# Report to Health Scrutiny Sub-Committee

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| **Report of:** | *Jennifer Hill, Medical Director (Operations) and Angie Legge, Quality Director, STHT* |
| **Report to:** | *Health Scrutiny Sub-Committee* |
| **Date:** | *1st June, 2023* |
| **Subject:** | *Sheffield Teaching Hospitals Trust Quality Report* |

**Purpose of Report:**

To share the Quality report with Sub Committee Members and invite comments, to feed back to the Trust by their deadline of 13th June

**Recommendations:**

**For members of the sub-committee to:**

1. **note the content of the Quality Report**
2. **Discuss and make comments on the report, to be fed back to Sheffield Teaching Hospitals Trust by the deadline of 13th June**

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

# Quality Report

2022/23

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PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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# Part 1

## Introduction

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# Chief Executive's Statement

Getting back on Track was the focus of 2022/23 but it was not without significant challenge. We continued to manage several peaks in COVID-19 cases, and we also saw the return of a more virulent flu season. We have now cared for almost 14,000 inpatients with COVID-19.

Demand for both emergency and elective care remained high and our work to catch up the backlog of paused procedures continued at pace. This work was compounded as we saw an unprecedented amount of industrial action by different professions, which had a significant impact on our delivery of planned care and required Herculean efforts by our staff to ensure we could continue to provide emergency and inpatient care.

We continued to have a robust incident command structure in place, with daily Gold, Silver and Bronze Commands for a large part of the year, so that we could plan and respond quickly to the different challenges and opportunities we were faced with. Decision making on COVID-19 was informed by our Clinical Expert Group who ensured there was constant consideration of national and local guidance and best practice.

As COVID-19 prevalence levels dropped throughout the year it was brilliant to be able to fully restore visiting to our wards and welcome our wonderful volunteers back to the many roles they fulfil across our hospitals.

We continued to lead the COVID-19 vaccination programme for South Yorkshire and Bassetlaw following the expansion of eligible cohorts and then the introduction of subsequent booster doses. Whilst we were the lead provider, the delivery of the programme has been a collective effort by the region's NHS organisations, local authorities, volunteers, and public health colleagues. As the year came to an end, we closed the mass vaccination site at Longley Lane and our staff swabbing service has also closed after delivering thousands of PCR tests for our staff and neighbouring Trusts.

Our number one priority for 2022/23 was to accelerate the recovery of our clinical activity to see and treat as many patients as we could, prioritising according to clinical need and risk. This has included increasing our capacity where possible out of normal working hours, recruiting additional staff and adopting new ways of working including more procedures being carried out as day cases which traditionally would have included an inpatient stay. We launched our Getting Back on Track programme not just to focus on the recovery of planned care but to galvanise our efforts on all the aspects of our organisation which had been impacted on by the past three years of COVID-19. Our workstreams are shown below:

In many areas our activity is back to pre-pandemic levels, but we have significant work to do to achieve some of the new national standards on waiting times and recovering our paused elective work. Previously we have had some of the best waiting times in the NHS and we want to return to that position because it is what our patients deserve from us.

We have continued to invest in new facilities and innovative models of care to support teams to deliver our ambitions including a new state of the art Elective Orthopaedic Centre at the Royal Hallamshire Hospital which opens in April 2023. This will be the home for elective lower limb, foot and ankle, shoulder and elbow and knee surgery, with emergency orthopaedic and trauma care, spinal and limb reconstruction continuing to be delivered at the Northern General Hospital. This is a major change in the way we deliver orthopaedic surgery across the Trust and should reduce the incidence of cancellations because it will be protected capacity from emergency

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demand. Patients can be admitted, have their surgery, recover, and be discharged – all from one purpose-built area.

Another innovation is the Enhanced Care Unit (ECU) which is a high dependency unit for surgical patients, who need monitoring, treatment or care greater than those on normal wards but are not expected to require critical care. Before the unit was established, many patients were admitted to the Intensive Care Unit because there was no other alternative. The introduction of the ECU has reduced the number of patient admissions to Intensive Care, improved quality of care and reduced long waits or cancellation of inpatient surgery.

It has been widely reported that there is considerable pressure on emergency care across the NHS with increased ambulance response and handover times being a concern as well as waiting times within A&E. This has made our work with Yorkshire Ambulance Service even more important. Together we have redesigned how we receive patients from ambulance crews and have further improved our joint systems to predict and communicate peaks in demand.

Providing timely emergency care has been further compounded by a poor flow of patients out of our care during this year. The number of patients who were medically fit but their discharge was delayed because of social and nursing home care waits increased to one of the highest levels we have seen for some time. The knock-on effect of this is that we had less beds available for patients waiting to be admitted from A&E and for those coming in for planned operations. We have taken several measures to manage this situation both internally and in partnership with Sheffield City Council and other care providers.

For example, we opened a new Same Day Emergency Care (SDEC) Assessment Unit to enable appropriate patients to be seen, diagnosed and treated or discharged without needing to come through A&E or be admitted on to a ward. This has provided a better patient experience and reduced some demand on pressured aspects of our emergency services.

As part of the city-wide response, additional capacity was commissioned for social care support along with more intermediate care beds. Our ward and community teams have been instrumental in reviewing how the current transfer of care processes work and along with social care colleagues have made significant improvements. Sustaining the position is difficult in the current climate but continued joint working, particularly in attracting and retaining people to work in social care, will be key to meet the demand we are experiencing.

We have also looked at how we can improve the timeliness of discharges for patients who do not need social or nursing home support. We launched the "Home in time for tea" initiative to encourage discharges earlier in the day and to empower staff and patients to ask: "what is preventing this patient from going home today?", "what needs to be done to progress the patients care?" and "what is the barrier which needs to be removed?" To support this work, we have expanded the use of our discharge lounge and established a Domestic Services Rapid Bed Cleaning Team. The team carry out duties normally undertaken by clinical staff such as cleaning the bed and mattress, and making up the bed with clean linen as soon as the patient has left. They have also taken responsibility for updating the bed clean status on the ward whiteboards so that there is real-time information about bed availability at-a-glance. This means that patients can be transferred from A&E or Assessment Units as soon as the bed is ready. In most cases the bed is ready for the next patient within less than an hour of a patient's discharge.

