Report to Health Scrutiny Sub-Committee

Report of:	*Yvonne Millard, Chief Nurse, Sheffield Children's Hospital Trust*
Report to:	*Health Scrutiny Sub-Committee*
Date:	*1st June, 2023*
Subject:	*Sheffield Children's Hospitals Trust Quality Account*

Purpose of Report:

To share the Quality Account with Sub Committee Members and invite comments, to feed back to the Trust by their deadline of 2nd June

Recommendations:

For members of the sub-committee to:

1. **note the content of the Quality Account**
2. **Discuss and make comments on the report, to be fed back to Sheffield Children's Hospitals Trust by the deadline of 2nd June**

Sheffield Children's NHS
NHS Foundation Trust

Quality Account 2022/23

QUALITY ACCOUNT

About Sheffield Children's NHS Foundation Trust

Sheffield Children's NHS Foundation Trust is an integrated children and young people's NHS foundation trust. This means that we have responsibility for most areas of local child health, excluding the provision of GP services and maternity.

Our services encompass:

- **primary child healthcare** – e.g. our 0-19 team made up of health visitors and school nurses.
- **secondary healthcare** – e.g. acute medical and surgical care delivered primarily at Sheffield Children's Hospital but also therapies, medical and nursing care across our community sites.
- **tertiary child care** – e.g. neurosurgery, cancer care, critical care and critical care transport.
- **children and young peoples' mental health services** – community, day patient and inpatient mental health services.
- Our health visitors and school nurses work with the local authority and GPs to ensure that children are kept healthy. Our community paediatricians, nurses and therapists work with families to avoid or minimise hospital stays.

We hope that you find our annual Quality Account informative.

Part 1: Statement from the Chief Executive

After two years of disruption from the Covid-19 pandemic, 2022/23 has been a year when we have looked to return, renew and refresh our services to pre-pandemic levels using the CQC's framework of safe, effective and responsive care whilst also recognising we face significant challenges including increasing acuity of patients, significant disruption from industrial dispute and the need for tighter financial management.

Highlights in the past year from a quality perspective have included:

- Starting work on our new Helipad and securing the funding for a new National Centre for Child Health Technology.
- Securing a rating of 'Good' for our inpatient wards at the Becton Centre following a CQC inspection in July 2022. At the same time, community CAMHS improved across three domains.
- Rapidly reducing our waiting lists, especially for those patients waiting longer than 78 weeks.
- Implementing a number of new quality-related IT projects including Vitals e-Observations, the Patient Information Library, Digital Whiteboards (Patient Flow) and the Connect digital handover tool project.
- Increasing our work around Super Saturdays, Health Inequalities work on 'you matter care packs' and our Was Not Brought approach.
- Specific engagement undertaken with under-represented communities (including Somali, Roma, people living with autism, Special Education Needs engagement).
- Recruitment of nearly 60 internationally trained nurses and nearing 100% nursing fill-rate.
- Ensuring all new doctors in training are given access to the Health Toolbox platform.

We also launched our new Caring Together Strategy in September 2022 and will be supplementing this with work on a new Quality Strategy due to go live in May 2023 around safe, kind and great care.

We look forward to you joining us on our journey.

Ruth Brown
Chief Executive

30 June 2023

Part 2 Priorities for Improvement and Statements of Assurance from the Board

Priorities for Improvement 2022/23

At Sheffield Children's NHS Foundation Trust, we are absolutely committed to continually improving patient safety and the quality of our care across our acute, community and mental health services. We have therefore carefully considered our quality priorities for 2022/23 by:

- Reviewing the national improvements that all NHS organisations have to make (standards and targets).
- Actively listening to issues that have been highlighted by children, young people, families and our colleagues.
- Reviewing patient and carer feedback around improvements that they would like to see.
- Reviewing the themes that have been identified through the year for quality and safety.
- Assessing our performance for quality and safety against best practice.
- Considering our strategic direction to ensure that all our priorities are aligned.

Our quality priorities for 2022/23 are therefore as follows:

Implement the Patient Safety Incident Response Framework to improve systems, processes and training for patient safety

Our reason for selecting this priority is because it introduces a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates compassionate engagement and involvement of those affected by patient safety incidents, application of a range of system-based approaches to learning from patient safety incidents, provides considered and proportionate responses to patient safety incidents and supportive oversight focused on strengthening response system functioning and improvement.

We will:

- Shape the Patient Safety Partner Model which empowers and champions the patient/family voice in contributing and being involved in 'their own care'.
- Teaming up with Care Group colleagues engaged in the PSIRF implementation stakeholder task & finish group regarding improved internal processes for involving patient/families in the mandated engagement process.
- Take significant learning from Serious Incidents (SIs) / Patient Safety Incident Investigations (PSIIs) which reveal families have felt unheard and demonstrate the safety improvements we are making to strengthen the ability for them to be heard and to feel listened to. We should also use this opportunity to add how Sheffield Children's intend to strengthen the patient/family voice by growing the Patient Story model and expanding that to ensure it pollinates care groups.
- Supports the key principles of a patient safety culture, focusing on understanding how incidents happen, rather than focusing solely on human factors which naturally facilitates the perception of the apportioning of blame.
- Ensure the NHS can focus on understanding how incidents occur, rather than apportioning blame on individuals involved, allowing for more effective learning and improvement and ultimately enabling NHS care to be safer for patients.

- Develop a Patient Safety Incident Response Plan (PSIRP) and Policy which will identify our Trust's unique patient safety incident profile and will enable the Trust to review existing safety improvement work to identify the Patient Safety Incidents/Events that will benefit most from Learning Responses and maximise the opportunities for improvement by way of other methodologies and tools.

- Ensure organisational wide learning resources are developed to more effectively share and cross pollinate care groups/specialties. These new resources will be adopted and adapted during the implementation and establishment phase (2023/24) to ensure shared learning is evidencable and sustainable.

- Support development of a Patient Safety Incident Response System that prioritises compassionate engagement and involvement of those affected by Patient Safety Incidents regardless of gender identity, race, socioeconomics, background or belief.

Reduce elective waiting times to achieve 65 weeks, whilst ensuring "well prepared" outpatients and surgical pathways

Our reason for selecting this priority is because our waiting times in both outpatient and inpatient pathways have grown during the covid-19 pandemic. We are seeking to ensure that children and young people on our waiting lists remain safe and access their treatment as soon as possible.

We will:

- Ensure no patients requiring physical healthcare are waiting over 65 weeks for their first treatment. We will do this by creating more capacity, changing our clinical pathways, and engaging with other health and social care partners.

