.	We have not identified any such material inconsistencies or misstatements.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

The Chief Executive as Accounting Officer is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are also required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General (C&AG), having regard to the guidance on the specified criterion issued by the C&AG in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

We certify that we have completed the audit of the financial statements of Sheffield Teaching Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Cameron Waddell
For and on behalf of Mazars LLP

Salvus House
Aykley Heads
Durham DH1 5TS

24 May 2018

For more information or if you would like this document provided in a different language or large print please contact:

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