As mentioned earlier, our Getting Back on Track programme has a much wider remit than the recovery of performance and activity. Most significantly it has been the driver for the extensive improvement work we have undertaken in response to the two Care Quality Commission (CQC) Inspections we had in 2021. The CQC required significant improvements to be made following publication of its inspection report in April 2022, including in maternity services. They re-inspected in September 2022 and the findings were published in December. I am pleased to

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report that the CQC has now lifted all previous inadequate ratings at the Trust, including maternity services.

The improvements they found also meant that none of the Trust's services are now rated as inadequate across the five inspection domains – safe, effective, caring, responsive and well-led. The Trust's overall rating for the Caring and Effective domains in the inspection also both increased to Good, but there is no complacency and improvement work will continue as a priority to return all services back to a Good rating or better. Overall, the Trust is rated as Requires Improvement but with many services now rated as Good or Outstanding. The CQC team stated that throughout their inspection they saw staff treating patients with compassion and kindness and delivered care which respected people's individual needs. They felt people's observations were undertaken in a timely manner, and work had been undertaken to support staff to identify and respond to deteriorating patients. Also, that there was good multidisciplinary team communication.

The need to recruit more staff in some areas, including nursing, was a significant concern, and I am pleased to report that we have recruited over 500 new nurses since the inspection. We now have one of the lowest nurse vacancy rates for many years. Recruitment continues to be a priority as we move into 2023/24. We have launched a new fortnightly jobs bulletin which is shared by 800 community groups to local communities and has resulted in a significant increase in applications for different roles.

An improvement in care for patients with mental health conditions was another area where we had already started to make improvements internally, but also with partners across the city who also have responsibility for the care of people with mental health conditions.

Other key points the CQC raised were:

- Most services had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff assessed and managed the risk to patients including the risks due to deterioration in patients' physical or mental health.
- The Trust had implemented new and regular audits and reviews to ensure care met fundamental standards.
- Leaders had reviewed and improved governance systems and oversight of risk, issues and performance in frontline services.
- Staff supported and involved patients, families, and carers to understand their conditions.

Areas where further work is underway includes:

- Training more staff to ensure physical restraint of patients who require it for safety or clinical reasons can be undertaken safely and appropriately.
- Storage for medication and oxygen cylinders.
- Reducing waiting times so that patients can access services when they need them and receive care promptly.
- Further strengthening processes for identifying and reporting serious incidents and expediting investigation and learning.
- Embed the requirement that all patients who have Deprivation of Liberty Safeguards must have a recorded capacity assessment or decision recorded in their best interest.
- Improved physical health monitoring after administering rapid tranquilisation.

A concern for us and the CQC was our maternity service which was described as inadequate following the 2021 inspection. This has been a particular focus of attention throughout the year, and I am pleased to report that the service is in a very different place today compared to 18 months ago. Some of the changes include the recruitment of additional midwives, midwifery support assistants and nurses as well as overhauling our governance and risk processes. Elements of our assessment process needed further review which we have also done. In addition, we are one of the first four hospitals in England to offer the Tommy's App. The Tommy's App personalises maternity care by identifying each woman's

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chance of having a premature birth (when baby is born early) and of developing complications during pregnancy such as problems with placental function. By identifying the chance of complications early, the Tommy's App ensures that the right monitoring and care can be offered throughout pregnancy according to each woman's individual needs. Most importantly, feedback from parents and the Maternity Voices Partnership has been extremely positive in response to the changes that have been made.

We know a key driver to make further improvements will be the implementation of our new Electronic Patient Record System. Following a rigorous clinical and financial evaluation we have chosen Oracle Health as the provider for the new system. We were successful in securing national funding and preparatory work is now underway to support a go-live in October 2024.

This is one of the biggest investments by the Trust in over 20 years and it is one of the most important. Ensuring our staff have the tools they need to help them deliver safe, timely and good quality patient care is key. The EPR system is just one part of a wider transformation programme called STHConnect 2024 to change our processes and pathways so that we can get maximum patient benefit from the new integrated EPR. We will reduce the number of different IT systems currently in place to make it easier and quicker for staff to access a single, contemporaneous and accurate source of information. We also want to introduce a patient portal in future phases of the system's implementation to enable patients to access their medical records and book/manage their appointments. Another key consideration in the procurement of the new system was also the potential for the integration of other systems and interoperability with other NHS partners in the future given the increasing emphasis on system working and collaboration.

### Clinical innovation

Despite the pressures we faced during the past 12 months, we have not lost sight of the importance of making time for innovation in our clinical services. There are too many to mention but a few examples include the following.

We became the first centre in South Yorkshire to deliver CAR-T cancer therapy, a revolutionary new treatment therapy that uses the patient's own genetically modified cells to find and kill cancer cells.

We were also one of the first Trusts to offer patients with Spinal Muscular Atrophy (SMA) two new novel treatments called Nusinersen and Risdiplam, which can stabilise and improve the condition which would otherwise get worse over time. The drugs work by modifying the effects of an abnormal mutation to the SMN1 gene, which is the cause of the most common form of SMA. Previously there was no treatment, and the care was focussed on symptom management. A 'one-stop shop' service model was also established by the SMA team, providing a single multi-disciplinary outpatient clinic where initial assessments and therapy can take place during the same visit, enabling disabled patients to minimise hospital visits.

We also launched a new regional service for the treatment of Thrombotic Thrombocytopenic Purpura (TTP), a rare, life-threatening blood disorder. Our Haemophilia and Thrombosis Centre is one of nine specialist regional centres and 11 participating hospitals commissioned by NHS England to provide specialist treatment for TTP.

Wherever possible we improve and re-design our services in collaboration with patients and staff and encourage patients to be in control of their care where it is safe and possible to do so. During the year we strengthened this approach by establishing a core patient group called the Patient First Group consisting of patient and carer representatives. So far, the group have provided feedback on our PROUD behaviours consultation, communication with patients, outpatient booking systems and patient discharge process. The Group provides us with valuable insights which help transform and improve services for patients by putting their experience at the core of changes.

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One improvement the Patient First Group have been instrumental in providing feedback for is the rollout of the My Pathway App which creates an electronic contact point between the patient and our services. It is personal to the user and allows them to interact with their care teams around details of their condition, care and appointments in a digitally secure environment. Appointment reminders can be sent to the patient which results in less DNAs. Last minute cancellations can be sent to other patients to fill appointment slots and remote monitoring can enable the clinician to decide whether an appointment is needed.