- Actively keep our Child and Adolescent Mental Health Services waiting lists under constant review and ensure that high risk patients receive a review within two weeks of referral

- Look to enhance our Mental Health offer in terms of crisis care, provision in education settings and on attendance to hospitals across the city.

- Seek to reduce our non-Consultant waiting times (these include Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology and Neurodiverse pathways) and support patients whilst they wait for care.

- Ensure that risk of harm is considered when prioritising patients on waiting lists. This will be done through the harm review panel, chaired by the Medical Director

- Ensure effective use of our existing capacity through ensuring families and clinicians are well prepared for their outpatient appointments and procedures

- Communicate with patients whilst they wait and engage them in preparing for their treatment

- Ensure that as a Trust we are seeking to communicate and engage patients in ways that allow us to address inequalities and that involves patient and families in their care. This will include coproduction of information and clinical advice

A focus on ensuring outstanding experience at Sheffield Children's through co-production of a vibrant involvement and engagement approach with children, young people, families, and communities.

Our reason for selecting this priority is so that:

- When everyone; regardless of race, gender, disability, poverty or any other factor, has agency to shape their experience we will be able to deliver better health outcomes

- We can be a brilliant place to work when colleagues are enabled to fully participate and are free to involve children and young people (C&YP) and families in their services
- As a Trusted organisation by C&YP, families and communities we have a strong voice to lead, advocate and influence for C &YP and work collaboratively with partners for the greater good.

What we plan to do about it

- We will foster a **learning environment** and develop the skills to engage, listen and act on voice well throughout our organisation, working with partners. This will work both at a patient facing level, developing coaching and co-decision-making skills for colleagues working with families. We will also develop more strategic level skills, including formal consideration of how we better incorporate voice into our governance structures and develop greater cultural competence & co-production skill sets in our leaders.
- We will strengthen our **infrastructure and governance** for overseeing our approach to capturing the child, young person and family voice. We will test, trial, and develop exemplar models of practice, which will then be spread more widely across the organisation.
- We will reach out to existing partner, voluntary, faith and community groups, to **work in partnership to most effectively reach out to communities that experience health inequalities** focussing on those seldom heard voices so that we are attentive to their needs and are able to improve services with a particular focus on communities that experience Health Inequalities
- We will continue to develop our **Youth Forum** to represent the diverse range of communities we serve and establish new routes to have two-way conversations around 'what matters' to children and young people.
- We will **strengthen our links with schools** to connect with a diverse range of children and young people and meet them in their own environment.
- We will **advocate** for Children and Young People working collaboratively with partners for innovative models of care to have the greatest impact.

Our Progress against our 2021/22 priorities

Last year we set ourselves the following three quality priorities:

- A focus upon care recovery on inpatient and outpatients waiting times across all our integrated services.
- Ensure the protection of colleagues, children, and young people against infectious diseases..
- Improve patient safety through the implementation of digital technology.

The next section sets out the progress we have made against these priorities.

A focus upon care recovery on inpatient and outpatients waiting times across all our integrated services.

Actions:	Progress:
• Reduce the number of patients requiring physical healthcare waiting over one year for their first treatment. We will do this by creating more capacity, changing our clinical	The Trust reduced the longest wait for physical consultant led healthcare from 104 weeks down to 78 weeks for all but a few patients. This was despite the multiple periods of Industrial Action that severely

pathways, and engaging with other health and social care partners.	hindered the number of patients that could receive care.
• Actively keep our Child and Adolescent Mental Health Services waiting lists under constant review and ensure that high risk patients receive a review within two weeks of referral	The Trust continued to offer appointments for those patients requiring rapid assessment for mental health conditions. The last four months of 2022/23 have also seen a reduction in the overall waiting times and with the significant investment secured for 2023/24 this is expected to continue.
• Look to enhance our Mental Health offer in terms of crisis care, provision in education settings and on attendance to hospitals across the city.	The Trust has expanded the crisis team offer through its Supportive Treatment and Recovery (STAR) team and continues to work with education settings to improve access to care. 2023/24 will see the introduction of the Parent and Infant Relationship Service (PAIRS) that will support patients in the peri-natal and post natal stages.
• Continually review our non-Consultant waiting lists (these include Physiotherapy, Occupational Therapy, Speech and Language Therapy, psychology and neurodiverse pathways) and to support patients whilst they wait for care.	These remain a significant focus for the organisation. Psychology waits have reduced significantly. Referrals for our neurodiverse services have increased significantly and remain a challenge for the Trust and the wider system. The Trust has committed £800k into this service to expand capacity. Speech and Language has also received a significant increase in funding that will help reduce waiting lists through 2023/24
• Ensure that risk of harm is considered when prioritising patients on waiting lists. This will be done through the harm review panel, chaired by the Medical Director	All patients awaiting a surgical procedure are harm waited and prioritised by clinical teams alongside those patients that have waited the longest . The whole process is overseen by the Medical Director.
• Work to restore our vaccination and immunisation programme to ensure that school age vaccinations paused during the pandemic are administered	As society and schools opened up, vaccination of patients has been made easier . The Trust has been successful in a tender to expand the services it is commissioned to provide
• Communicate with patients whilst they wait and engage them in preparing for their treatment	The Trust is in regular contact with patients whilst they wait through various different media. A number of our services, such as neurodiversity, have a range of materials online such as videos and information leaflets.
• Ensure that as a Trust we are seeking to communicate and engage patients in ways	The Trust reviews all of its waiting list data through a deprivation and ethnicity lens. The Trust has completed a significant amount of work on this agenda to support patients and families from

that allow us to address inequalities and that involves patient and families in their care. This will include coproduction of information and clinical advice	different backgrounds to attend their appointments etc.

Ensure the protection of colleagues, children, and young people against infectious diseases.

Actions:	Progress:
• Identify and train a team of colleagues who can deliver our colleague influenza vaccination programme as well as respond to any forthcoming JCVI recommendations for NHS staff Covid 19 booster vaccinations.	There are several colleagues across our acute and Becton site who are trained to administer influenzae and Covid-19 booster vaccinations to colleagues. In addition to our clinical colleagues there are a core team of seven vaccinators who can respond to any recommendations for NHS staff Covid-19 booster vaccinations to support the ward/dept based vaccinators.
• The team will respond to JCVI guidance on any further Covid 19 vaccinations recommended for those children and young people who are immunosuppressed or extremely clinical vulnerable or living with a family member who is immunosuppressed.	The core vaccinators have facilitated several vaccination sessions for children and young people who are immunocompromised or classed as extremely clinical vulnerable or who are living with someone who is immunosuppressed. This team can respond in a timely way if further vaccinations are recommended.
• Explore whether the Trust can support the administration of childhood vaccinations when children and young people are accessing defined areas of the Trust. The vaccination status of children and young people who attend initially for out-patient appointments and elective admissions will be verified and vaccinations which are due or outstanding will be offered. This will reduce inequalities in health by enabling children and young people to have greater access to protection.	There is currently an active working group which is tasked with looking at vaccinating children and young people under the 'Ad-hoc service specification for vaccination and immunisation'. It is proposed that initially patients attending immunology clinic will be able to access any missed vaccinations. Once the model is embedded it will be rolled out to other clinics. It is proposed that vaccination will be verified at pre-op clinics and children vaccinated as part of their pre-op appointment.