Another example where patient experience has been at the heart of an innovation is the CFHealthHub. This is a digital learning health system developed by researchers here at the Trust to help patients with Cystic Fibrosis monitor their condition and reduce the need for hospital admission. Now used in 60% of adult Cystic Fibrosis centres in England, the platform has helped over 1,400 patients stay fit and healthy by creating habits and a behaviour of self-care.

### 'Making a difference – the next chapter'

Patient, staff, and partner insight along with learning from the past 12 months and the findings of the CQC inspections has helped shape our future direction of travel which has now been set out in our new corporate strategy called 'Making a difference – the next chapter'. Our mission, vision, values, and strategic aims have remained broadly the same, but we added a sixth aim which is to create a sustainable organisation. We have developed a comprehensive Sustainability Plan that contains a wide range of carbon reduction initiatives and broader sustainability goals. Some of our activities during this year include a low temperature hot water system at the Central Campus to replace old steam-generating boilers with gas condensing boilers. We have installed solar panels at the Northern campus to generate our own electricity during the day and considerable work has taken place to reduce medical gas emissions.

In line with our new corporate strategy ambitions, we also began to look at how we could accelerate the work already undertaken on job creation, widening education opportunities, and improving population health. You can read more about this later in the report.

### Caring for our staff

The past year has taken a further toll on all our staff, regardless of their role or seniority. Not only have they had to work relentlessly to deliver the care patients require, but they have had the added pressure of industrial action, which has not been easy for those who participated and those who didn't. On top of this the cost-of-living crisis has been an added burden on so many of our colleagues. All of this made our strategic aim Caring and Cared for Staff even more of a priority in 2022/23. We have spent a lot of time listening to what our staff were feeling and needed during the past year and trying to do all that we could to keep them well physically and mentally during such difficult times.

Along with many practical initiatives, I think the biggest thing we continued to do was focus on being kind to each other, encouraging a culture of recognition and understanding of the situations people were in, both professionally and personally.

We spent much of the year talking to staff about what they would like to see reflected in our PROUD behaviours framework which has been developed to support our PROUD values. The new framework sets out the behaviours which we want to see displayed to our patients, visitors and each other. Following on from the success of the staff framework, we also began working with our Patient First Group and our local communities to develop a similar framework for patients and visitors. This was launched in March 2023, and we are now raising awareness across the organisation.

Our People Strategy was due to expire in 2022 and so we took the opportunity to ask colleagues across the Trust what they felt was important to them to include in our new People strategy which will be launched in April 2023. We also scrutinised the comments and data from the staff

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survey, pulse surveys and other insights gained throughout the past 12 months.

The NHS Staff Survey has gone through significant changes since 2020 and in 2022/23 there was a theme for each of the seven elements of the NHS People Promise. We scored above average for Acute/ Combined Acute Trusts for one theme: Morale, and average for five themes:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning.

We were slightly below average in:

- We work flexibly
- We are a team
- Staff engagement

These will be areas for improvement next year.

We were very pleased that despite it being another very challenging year with more patients than ever receiving treatment, the number of staff recommending STH as a place to work (62%) and for treatment (76%) both remains above average for Acute/Combined Acute Trusts.

However, we were disappointed that the overall percentage of staff who said they would recommend us as a place to work or receive care had dropped. We are determined to address the reasons why our staff felt this way by understanding the factors which are influencing their frustrations or concerns. One major thing we know impacts our staff every day is the inefficiency of our electronic patient record system.

We have already committed to changing this by procuring a new system which our staff will influence in terms of the design and functionality. Our new People strategy is called – A Brilliant Place to Work and will be launched in April 2023. It is aligned with the themes of the NHS People promise and focuses on three key areas of Attract, Grow and Retain.

With the support of our Staff Network groups and Equality, Diversity and Inclusion (EDI) Board members we continued to implement the improvements outlined in our new EDI strategy.

We were delighted to be given a Stonewall Gold Award for our commitment to inclusion of lesbian, gay, bi, trans and queer (LGBTQ+) people in the workplace. We want everyone to have a voice, to feel they belong and to be equally valued and important – valued staff are happier staff and that contributes to providing the best care for our patients.

Since its launch in June 2021, several colleagues have benefited from participating in our Reciprocal Mentoring Programme. The programme matches senior leaders from across all areas of the Trust and members of the Staff Network Groups. Leaders gain an insight into the lived experiences of our Staff Network Group members, who in return are coached and supported in terms of their personal and career aspirations. We also launched our first Race Equality Charter during the year.

This year, we have been working with our charity to create more outside spaces and calm rooms to provide somewhere away from the hustle and bustle for staff to take a break, clear their minds and reflect. Our new Secret Garden at the Northern General opens in 2023 and plans are underway for something similar at the Central Campus.

### Investment in facilities

During 2022/23 we continued to invest in facilities and equipment to support the efficient delivery of patient care and ensure staff had the tools and environment they needed to deliver that care. In addition to a significant financial investment in the new Electronic Patient Record system and Orthopaedic Centre mentioned earlier in this report here are a few examples of where else we spent capital.

Our Urology outpatient department became the first in South Yorkshire to install a new Lithotripter machine to deliver shock wave lithotripsy which is a faster, non-invasive treatment for kidney stones.

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It is carried out as a day case procedure and takes less than half an hour. We provide the treatment for patients from Doncaster, Rotherham and Chesterfield as well as Sheffield.

We have also become the first in the world to install the latest Elekta Esprit Gamma Knife, a machine used to treat brain tumours and other brain conditions. The Trust is home to the National Centre for Stereotactic Radiosurgery.

We also created a new Fracture Clinic and carried out improvements on Jessop Wing Theatres, B Road at the Hallamshire Hospital and our CCTV system.

### Partnership working

Prior to the global pandemic, demand for NHS services was increasing rapidly due to a growing and aging population requiring increasingly complex care. This exacerbated long standing pressures facing the NHS. To meet these challenges, the health and care system is transforming. A major part of this transformation was the Health and Care Act, which signalled the establishment of Integrated Care Systems (ICSs). Integrated Care Systems bring together NHS organisations with local authorities and wider system partners to collectively plan to meet population needs, deliver better integrated care and tackle health inequalities.

The national shift away from an internal market and towards greater integration has been reflected in the evolution of the South Yorkshire and Bassetlaw Integrated Care System (NHS South Yorkshire) in July 2022.

An important aspect of the establishment of the ICS is the development of Provider Collaboratives with other trusts in one or more ICS. There are also place-based partnerships that involve the NHS, councils, voluntary organisations, residents and service users, working together to design and deliver integrated services in a specific, geographical area. This presents exciting opportunities to collaborate and integrate where appropriate. We have learnt how to successfully integrate and transform services across community and acute interfaces over many years.

We have also learnt how to provide services locally at scale across a broad geography in partnership with other local trusts. We can see that further opportunities also exist to build a resilient network of health and social care for the people we serve, and our existing and emerging partnerships will bring these to fruition. One example is the development of the South Yorkshire and Bassetlaw Pathology network which we will host and are currently designing with our partner NHS Trusts.

The Sheffield Health and Care Partnership has continued to develop from the early work of the Accountable Care Partnership. A health and care vision has been developed for 2030 that focuses on integration of care across services within the city; the need to reduce and remove inequalities; and to ensure we involve those people and communities that use the services we collectively provide.

We are also a partner in the South Yorkshire and Bassetlaw Acute Federation which is a collaboration of the Acute Trusts across South Yorkshire and Bassetlaw. Our aim is that, by working more effectively together, we can improve clinical standards and the care outcomes for our patients, as well as making our organisations better places to work. During the year the Acute Federation has undergone a period of significant development with closer integrated working across the partners to support each other to recover from the COVID-19 pandemic and continue to develop new ways of collaborative working for the future.

It is important that we are involved in these partnerships because as an anchor institution, we need to influence positively the wider social determinants of health for example by:

- tackling the climate emergency
- providing access to good quality education and employment
- making a positive impact on our economy
- taking action on prevention and healthier lifestyles.

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These complex issues require collective action both internally and externally, working in partnership to deliver a clear place-based strategy and aligning discrete interventions so that we are greater than the sum of our parts.

Strong relationships with the city's universities, NHS partners, voluntary organisations and business community have also given us an opportunity to consider how together we can tackle the wider implications of the pandemic's impact on our region.

### Research and innovation

With COVID-19 research no longer a national urgent public health priority, we began to refocus on delivering research and innovation that seeks to improve the patients' outcomes across a wide range of disease areas.

We continued to work in partnership with the city's universities to pioneer international and national research, leading the way with a world-first trial which is comparing the use of stem cell transplant against the latest, most highly effective disease modifying therapies in patients with 'aggressive' multiple sclerosis. The ground-breaking StarMS trial could see stem cell transplant offered as a first-line therapy to patients with the relapsing-remitting form of the disease, instead of only when other treatments have failed.

The excellent collaborative partnerships between our clinicians and the city's academics and scientists were signified by a £12 million funding boost from the National Institute for Health and Care Research (NIHR) for the Sheffield Biomedical Research Centre (BRC). Nearly 3,000 patients with devastating neurological conditions have accessed novel, innovative treatments since the BRC was first established in 2017. The new funding will allow scientists and clinicians to expand the Centre's pioneering research portfolio into areas such as infection, immune disorders and cardiovascular diseases in addition to neurology research.

An important paper published in the New England Journal of Medicine, the world's leading medical journal, also highlighted Sheffield's game-changing work, with researchers showing that the experimental tofersen drug was able to slow and even reverse some of the physical decline caused by motor neurone disease in patients with the faulty SOD1 gene after 12 months. Although only 2% of patients with the muscle-wasting condition develop this gene, the international research findings – in which Sheffield played a leading role – were described as a "real moment of hope" for patients with the disease.

The vital role our clinical research facilities have in bringing cutting-edge research to the region was further bolstered by a £7.9 million investment in the NIHR Sheffield Clinical Research Facility. The multi-million funding will allow the facility to continue to support the development and testing of new treatments for diseases, many of which currently have no cure.

As a highly research active Trust, we provided thousands of patients with the opportunity to take part in meaningful health and care research. One example was the development of a new at-home test which uses saliva rather than blood to provide a simpler, quicker way to diagnose adrenal insufficiency – a common disorder caused by the lack of the body's main stress hormone, cortisol. The breakthrough test was found to have a high degree of accuracy, made the patient journey easier, and could change future clinical practice.

Another trial investigating the effectiveness of three treatments in relieving pain in patients who suffer with diabetic neuropathy (nerve damage), one of the most miserable complications of the disease, showed that despite huge variations in cost and availability of each medication, all treatments provided similar and significant pain reduction for patients with diabetic neuropathy. The key findings have the potential to influence future treatment guidelines for diabetic neuropathy – which develops in around 50% of patients with diabetes – in both the UK and across the world.

The breadth and diversity of our research was reflected by the innovative Nurse, Midwifery and

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Allied Health Professional Research Internship Programme. This has led to the development of four novel research projects including a study looking at why certain ethnic groups are less likely to be treated for lung cancer in the region. This success has seen the programme extend to 12 current Internships.

Another project that is innovative in its scope, scale and focus is the Equity in Doctoral Education through Partnership and Innovation (EDEPI) programme. The four-year programme, which we are delivering in partnership with Sheffield Hallam University, aims to increase participation of Black, Asian and Minority Ethnic groups in postgraduate research.

We also became actively involved in the Healthcare Entrepreneur Exchange Programme (HEEP). This pioneering international competition fosters collaborations between the NHS organisations participating and the Catalan Health Institute of Spain, which is one of the leading hospitals in Europe.

With the global effort to develop COVID-19 vaccines behind us, we were able to restart work on developing our new research and innovation strategy. The new strategy aims to set out how we plan to work with our partners to support innovative, high-quality research that seeks to benefit patients, our population, the workforce and the economy and better meet the needs of the public we serve, and we have held workshops with patients and our key partners to ensure patients and the priorities of our organisation remain at its heart.