• Work as an integrated Trust with our partners across the city to increase vaccination rates by joining in engagement and involvement activities to understand barriers to vaccination and how these can be effectively addressed. This continues early work with faith and other groups to ensure that access to vaccinations is optimised where inequalities in healthcare exist.	The School Aged Immunisation Service (SAIS) team meet regularly as part of the wider regional group to review practice and explore the widening health inequalities gap, alongside the barriers to vaccination. Vaccination fatigue has been recognised nationally as a challenge and locally we are seeing the effects of this. Discussing the challenges regionally is offering the opportunity to ensure that coordinated messages are disseminated and widen the opportunities for families to receive timely vaccination. The SAIS team meet regularly with the commissioners and the local authority to explore local barriers to vaccination including pre-school booster uptake. There is an active community group within North Sheffield (locality B) including faith leaders, General Practitioners, education providers, 0-19 service, and community leaders. The groups agenda has developed from evidence and learning from the pandemic which has further exposed some of the health and wider inequalities that exist. Covid-19 has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, specifically those from Black, Asian and minority ethnic communities. The community group are working with the to increase vaccination uptake by utilising a family based approach.

Improve patient safety through the implementation of digital technology.

Actions:	Progress:

• Launch our 'Vitals' electronic observations programme across acute wards by June 2022, with training and devices provided to all clinical staff who will use the new system. This will enable point of care recording of vital signs (observations) and alert medical staff to patients who more urgently require their attention. This aligns with a national programme to standardise the recognition of the deteriorating child, known as Paediatric Early Warning Score (PEWS).	This was achieved. Vitals electronic observations solution go-live commenced with implementation on Ward 1, from 12th May 2022 (International Nurses Day). Roll-out to all other acute inpatient wards was completed by end June 2022. System design and roll-out has been overseen by a multi-disciplinary team, including dedicated lead nurse and matron roles. This support remained in place for 6 months from initial go-live to ensure the system was fully embedded. Two permanent 'Lead Nurse for Digital Technology' roles have also been recruited to subsequently.
• Replace our current patient ward whiteboards with electronic versions in a phased approach, ensuring alignment with our existing electronic bed management and clinical handover systems, in addition to Vitals. Initial scoping is for acute site inpatient areas by end September 2022, including change management support for all users, before extending coverage to theatres, the emergency department and the CAMHS services on our Becton site.	This was achieved. Although slightly delayed beyond initial target date, our Digital Whiteboards roll-out was successfully completed across all acute site inpatient wards, November to December 2022. The new Digital Whiteboards are in effect interactive touchscreens, which (when activated by appropriate user access control), provide a real-time view of bed status along with our patients' individual requirements, including dietary needs, expected date of discharge and discharge plans. The new digital whiteboards also benefit from live links with other inpatient clinical systems (including Vitals, as above) for task orchestration, observations overview and alert notification. Roll-out beyond the acute hospital site will be progressed through 2023/24, as required.
• Implement electronic prescribing and medicines administration to improve patient safety making significant reductions in human error associated with drug prescribing and administration. This will be achieved through defined system protocols and alerting. Initial wards will go-live by December 2022, with acute site roll-out to be completed across inpatient and outpatient areas by end June 2023. • Whilst the above projects are focused on acute site implementation through 2022-23, the Trust's Digital Team is actively planning	This was achieved and is ongoing. Implementation of our new Electronic Prescribing solution commenced on Ward 5 from 20th March 2022, as our chosen early adopter location. Roll-out to other acute wards is planned to continue in June to July 2023. This allows time to review and optimise the system, as well as associated clinical processes, learning from experience and user feedback from the early adopter ward. Roll-out to Outpatients will then be planned for later in 2023 calendar year, alongside consideration for extending implementation to other sites and settings (including Becton). Multi-disciplinary project resource is in place to facilitate this, which

for subsequent implementation phase(s) to extend equivalent functionality to inpatient CAMHS services at the Becton site in 2023/24. • Patients and families will be kept informed and engaged at all key implementation stages and our 'Digital Theo' branding has been adopted to support this.	includes new permanent roles in Pharmacy Department. All the implementation events described above have been supported by regular internal communications activity, including bulletins, posters, intranet content and open meetings. Patients and families have also been updated throughout the respective go-live and roll-out periods. Digital team members have maintained a presence on the relevant wards for the initial 2 weeks of each respective ward go-live, wearing identifiable 'Digital Theo' t-shirts and actively engaging with families to describe the changes, expected benefits and how this supports improved clinical outcomes. A number of video interviews have also been completed, which are now feeding into benefits realisation and lessons learned reviews.

How Performance will be Monitored, Measured and Reported

In addition to monitoring through our internal governance structures such as the Care Group Quality and Performance reviews, a report on progress against all quality account indicators will be presented regularly to the Quality Committee, with escalation by exception to Trust Board. The Board will share its reports with the Council of Governors and its commissioners in NHS Sheffield and NHS England. All board reports will be published on the Trust website.

Statements of Assurance from the Board

Sheffield Children's NHS Foundation Trust continued to provide relevant health services as detailed in the contracts held with NHSEI Prescribed Specialised Services, NHSEI Public Health, NHSEI Dental, NHSEI Health and Justice, NHSEI Mental Health and Sheffield CCG/ICB. The Trust also provided a number of health services which are managed through Service Level Agreements and NHS sub-contracts.

On 1 July 2022, commissioning in Sheffield and across the UK changed with Sheffield Integrated Care Board (ICB) taking on contracts managed by Sheffield CCG.

The Trust has reviewed the data available to it on the quality of care in all of these relevant health services.

As of 1st October 2021, the Trust in-patient Tier 4 services for specialist mental health, learning disability & autism (LDA) services transferred from NHSE Specialised Commissioning to the South Yorkshire and Bassetlaw CAMHS Provider Collaborative. The Trust has become the Lead Provider for the Provider Collaborative.

National Clinical Audit and National Confidential Enquiry Assurance

National clinical audit is a system designed to improve patient outcomes and to ensure standardised, high quality care across the United Kingdom. The aim is to ensure the national process engages all healthcare professionals in the systematic evaluation of their clinical practice against both recognised standards and other services and seeks to support and encourage the development of actions to transform care where appropriate.

Sheffield Children's understands the importance of national reporting and the learning that can arise from these projects. The ability to benchmark ourselves against a national picture allows us to ensure that our care is the best it can be and to identify areas where we need to improve.

National Clinical Audits and National Confidential Enquiries for which the Trust was Eligible to Participate	
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Transition from Child to Adult Health Services	National Child Mortality Database
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Testicular Torsion	National Joint Registry
Epilepsy 12: National Audit of Seizures and Epilepsies for Children and Young People	National Paediatric Diabetes Audit
Inflammatory Bowel Disease Audit	National Perinatal Mortality Review Tool
LeDeR – Learning from Lives and Deaths of People with a Learning Disability and Autistic People	Neurosurgical National Audit Programme
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Confidential Enquiries	Paediatric Intensive Care Audit Network (PICANet)
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Prescribing Observatory for Mental Health (POMH): Use of Melatonin
Mental Health Clinical Outcome Review Programme: Real Time Surveillance of Patient Suicide	Royal College of Emergency Medicine Quality Improvement Programme: Pain in Children
Mental Health Clinical Outcome Review Programme: Suicide (and Homicide) by People Under Mental Health Care	National Acute Kidney Injury Audit

Mental Health Clinical Outcome Review Programme: Suicide (and Homicide) by People in Contact With Substance Misuse Services	UK Renal Registry Chronic Kidney Disease Audit
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
National Bariatric Surgery Register	Trauma Audit & Research Network (TARN)
National Cardiac Arrest Audit	UK Cystic Fibrosis Registry
Data was not submitted for the following national audit projects in 2022-2023 due to operational/workforce challenges faced by the Trust:	
Epilepsy 12: National Audit of Seizures and Epilepsies for Children and Young People	
Prescribing Observatory for Mental Health (POMH): Use of Melatonin	
Royal College of Emergency Medicine Quality Improvement Programme: Pain in Children	

National Audit and Confidential Enquiry Reviews

The following reports were received and reviewed at the Clinical Audit and Effectiveness Committee during 2022-2023:

April:

- National Paediatric Diabetes Audit (NPDA)
- National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report
- National Confidential Enquiry into Patient Outcome and Death: Review of Health Inequalities Short Report

August:

- National Diabetes Audit, 2017-2021. Adolescent and Young Adult Type 1 Diabetes
- National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Child and Young Person Asthma 2021 Organisational Audit

October:

- National Paediatric Diabetes Audit (NPDA): Parent and Patient Reported Experience Measures (PREMs) 2021

December:

- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Perinatal Mortality Surveillance Report (Jan-Dec 2020)
- National Perinatal Mortality Review Tool (PMRT): Learning from Standardised Reviews When Babies Die (Fourth Annual Report)
- National Child Mortality Database (NCMD): Sudden and Unexpected Deaths in Infancy and Childhood

Due to ongoing challenges with having subject experts present and contextualise the results of these reports at the CAEC meeting, it has been decided that teams will begin to submit a summary report rather than be

required to present. This report will give an overview of the report, the Trust results in context, and any learning that is applicable to the Trust.

Local Audit and Service Evaluations

Trust wide colleagues are encouraged to set up and run local audits and evaluations with a view to evaluate, review and improve their own services. The motivation for these local projects is generated from the shared objective to ensure that the Trust is delivering outstanding care for our patients. The local audit and evaluation programme currently features 239 projects in which data collection is ongoing or the report is being written and 70 where actions are being implemented. A further 69 have had their actions fully implemented, while an additional 60 have had their action plans abandoned. This is due to the actions no longer being relevant due to service and priority changes post-Covid. 76 projects were abandoned during data collection as they were deemed no longer relevant to the service.

Research and Innovation

The past year has been busy for Research and Innovation at the Trust. As of the end of March 2023, we had recruited 1544 patients, staff and healthy volunteers to our research.

Research is core business for the Trust and remains a strategic priority. We have been developing a new ambitious 5 year strategy for Research & Innovation at the Trust that will complement the Trust's Clinical Strategy and seek to see the Trust build its reputation as a centre of research excellence and a world leader in cutting edge innovation. Increasing our commercial portfolio will be a core theme of the strategy. We plan to deliver more early phase clinical trials, vaccine research and more studies examining the benefits of gene therapies in future. Furthermore, we aim to adopt more medical device trials for children to expand our offer of developing the world's best technology for child health. The new strategy will launch in Spring 2023.

Our clinical trial portfolio has grown rapidly in recent years. We have a sizable and varied portfolio of complex clinical trials for a specialist trust of our size. Through strategic partnerships with industry and excellence in the delivery of trials in our Trust, we are now considered a key centre for industry sponsored clinical trials across a number of specialties and currently we are supporting commercial trials in the fields of neurology, metabolic bone, rheumatology, dermatology, diabetes and endocrinology, oncology and haematology, ophthalmology, allergy and nutrition. We also run a large portfolio of non-commercial research Trust wide. In 2022/23, 341 commercial and non-commercial studies have been active at the Trust and of these the Research Delivery Team and Clinical Research Facility (CRF) have supported 56 studies on our recently refurbished CRF. This year saw us support our first overnight stays on our CRF to support patients on an early phase clinical trial requiring close monitoring and longer study visits. This was a great success and we received excellent feedback from the family about their experience of research participation at our Trust and of their stay on our CRF. We hope to support more of this work in the year ahead. Many of the clinical trials delivered on our CRF have been complex clinical trials and early-phase/experimental research, ultimately improving the health and saving the lives of the children under our care.

Working with Artfelt to Create a Clinical Research Facility Space for All

During 2022/23 we have been working with the team at Artfelt and with local Designers to create a decorative theme for our newly refurbished Clinical Research Facility. Through funds raised by The Children's Hospital Charity we are hoping to create a CRF space that offers a relaxing and enjoyable experience for all who visit it. We support children of all ages from newborns to adolescents, so we understand that the space needs to feel right for everyone who we care for. We have engaged children and families in the generation of ideas for artwork for our wall space and sought feedback on how we might support neurodiverse children to have the best experience of research when visiting us. To this end we are developing a clinical room that will be designed to support children with additional needs who need to be supported in a calming environment. We also now have a Learning Disabilities and Autism Ambassador in our Team and they have been working with families and colleagues in the Trust to develop our sensory room on the CRF.