Other key research undertaken this year included a new study aimed at understanding why surgery is not considered sooner for many people living with ileocaecal Crohn's – one of the most common forms of Crohn's disease, a lifelong inflammatory gut condition. Researchers also led the way with the development of a pioneering artificial intelligence (AI) tool which can analyse vital diagnostic measurements from MRI heart scans within seconds, speeding up diagnosis and improving future heart disease care. The team are now aiming to make the AI tool more widely available on the NHS thanks to a Medipex NHS Innovation Award win. AI research has been identified nationally as "vital for the UK's international influence as a global superpower".

COVID-19 research also remained a key strand of our research activity, with our researchers continuing to input into flagship national studies and winning the Warwick Turner Lecture Prize for the Yorkshire region for scientific work modelling transmission chains of the SARS-CoV2 virus.

## Conclusion

As we move into 2023/24, our overriding priority will continue to be to deliver safe, high-quality care for all our patients and provide a brilliant place to work for our staff.

I am in no doubt that this next phase of resetting our services and continued focus on providing high quality, safe services for all our patients will be met with the same determination, creativity and pride that drove the improvements delivered last year. The following pages give further details 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.

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

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# 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 2022/23 at Sheffield Teaching Hospitals NHS Foundation Trust.

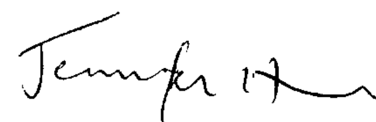
Whilst it is impossible here to include information about every service the Trust provides, it is, nevertheless, our hope that the report goes some way to reassure our patients and the public of our commitment to deliver safe, effective and high quality care.

The Quality Report Steering Group, which reports to the Quality Committee and incorporates stakeholder membership including staff, Governors, Healthwatch Sheffield and voluntary and community sector representation, oversees the selection of the Trust's quality improvement priorities.

As a Trust, we have considered carefully which quality improvement priorities we should adopt for 2023/24. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with Governors and with representatives from NHS Sheffield Integrated Care Board and Healthwatch Sheffield.

In developing this year's Quality Report, we have considered the comments and opinions of internal and external parties on the 2021/22 Report. The proposed quality improvement priorities for 2023/24 were agreed in May 2023 by the Quality Committee, on behalf of the Board of Directors. The final draft of the Quality Report was sent to external partner organisations for comments in May 2023, in readiness for the publishing deadline of 30 June 2023.

In response to the publication of the CQC Inspection Report in December 2022, the Trust developed a high-level action plan covering all 'must do' requirements and 'should do' recommendations. The approved high-level action plan was submitted to CQC on 26 January 2023 with a number of improvements now embedded with other improvements continuing to progress and will remain a priority during 2023/24. The implementation of the actions will be overseen by the Trust Executive Group and the Quality Committee.



**Dr Jennifer Hill**
**Medical Director (Operations)**

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# Part 2

## Priorities for Improvement

*This section describes progress against the priorities for improvement during 2022/23 and outlines the priorities for 2023/24, along with an explanation of the process for their selection.*

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# 2.1 Priorities for Improvement 2022/23

# Safety

## Priority 1: Improve the identification, escalation and response to deteriorating patients

### Background

There had been several serious incidents relating to the recognition of and response to patient deterioration, and this was raised as a concern in the CQC inspection report published April 2022. In addition, this objective supported the CQUINs CCG3: recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.

### Objective breakdown

The purpose of this objective was to improve the identification and timeliness of response to deteriorating patients and would include the following:

- Audit compliance with NEWS2 to identify a baseline on six wards with highest numbers of deteriorating patients.
- Introduce a deteriorating patient bleep holder on all inpatient wards and audit compliance. Address any barriers to deteriorating patient bleep holders identified.
- Test and introduce an e-whiteboard alert for escalation of patient deterioration and audit use.
- Audit inclusion of deteriorating patients in ward safety huddles.
- Audit time from escalation to response and identify areas requiring further education and input.

### Achievements against objective

- Deteriorating patient bleep visible on eWhiteboard in inpatient areas.
- e-Whiteboard alert pilot operational.
- Safety huddles include deteriorating patient check and challenge.
- Deteriorating patient screening tool revised and in practice.
- Deteriorating patient study day relaunched in key areas.

This was a one-year objective, and the objective aims are complete. Deteriorating Patients is a key workstream for the Trust with oversight by the Deteriorating Patient Group.

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# Patient Experience

## Priority 2: To improve care delivered in last days of life and the documentation of this care

### Background

National guidance relating to End of Life Care (EoLC) promotes personalised care planning as the gold standard. CQC inspection reports and the Trust's 'National Audit of Care at the End of Life' results (2018-2021) identified an ongoing need to improve the delivery and documentation of personalised EoLC for our patients and those important to them. Staff feedback also highlighted their need for a document to provide prompts to aid them in the delivery of care at the end of life.

In response to this, a 'Caring for Dying Patients: Personalised Plan of Care' document and digital nursing care plans were developed to ensure that patients who are in their last days of life have a documented personalised plan which establishes and addresses their individual needs, wishes, and priorities for their EoLC.

### Objective breakdown

The purpose of this objective was to improve documentation of care delivered in last days of life and to improve escalation and advance care planning through the implementation of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and would include the following:

- Engagement for the second phase roll-out of the 'Caring for Dying Patients: Personalised Plan of Care' for last days of life across the Trust.
- Engagement with the city-wide ReSPECT Project Group with regards to roll out of ReSPECT at the Trust.

### Achievements against objective

- Caring for Dying Patients: Personalised Plan of Care' (CfDP:PPC) document rolled out Trust-wide ahead of schedule:
  - Comprehensive and well-executed staff awareness and engagement plan.
  - Audit of phase 1 of the roll-out (9 inpatient wards):
    - using CfDP:PPC led to improvement in all EoLC standards, except for daily review of the patient's nutrition which remained static.
    - to address this: CfDP:PPC was updated with additional prompts and a key points video on 'nutrition and hydration' developed.
- E-whiteboard icon used to identify dying patients rolled-out February 2023.
- Staff training:
  - ReSPECT PALMS training live across the Trust Level for all staff.
  - ReSPECT Training Standard Operating Procedure (SOP) for Advanced Care Practitioners (ACP), Clinical Nurse Specialists (CNS) and Allied Health Professionals (AHP).
  - Targeted engagement for ReSPECT with Clinical Directors and Consultant groups.
  - ReSPECT community of practice and Intranet page in development.
- Patient leaflets and ReSPECT plan in place.
- Co-ordinated place-based communications for public/patient ahead of launch.