Patient and Public Involvement and Engagement (PPIE) in Our Research

Our PPIE activity is wide ranging and wide reaching. We continue to support our researchers with engaging patients and the public in shaping their research plans. Most recently we have worked with a researcher in Radiology to deliver some PPIE conversations to help develop a study tool to determine the impacts of reduced oxygen supply to the brain on patient development. We have also created resources for recruitment to a newly

formed Patient & Public Involvement & Engagement group. We are now working with our Research Communications Officer to launch recruitment to the group on social media.

In the last few weeks, we have visited a school and engaged with children of different age groups, delivering talks about the NHS and what it is and different careers options for those who might be considering a career in healthcare. The content of the presentations was tailored to each year group to give an insight into the different roles of professionals that make up the NHS, including research roles, and the different attributes of teamwork as well as the different requirements for specific careers. In the next few weeks, we will be working alongside colleagues from the University of Sheffield to deliver similar talks to a local secondary school. We were recently invited to present at an National Institute for Health and Care Research (NIHR) 'Research for All Conference'. We spoke at the main event, giving fellow researchers from the Yorkshire and Humber region and representatives from various community groups an insight into children's health and research and how we support Patient & Public Involvement and Engagement in our work.

In addition to our ongoing participation in regional and national groups, we are designing promotional materials (posters, information sheets and social media content) that we hope will engage visitors to our Trust and those who follow the Trust on social media in our research and innovation activity. Our PPIE work has been supported financially by the Yorkshire and Humber Clinical Research Network and this support will continue through 2023/24.

Equality, Diversity and Inclusion are high on our agenda and we are looking at ways we can increase engagement in our research from those patients and families from underserved communities. We are also working with Sheffield Hallam, Nottingham Trent and Liverpool John Moore Universities on a programme called EDEPI (Equity in Doctoral Education through Partnership and Innovation) that aims to support more NHS staff from racially minoritized groups into further education and specifically PhD programmes.

Dermatology Research at Sheffield Children's

One research story highlighted 2022/23 was that of sisters Ammarah, Summayah and Ayaana. They are regular visitors to our CRF because all three are taking part in a clinical study! Ammarah, the youngest sister at seven years old, has severe atopic dermatitis which is more commonly known as eczema. This is a condition which causes the skin to become itchy, dry, cracked and sore. Along with her sisters, Ammarah is taking part in the PELISTAD trial. Run by Sanofi and Regeneron, this study is investigating the effect of the drug dupilumab on the skin barrier function for children aged 6 to 11 years old who have moderate to severe atopic dermatitis. Dupilumab has been approved to use in the UK for patients aged six and older with moderate to severe atopic dermatitis since December 2021.

Developing our Mental Health Research Portfolio

With our Clinical Strategy focussing on addressing health inequalities in Sheffield and beyond, children and young peoples' mental health is an area where there is huge potential for increasing research and innovation activity but at the moment our clinical teams are so stretched there is little time to engage with research despite the best efforts of the teams. In the last year R&I has funded 2 CAMHS nurses part-time to support research activity and slowly the team are building a small research portfolio. The nurses are currently supporting the Lucy Project for which Sheffield Children's is a participating centre. The project is supported locally by our Psychology Team and offers those aged 18 and under the opportunity to refer themselves for a drop-in psychological session as part of the research study. The project seeks to provide information, a space to talk, psychological support and treatment, and referral to other services and organisations. It has already been successfully trialled in London where patients showed reduced emotional and behavioural symptoms and experienced a better of quality of life:

https://www.sheffieldchildrens.nhs.uk/news/research-project-offers-drop-in-psychological-help/

To support further growth of research and innovation in this Care Group we worked with the Psychology team to develop a request for funding to be submitted to the Clinical Research Network for Yorkshire and The Humber (CRN). The CRN were supportive of our request and have now awarded us funding for a full-time research psychologist for 12 months to support the growth of research activity in CAMHS. Once appointed they will work with Drs Steve Jones and Rebecca Jones in the Psychology team to work up ideas for grant applications and support existing research work. This post is a first for our Trust and it is hoped that the team will be able to obtain funding to continue the post beyond the initial 12 month period.

NIHR Children and Young People MedTech Co-operative

NIHR CYP MedTech is a research programme funded by the UK National Institute for Health Research (NIHR). The programme aims to support the development of innovative medical technologies (MedTech) that can improve the health and well-being of children and young people (CYP). The program provides funding and support to academic and industry-led research projects that focus on developing and evaluating MedTech devices, diagnostics, and digital technologies that can be used to diagnose, monitor, or treat medical conditions in CYP.

NIHR CYP MedTech brings together experts from a range of disciplines, including clinical medicine, engineering, and computer science, to collaborate on the development of innovative MedTech solutions for CYP. The programme also provides training and support to researchers, clinicians, and industry partners to help them navigate the complex regulatory and ethical frameworks that surround the development and evaluation of MedTech products.

The goal of NIHR CYP MedTech is to improve the health outcomes and quality of life for children and young people through the development and adoption of new and innovative medical technologies. The programme has the potential to have a significant impact on the healthcare system by providing clinicians with new tools and technologies to improve the care and outcomes for CYP with a range of medical conditions. In January 2021, NIHR CYP MedTech welcomed a new addition to its portfolio - the Neonatal Technologies theme. This theme is spearheaded by Professor Don Sharkey at Nottingham University Hospitals NHS Trust. Its focus is on developing innovative medical technologies that can improve the health and well-being of newborns in the neonatal care setting. As a national consortium focused on advancing the development and assessment of child health technologies, NIHR CYP MedTech has been successful in leveraging £13.4 million in funding over the course of 5 years. The consortium has enabled the initiation of 176 projects, with 55% of them being in partnership with industry players. These collaborations involved 135 SMEs and 44 global companies and have led to the submission of 79 funding applications. The partnership efforts have resulted in 34 peer-reviewed publications, and 119 newsletters published, as well as the organisation of the UK's first two child health technology conferences. These conferences featured 106 speakers and 384 delegates from 27 countries. In addition NIHR CYP MedTech has given 68 conference and event presentations. Importantly, NIHR CYP MedTech is keen to develop the future workforce in this field, and has hosted 15 PhD students working in a number of different technology domains. NIHR CYP MedTech now has nearly 3,000 Twitter followers, demonstrating the interest in this field and supporting our ambition to create a global child health technology community.