This was the second year of a two-year objective, and the objective aims are complete. On-going work to ensure this is fully embedded is being overseen by End of Life Care Steering Group.

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# Patient Experience

## Priority 3: To Improve the care of patients with Learning Disabilities

### Background

A Coroner's Regulation 28 notice identified issues in relation to learning disability (LD) patients and in particular use of the Health Passport to support care.

A national learning disability survey suggested that the Trust was performing below average in relation to communication and personalised care for LD patients.

A recent audit highlighted communication as an issue during visiting restrictions and the need to raise awareness of the Health Passport.

### Objective breakdown

The purpose of this objective was to review LD patients waiting for care to ensure equality of access and improve use of the Health Passport across the Trust and would include the following:

- An audit of the use of the Health Passport to identify what areas need focus. Development of improvement actions to embed use of the Health Passport.
- Assess the quality of data on LD for patients on the waiting list. Identify areas where pathway improvement is required and agree an action plan.
- Develop and roll out training material to support data collection of LD flag.

### Achievements against objective

- Confirmation that waiting times have not compromised timeliness and quality of care for patients with LD compared to those without LD. Data quality issues were giving the impression of long waits. Treatments had commenced but pathways had not been closed correctly.
- Full understanding of current data collection processes to facilitate further development.
- An initial 208 members of staff received training on 'The Health Passport'. This has included other important information such as providing reasonable adjustment and the LeDeR process. This training has evaluated well.

This was a one-year objective. LD and autism are a key workstream for the Trust with oversight by the Mental Health Steering Group.

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# Effectiveness

## Priority 4: To improve individualised care of patients with dementia

### Background

At any one time, one in four hospital beds are occupied by people living with dementia. Hospital admission can trigger distress, confusion and delirium for someone with dementia. The National Audit of Dementia also identified areas for improvement.

### Objective breakdown

The purpose of this objective was to improve staff training on Dementia care and embed cognitive assessment on admission. The objective also aimed to enhance dementia/cognitive care planning and would include the following:

- Development of training materials and launch of training plan. Monitor and performance manage training compliance.
- Develop and launch a new care plan. Monitor and performance manage care plan completion.
- Scope which directorates are completing cognitive assessments on Lorenzo and which on paper. Engage with directorates as to preferred format of assessment.

### Achievements against objective

- Job Specific Essential Training agreed and launched.
- Care Plan piloted.
- Bespoke training sessions delivered to over 500 members of staff, plus induction training for an additional 225 internationally educated nursing staff.
- Over 200 one-to-one stimulation sessions completed, delivering >650hrs of contact time to patients with dementia.
- Dementia Champion Network expanded.
- Estates ensuring all works are in line with dementia friendly environment guidelines.
- Resource library created available for all staff to access to support them in caring for patients with dementia.
- Involvement in Round 5 of National Audit of Dementia.

This is a two-year objective and will continue in 2023/24.

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# 2.2 Priorities for Improvement 2023/24

*This section describes the Quality Improvement Priorities that have been adopted for 2023/24.*

To ensure the Trust is constantly improving the quality of care and the patient experience, new Quality Objectives are selected each year.

Our 2023/24 Quality Objectives have been selected after consideration of data from audit, incidents, complaints and other patient feedback, and consideration of areas likely to have a significant impact on the quality of care delivered to our patients.

Following discussion on 22 March 2023 at the Trust's Quality Report Steering Group, chaired by the Medical Director (Operations) with membership including the Chief Nurse, Trust governors, senior managers, Sheffield Healthwatch and voluntary sector representation (Sheffield Churches Council for Community Care), three Quality Objectives were agreed. These Quality Objectives were approved by the Quality Committee, on behalf of the Board of Directors, in May 2023.

### 2023/24 Objectives

The objectives for 2023/24 span the 'Patient Experience', 'Safety' and 'Effectiveness' domains within the Trust's Quality Strategy. These are as follows:

### Patient Experience

### Improve the quality of Accessible information for patients

Objective breakdown:

- Identify if we can capture and better use patient information within the current EPR to improve the patient's journey and experience regarding accessibility of information, including interpreting.
- Ensure that there is a clear specification for the new Cerner EPR to support compliance with the Accessible Information Standard.
- Raise awareness of the Accessible Information Standard and ensure all staff understand their roles and responsibilities regarding meeting people's needs under the Accessible Information Standard, including access to interpreting services.
- Implement the Accessible Information Standard Policy across the Trust.
- Complete a stock-take of processes currently in place to support accessible information including access to interpreting and translation services and where required establish targeted communication methods based on patient profile.
- Develop regular reporting of key metrics including activity regarding interpreter and translation usage.
- EDI Dashboard established and in use to understand the patient profile within specific service areas.

Objective output/metrics:

- Increased patient satisfaction with the accessibility of information including interpreter services.
- Reduced patient/carers complaints, claims, serious incidents related to access to our services/provision of information/access to interpreters.
- Staff compliance with training.
- Increase in amount and quality of data captured for patients in relation to their needs (which is subsequently used to positively influence their care).
- Interpreting and translation service activity data sourced, reported on and monitored.

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## Safety

### Improve the management of medicines to ensure patient safety.

Objective breakdown:

- Audit medicine storage across inpatient areas within the Trust, including fridge temperatures, and implement an improvement programme.

Objective output/metrics:

- After 2 years 95% or higher compliance with all aspects of the Medicines Management checklist completed over last quarter.
- Embedded daily fridge monitoring compliance at 95% or higher.
- Embedded daily ambient temperature monitoring compliance at 95% or higher.

## Effectiveness

### Improve individualised care of patients with dementia (Year 2)

Objective breakdown:

- To improve staff training on Dementia care.
- To enhance dementia/cognitive care planning.
- To embed cognitive assessment on admission.

Objective output/metrics:

- JSET compliance over 90%.
- Care plan in use on all patients.
- Cognitive assessment complete in over 90% patients over the age of 60.