The National Centre for Child Health Technology

On 2nd February 2023 we announced that we have secured full funding to build the National Centre for Child Health Technology (NCCHT), following the commitment to £6 million in funding from the South Yorkshire Mayoral Combined Authority, to add to the funding received from the Autumn Statement in 2021.The goal of the NCCHT is to improve the health outcomes and quality of life for children by developing and implementing innovative medical technologies. The centre’s research has the potential to make a significant impact on the healthcare system by providing clinicians with new technologies to improve the care and outcomes for children with a range of medical conditions.

The NCCHT will bring together experts in health, academia and industry to stimulate and accelerate innovation, attract inward investment, support sustainable change and reduce costs to the NHS. The NCCHT will be an international centre of excellence positioning the UK as a global leader in the field of child health technology. It will develop technologies to address key national strategic priorities in child health including childhood obesity, child and adolescent mental health, cancer, disabilities, long term conditions and prevention.

Over the next year, we will begin construction of the National Centre for Child Health Technology (NCCHT) with the goal of opening its doors in 2025. Our primary focus during this period will be to strengthen our partnerships with industry and academic institutions. By collaborating with experts from various fields, we aim to ensure that the NCCHT develops cutting-edge medical technologies that can effectively support the health and healthcare needs of children and young people, both in the UK and around the world.

Serious Incidents

During the financial year 2022/23, the Trust reported a total of 28 Serious Incidents. All incidents are scrutinised at the weekly patient safety meeting, with those identified as potential Serious Incidents (SI) discussed in detail at the weekly SI Triage Panel. Each investigation was subject to a full systems based root cause analysis (utilising the legacy '5 whys' methodology) to understand if the incident was avoidable and to capture any learning that could be shared with the wider organisation to enable safety improvements be implemented and measured for efficacy and sustainability.

Learning from Serious Incident reports are shared within the Care Group initially and after discussion at the Executive Risk Management Committee, shared widely across the organisation via executively sponsored monthly learning bulletins and learning workshop Q&A sessions. The Executive Team and Board are regularly updated if there is urgent learning that requires immediate actions to be implemented.

The Trust commits to produce a full report and learning response analysis at the earliest opportunity but acknowledges that occasionally this may be delayed particularly where other trusts are involved or there is a coroner's inquest pending. In circumstances where a coroner's inquest is pending, the Trust provides a report to the ICB, which may be subsequently amended to reflect the conclusion of the inquest or child death review.

Sheffield ICB monitors the timeliness of reports. The Trust Lead Investigator workforce has been impacted by a reduction in trained professional investigators within the central clinical governance function leading to unavoidable delays in achievement of the standard 60 working day serious incident report deadlines. All extension requests have been discussed and agreed with Sheffield ICB and have included relevant rationale for delays.

The Trust are preparing for the national launch of the new national Patient Safety Incident Response Framework (PSIRF) which will be implemented by 30th September 2023 and are increasing the number of professionally trained colleagues with funded time to undertake Patient Safety Investigations or Learning Responses. The Trust is monitored monthly by the ICB on its PSIRF implementation plan and its mobilisation and transition from National Reporting and Learning System (NRLS) to Learn from Patient Safety Events (LfPSE).

A total of 28 SI's were declared over 2022/23.

Once signed off by the Care Group triumvirate the Executive Directors scrutinise and sign off reports relating to Serious Incidents which are then submitted to Investigation Scrutiny Panel (ISP) for final sign off before being submitted to the external stakeholders and regulators (ICB/CQC). Following this the reports are shared with the relevant Associate and Clinical Director and Head of Nursing for learning which is cascaded at each care group quality and governance meetings (CQG) in addition to being shared with other care groups to ensure the cross pollination of learning occurs organisational wide.

Duty of Candour

'Duty of candour' arises where moderate or severe harm has occurred to children and young people whilst they are receiving care and treatment within our services. The statutory Duty of Candour is outlined in Regulation 20 of the Health and Social Care Act 2008. The Act:

- Requires the Trust to act in an open and honest way in relation to care and treatment provided
- Involves a representative informing and supporting patients and relatives, as soon as reasonably practicable, after becoming aware of a notifiable patient safety incident.
- Requires that we say that we are sorry for the event that caused the harm, explaining to patients and their families how the incident occurred and what now needs to be done,

- Requires that the above actions occur both in person and in writing. If the family cannot be contacted the Trust needs to keep a record of attempts made to do so.
- Requires that the Trust keeps patients and their families regularly updated if the investigation is ongoing.

Our compliance with this legislation is monitored through our Integrated Governance Report which is presented quarterly to the Quality Committee.

Of the 28 serious incident investigations undertaken in 2022/23 Duty of Candour was applicable in 23 cases. The Trust continues to keep under review its application of Duty of Candour.

Use of the Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of the Trust's income is conditional upon 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 payment framework (CQUIN).

Details of ICB and NHS England CQUINs are given below.

CQUIN	Description	Target	Q1	Q2	Q3	Q4	Narrative
CCG1: Staff flu vaccinations	Uptake of flu vaccinations by frontline staff with patient contact.	70-90%	N/A	N/A	58%	59%	Lesson's Learnt Review of this year's programme in place to help plan for next year
CCG7: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, via secure electronic message.	0.5-1.5%	0%	0%	0%	0%	The EPMA is now live on the early adopter ward. DMS is being progressed in the EPMA project but not as part of the first phase
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring major elective blood loss surgery patients are treated in line with NICE guideline NG24.	45-60%	N/A	100%	100%	100%	Work on-going to ensure patients get a pre-op
CCG12: Biopsychosocial assessments by MH liaison services	Self-harm7 referrals receiving a biopsychosocial assessment concordant with NICE guidelines	60-80%	85%	97%	95%	94%	

CQUIN	Description	Target	Q1	Q2	Q3	Q4	Narrative
PSS4: Delivery of Cerebral Palsy Integrated Pathway assessments for cerebral palsy patients in specialised children's services	Develop networks to support referral pathways, ensuring patients receive a Cerebral Palsy Integrated Pathway (CPIP) assessment and that it is entered into the national database.	10-60%	58%	77%	80%		
PSS6: Delivery of formulation or review within six weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	To maximise health outcomes for all children and young people.	50-80%	85%	67%	54%	80%	Total of 5 new admissions in Q4: 1 YP did not have a formulation recorded on the specified tab in S1. This Young person's admission was for 4 weeks.
PSS7: Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	This indicator will underpin measures that will need to be put in place to implement the Mental Health Units (Use of Force) Act 2018 that will come into force at the start of 2022.	65-80%	97%	97%	98%		

Proposed CQUINS for 2023/24 are as follows:

ICB Contract

- CQUIN01: Staff Flu Vaccinations
- CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge
- CQUIN15b: Routine outcome monitoring in CYP and community perinatal mental health services

NHSE Contract

- CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery
- CQUIN16: Reducing the need for the use of restrictive practices in CYPMH inpatient settings

Registration with the Care Quality Commission

Sheffield Children's NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. The Care Quality Commission has not taken any enforcement action against the Trust during 2022/23.

The Trust received a risk based unannounced inspection of the inpatient and community CAMHS services in July 2022, which led to the publication of two reports in November 2022. As a result, the trust's rating for both services did not change.

The Trust's current overall rating, issued in July 2019, is 'good'.

Full details of the trust's registration, and copies of inspection reports can be found at https://www.cqc.org.uk/provider/RCU

Information on the Quality of Data

A vast collection of data is created and used by the NHS. This includes information which helps hospitals and GPs to track patients and to make sure that all relevant information about them and their treatment, such as test results, is in the right place and can be found by the relevant staff. It is very important that the data is accurate and up to date, and hospital trusts are required to report on data collection and accuracy every year.

Sheffield Children's NHS Foundation Trust submitted records during 2022/23* to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data. The percentage of records in the published data which included:

- The patient's valid NHS number was: 99.7 per cent present for admitted patient care, 99.9 per cent for outpatient care and 99.7 per cent for accident and emergency care.
- The patient's valid general practitioner registration code was: 100 per cent correct for admitted patient care, 100 per cent for outpatient care and 100 per cent for accident and emergency care.

**as at February 2023 for admitted patient care and outpatients, as at January 2023 for accident and emergency care*

(The results should not be extrapolated further than the actual sample audited)

The Trust is committed to ensuring that it manages all the information it holds and processes in an efficient, effective and secure manner. This is achieved through the application of robust information governance

policies and procedures, in accordance with legislation, and is supported by a range of training and awareness activities.

The Trust's most recent published assessment for Data Security and Protection Toolkit confirms all 'Standards Met'. The completed assessment for the period 1 July 2022 to 30 June 2023 is not due for submission until end June 2023.

Improvements to the Quality of Data

Sheffield Children's NHS Foundation Trust will be taking the following actions to improve data quality:

- Implementing the recommendations of data quality-related audit reports
- Reconciling information from different systems to ensure data accuracy and completeness
- Continuing to improve clinical coding through improved clinical engagement
- Investigation and rectification of data quality variances identified through national benchmarking tools
- Continue to provide a forum through a monthly data quality group in which data quality issues can be discussed and addressed

Learning from deaths

During 202/23 54 of Sheffield Children's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 12 in the first quarter; 11 in the second quarter; 15 in the third quarter; 16 to date in the fourth quarter.

Quarter 1	12
Quarter 2	11
Quarter 3	15
Quarter 4	16

By the 29th March 2023, 12 joint agency response investigations, 34 hospital case reviews and three serious incident reviews (plus one ongoing serious incident review) have been carried out in relation to the deaths. All deaths are subject to a full case review as part of Child Death Overview Panel procedures. The table below confirms the grading of care for all of the deaths which have been reviewed.

Most reviews reveal elements of learning to improve care, even if the cause of death is not directly attributable to our care. Of the 2022/23 deaths where investigations are complete at the time of this report two deaths were considered to be attributable to problems in care in 2022/23.

During 2022/23 the reviews were graded using NCEPOD grading as follows:

	TOTAL
Grade 1 Good Practice. A Standard that you would accept from yourself, your trainees and your institution	28
Grade 2 Room for improvement. Aspects of clinical care that could have been better.	2
Grade 3 Room for improvement. Aspects of organisational care that could have been better.	0
Grade 4 Room for improvement. Aspects of organisational and clinical care that could have been better	4
TOTAL	34

Learning from the deaths is shared at the Child Death Review Meetings and the Trust Mortality and Morbidity Meetings. A summary of actions and what the Trust has learnt from the hospital reviews and investigations conducted in relation to the deaths are provided below:

- Where there are complex medical needs, involve the base hospital early on in the patients stay on PCCU– add to daily PCCU checklist.
- Consider a pathway where patients can be taken out of bed for cuddles with parent whilst on a ventilator when at end-of-life.
- Consider a pathway to allow withdrawal of care early in morning, for end-of-life patients to allow for quick burials when requested for religious reasons.
- Implementation of a system to easily track and identify trends in clinical investigations and response to treatment when the clinical situation is dynamic. Develop a trust wide tabulated results sheet.
- Electronic prescribing to be implemented to cover inpatient areas.
- Enable contemporaneous and chronologically accurate recording of clinical discussions, decision-making and management plans. Electronic patient records as part of the trust digital transformation plan.
- Ensure adequate detailed information is available and easily accessible for the weekend clinical team for children with complex clinical issues to enable robust clinical decision making. Embed system of written weekend plans. Adapt systems used by other clinical teams.
- Highlight complex patients at handover for consultants to consider whether an in-person consultant review is needed. Use careflow connect to flag.
- Working group set up to discuss nutrition for patients with a chronic lung disease.
- Respiratory team and Gastroenterology team to do a Service Evaluation looking at nutrition in babies with a chronic lung disease.
- Discussion in Consultant's meeting regarding monitoring & neuro protection measures in children with prolonged seizures.
- All children attending ED with abnormal observations to have observations repeated at discharge from ED.
- Importance of using the hospital record alert system highlighted.
- Provide written/electronic safety netting advice on discharge when relevant. Introduction of QR boards will allow parents/carers to access digital information.
- Long stay patients should have written records regularly scanned onto the electronic system during an inpatient stay.
- Introduction of a flow chart for automatic referral to Critical Care team for any inpatient scoring highly on PEWS, including parental/career concern as a factor.
- Establish a bedding in of new IT systems to allow training and troubleshooting before removal of existing methods.
- Bereavement pathway across Trust to be developed and include PSIRF processes.