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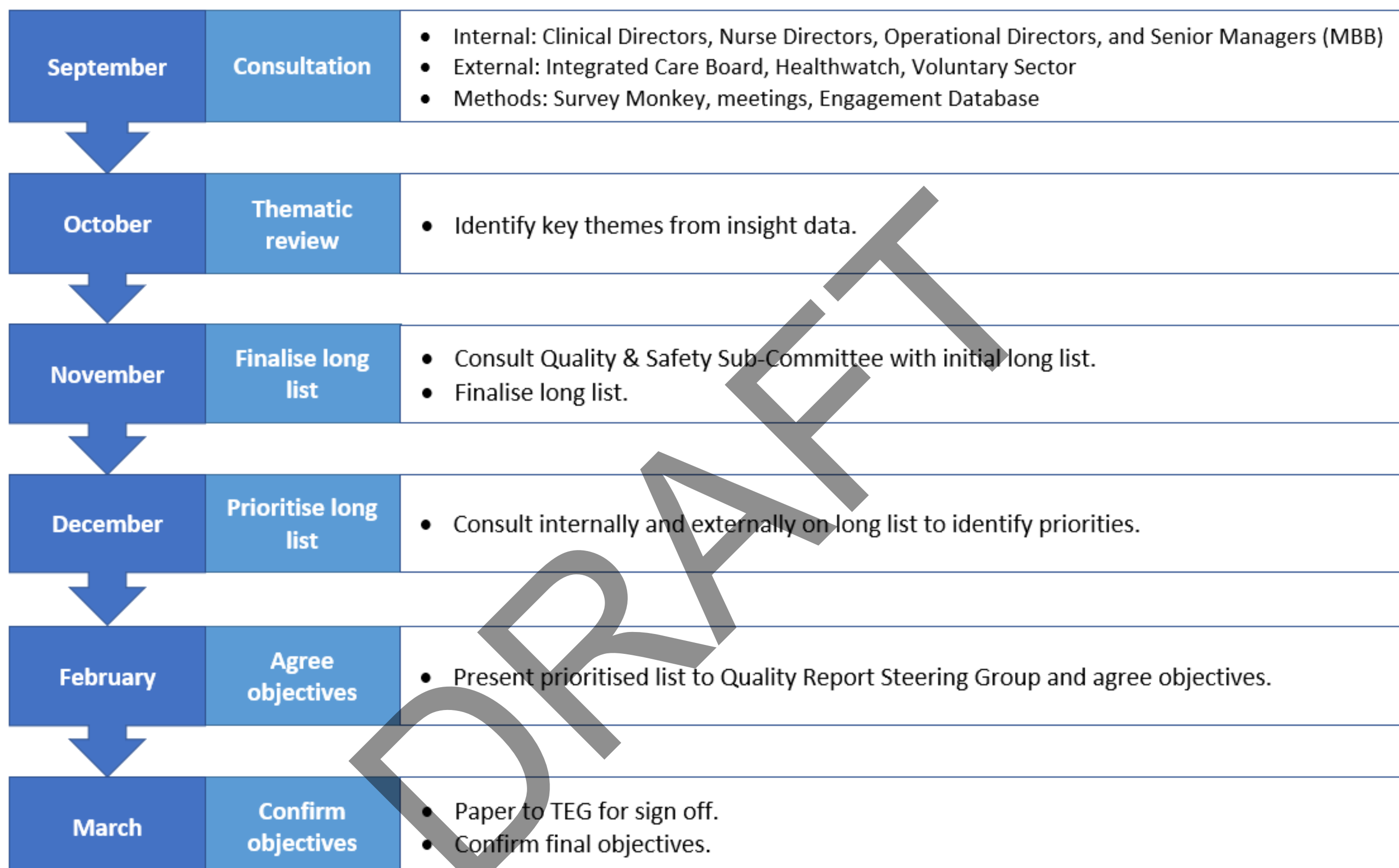
# 2.3 Quality Objective Selection Process

As outlined above, the 2023/24 Quality Objectives were selected from a long list of themes identified through audit data, incidents, complaints, patient feedback and consideration of areas likely to have a significant impact on the quality of care delivered to our patients. The final three Quality Objectives were agreed following discussion at the Trust's Quality Report Steering Group on 22 March 2023 and were approved by the Quality Committee, on behalf of the Board of Directors, in May 2023.

For 2024/25, a more robust process has been agreed, commencing earlier in the year and allowing greater time for consideration. This new process is presented below:

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# 2.4 Statements of assurance from the Board

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

*a. Services provided*
*b. Clinical audit*
*c. Clinical research and innovation*
*d. Commissioning for Quality Improvement (CQUIN) Framework*
*e. Care Quality Commission*
*f. Data quality*
*g. Patient safety alerts*
*h. Staff survey*
*i. Equality, Diversity and Inclusion*
*j. Annual patient surveys*
*k. Complaints*
*l. Delivering same-sex accommodation*
*m. Coroners' regulation 28 (Prevention of future death) reports*
*n. Never events*
*o. Duty of candour*
*p. Safeguarding*
*q. Seven-day service*
*r. Learning from deaths*
*s. Staff who speak up*
*t. Rota gaps*

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## a. Services provided

During 2022/23 Sheffield Teaching Hospitals NHS Foundation Trust were commissioned to provide 83 NHSE specialised service specifications, routine elective services, maternity and emergency/non-elective services. Routine elective services continued to be impacted because of reduced elective capacity and staffing shortages because of COVID-19. The focus for routine elective activity was to ensure the delivery of Priority 1 or 2 cases and to address long waiting patients with a particular focus on treating all patients who would have waited 78 weeks or more by the end of March 2023.

The funding of the relevant health services was on a block, based on costs incurred.

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

## b. Clinical audit

During 2022/2023, 62 national clinical audits and confidential enquiries covered relevant health services that Sheffield Teaching Hospitals NHS Foundation Trust provides.

During that period Sheffield Teaching Hospitals NHS Foundation Trust participated in 59 national clinical audits and confidential enquiries which it was eligible to participate in. The national clinical audits that Sheffield Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2022/23 and those that it did participate in are documented in the table below.

The national clinical audits that Sheffield Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below.