Reporting against Core Indicators

Patients readmitted to a hospital within 30 days of being discharged. (i) 0 to 15				
	trust	*National*		
financial year	%	*Average*	*Maximum*	*Minimum*
2021/22	9.9	*12.5*	*46.9*	*3.3*
2020/21	9.9	*12.4*	*64.4*	*2.8*
2019/20	9.6	*12.6*	*56.8*	*2.1*
2018/19	9.0	*13.1*	*68.9*	*1.9*

Patients readmitted to a hospital within 30 days of being discharged. (ii) 16 or over				
	trust	*National*		
financial year	%	*Average*	*Maximum*	*Minimum*
2021/22	13.9	*12.0*	*142.0*	*2.1*
2020/21	12.5	*13*	*112.9*	*1.1*
2019/20	16.9	*11.9*	*37.5*	*1.9*
2018/19	10.4	*12.3*	*57.6*	*2.1*

C-difficile Infection per 100,000 bed days				
		National		
Financial Year	Trust Rate	Average	Maximum	Minimum
2021/22	7.8	16.2	53.6	0
2020/21	25.6	15.4	80.6	0
2019/20	12.6	13.6	64.6	0
2018/19	26.5	12.2	90.2	0

The Trust considers that this data is as described for the following reasons:

Data for C-difficile infection indicator is taken from the UKHSA Fingertips database. Data for 2022/2023 is not yet available.

The Trust has a very stringent approach to testing all symptomatic children aged two years old and over for *C-difficile* toxin production. Investigations are completed for cases regarded as health-care associated according to Public Health England definitions. No specific IPC concerns have been identified so far. Comparison of the infective strains of *C. difficile* in this group of patient did not highlight any concerns for cross-infection.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services:

The Trust will continue to perform reviews on all Trust-associated C Difficile cases, with action plans generated if deficiencies that may have led to C. difficile infection are identified. Environmental and hand hygiene audits will continue to be performed on a monthly basis with the results now incorporated into quality reporting at a divisional and Trust level.

Patient safety incidents				
	2019/20	*2021/21*	*2021/22*	*2022/23*
Total number of patient safety incidents	4,404	4,725	5,743	5,607
Total number of patient safety incidents leading to severe harm or death	4	4	3	14
Percentage of patient safety incidents leading to severe harm or death	0.09	0.08	0.05	0.2
Rate of patient safety incidents per 1,000 bed days	107.39	118.64	178.48	TBC
Bed days	41,011	39,826	32,177	51,307

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe.

The Trust considers that this data is as described for the following reasons:

The Trust has a very low number of incidents that have resulted in severe harm or death. All incidents are reviewed weekly in the Patient Safety meeting, chaired by the Chief Nurse and attended by the Executive Medical Director. This provides assurance that incidents are appropriately reported.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services:

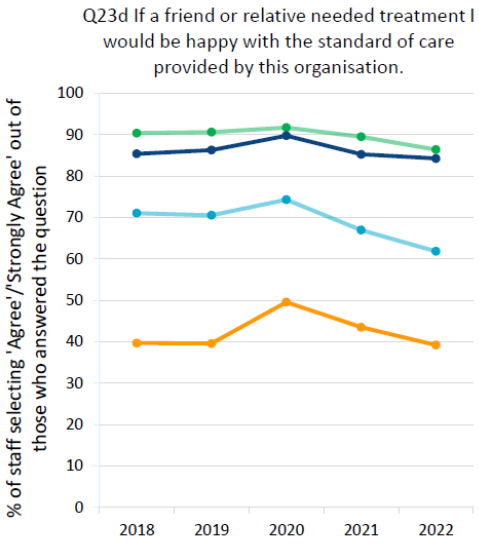
The Trust produces a monthly learning from incidents newsletter. We will continue to ensure conversations around this across all services are undertaken.

National NHS Patient Safety Strategy

In line with the National NHS Patient Safety Strategy the Trust has a Patient Safety Specialist who has been attending all of the NHS England led National Patient Safety Meetings to ensure learning from other organisations is identified and implemented as required. The Patient Safety Specialist has been proactive in starting to develop the Patient Safety Incident Response Plan ready for the national rollout of the Patient Safety Incident Response Framework, which is expected in September 2023.

Patient Safety Partners have been identified to ensure that moving forwards the Trust proactively involve patients and families in treatment pathways and outcomes of investigations. The Trust is rolling out the NHS Patient Safety Syllabus training programme.

Percentage of staff employed by the Trust who stated that if a friend or relative needed treatment they would be happy to recommend this organisation



	2018	2019	2020	2021	2022
Your org	85.4%	86.3%	89.8%	85.3%	84.3%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1681	1957	1446	1555	1587

The Trust considers that this data is as described for the following reasons:

Sheffield Children's NHS Foundation Trust staff survey report is available on the NHS staff survey website. The data is selected from this official source. The results show a decrease from 85.3% to 84.3% however, the Trust is well above the NHS average for its comparator group of 61.9% and nationally there has been a downward trend in this result.

We have seen an upward trend in our staff telling us that care of patients is the Trust's top priority and again the Trust is above NHS average (73.5% versus Trust figure of 84.1%).

ANNEX 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

A number of staff, families and organisations were involved in the consultation process to produce this report and the Trust is grateful for the time and effort of all who have contributed. The final version has tried to accommodate the comments received or the minutes of the meetings at which it was discussed but it is accepted the production of the report is ultimately the responsibility of the Board of Directors.

Consulted Agencies or Groups

Sheffield Integrated Care Board

The first draft report was provided to NHS Sheffield on xxxx. The following response was received on xxxx.

Sheffield Healthwatch

The first draft report was provided to Healthwatch on xxxx. The following response was received on xxxx.

Sheffield Children's NHS Foundation Trust Parent Register

The first draft report was provided to parents of children and young people currently using our services, who have been appointed to our Parent Register. We acknowledge that it can be difficult for families to attend events and the opportunity for families to contribute 'virtually' has again been very successful this year.

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

The first draft report was provided to Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy and Development Committee on xxxx. The following response was received on xxxx.

Council of Governors, Sheffield Children's NHS Foundation Trust

The following response was received on date: 9th May 2023.

ANNEX 2: Statement of directors' responsibilities for the quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The omission of the NHSE/I required additional reporting should be noted as directed from 2020/2021 in the reporting guidance.

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

- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to March 2023.
  - papers relating to quality reported to the board over the period April 2022 to March 2023.
  - feedback from commissioners dated xxxx.
  - feedback from governors dated xxxx.
  - feedback from local Health watch organisations on xxxx.
  - feedback from Overview and Scrutiny Committee on xxxx.
  - latest national staff survey dated March 2023.
  - CQC inspection reports dated 16 July 2019 and 18 November 2022.
- The Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality Account 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations).

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

……Date …….. Chairperson

……Date ……..…… Chief Executive

Sheffield Children's NHS Foundation Trust

Western Bank

Sheffield

S10 2TH

e-mail: ftoffice@sch.nhs.uk

telephone: 0114 271 7000

www.sheffieldchildrens.nhs.uk