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*Figure 1: Audit and confidential enquiries*

| Audits and confidential enquires | Participation N/A = Not applicable | % cases submitted |
|---|---|---|
| **Acute care** | | |
| Breast and Cosmetic Implant Registry | Yes | 75% |
| Case Mix Programme (CMP) | Yes | 100%* |
| The Trauma Audit & Research Network (TARN) | Yes | 100% |
| National Emergency Laparotomy Audit (NELA) | Yes | 77% |
| National Joint Registry (NJR) | Yes | 102.4% |
| *Note: Percentage of cases submitted to the NJR compared to HES/PEDW. The HES/PEDW data is based on figures received up to fiscal Q4 2021. The benchmark figure is 95%. Compliance with HES will sometimes appear lower when cases are sent from Trusts to the private sector and HES records the activity as being in the Trust. Compliance may be greater than 100% due to the timing of submission of data into the NJR and HES/PEDW. However, if results are consistently much greater than 100%, it suggests that the coding may need reviewing.* | | |
| Neurosurgical National Audit Programme | Yes | 100% |
| **National Vascular Registry** | | |
| National Carotid Interventions | Yes | 97% |
| Abdominal Aortic Aneurysm | Yes | 90% |
| Peripheral Vascular Surgery - Lower limb angioplasty/stenting | Yes | 23% |
| Peripheral Vascular Surgery - Lower limb bypass | Yes | 72% |
| Peripheral Vascular Surgery - Lower limb amputation | Yes | 66% |
| National Acute Kidney Injury Audit | Yes | 100% |
| Chronic Kidney Disease Audit/ The Renal Association/The UK Renal Registry | Yes | 100%* |
| Sentinel Stroke National Audit programme (SSNAP) | Yes | 90%+ |
| **RCEM Emergency Medicine (QIPS):** | | |
| Infection Control | Yes | Did Not Participate |
| Consultant Sign Off | Yes | 47.7% |
| Pain in Children | NA | |
| **Blood and transplant - National Comparative Audit of Blood Transfusion programme:** | | |
| Serious Hazards of Transfusion Scheme (SHOT) | Yes | 100% |
| **Cancer** | | |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes | 100% |
| **National Gastro-intestinal Cancer Programme:** | | |
| National Oesophago-Gastric Cancer Audit (NOGCA) | Yes | 100% |
| National Bowel Cancer Audit (NBOCA) | Yes | 100% |
| National Lung Cancer Audit (NLCA) | Yes | 100% |
| National Prostate Cancer Audit (NPCA) | Yes | 100% |
| **Heart** | | |
| National Cardiac Arrest Audit (NCAA) | Yes | 100%* |
| **National Cardiac Audit Programme:** | | |
| National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) | Yes | 100%* |
| National Adult Cardiac Surgery Audit | Yes | 100%* |
| Myocardial Ischaemia National Audit Project (MINAP) | Yes | 100%* |
| National Audit of Cardiac Rhythm Management Devices and Ablation | Yes | 100%* |
| National Congenital Heart Disease Audit (NCHDA) | NA | |
| National Heart Failure Audit | Yes | 100%* |

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| Audits and confidential enquires | Participation N/A = Not applicable | % cases submitted |
|---|---|---|
| Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry | NA | |
| National Audit of Cardiovascular Disease Prevention | NA | |
| National Audit of Cardiac Rehabilitation | Yes | 100% |
| National Audit of Pulmonary Hypertension | Yes | 100%* |
| **Long term conditions** | | |
| **Inflammatory Bowel Disease (IBD) programme:** | | |
| Inflammatory Bowel Disease Audit | Yes | 3,236 records submitted |
| *Note: The IBD registry extract is a cumulative return so every time we do a submission to the registry we submit all patients, not just new patients. There are currently 3,236 [STH] patients on the IBD database with a diagnosis recorded who will get submitted before 21/04/2023 in the next extract (compared with 2,665 in April 2022). There are still some patients with IBD who we have not yet captured on the database but have never accurately been able to quantify how many* | | |
| **National Asthma and COPD Audit Programme:** | | |
| Adult Asthma Secondary Care | Yes | 10% |
| Paediatric Children and Young People Asthma Secondary Care | N/A | |
| Pulmonary Rehabilitation | Yes | 100% |
| Chronic Obstructive Pulmonary Disease | Yes | 100% |
| UK Cystic Fibrosis Registry | Yes | 99% |
| **National Adult Diabetes Audits:** | | |
| National Diabetes Core Audit | Yes | 100% |
| National Pregnancy in Diabetes Audit | Yes | 100% |
| National Diabetes Footcare Audit<br>*Note: The systems in STH do not allow us to identify number of eligible cases. This is not unique to STH but anticipated to be a problem in most organisations* | Yes | Participated |
| National Diabetes Inpatient Safety Audit | Yes | 100% |
| **Mental health** | | |
| Learning Disability Mortality Review Programme (LeDeR Programme) | Yes | 100% |
| Mental Health Clinical Outcome Review | NA | |
| National Clinical Audit of Psychosis | NA | |
| **Prescribing Observatory for Mental Health (POMH-UK)** | | |
| a. Improving the quality of valproate prescribing in adult mental health services | NA | |
| b. The use of melatonin | NA | |
| National Clinical Audit of Psychosis | NA | |
| **Older people** | | |
| **Falls and Fragility Fractures Audit programme (FFFAP):** | | |
| National Audit of Inpatient Falls | Yes | 100% |
| National Hip Fracture Database<br>*Note: NHFD determine case ascertainment as total cases compared to last year. This figure is derived from 617 (year 2022)/604 (year 2021)* | Yes | 102.2% |
| Fracture Liaison Service Database | NA | |
| National Audit of Dementia | Yes | 21% |
| UK Parkinson's Audit | Yes | 90% |
| **Other** | | |
| Elective Surgery (National PROMs Programme) | Yes | See supporting statement |
| National Bariatric Surgery Registry | Yes | 90.48% |
| National Obesity Audit | Yes | 100% |

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| Audits and confidential enquires | Participation N/A = Not applicable | % cases submitted |
|---|---|---|
| National Ophthalmology Audit Database | No | Did Not Participate nationally/local audit |
| **BAUS Urology Audits:** | | |
| Muscle Invasive Bladder Cancer Audit | Did not participate | |
| National Audit of Care at the End of Life (NACEL) | Yes | 100% |
| National Early Inflammatory Arthritis Audit (NEIAA) | Yes | 100%* |
| Society for Acute Medicine Benchmarking Audit | Yes | 100% |
| Perioperative Quality Improvement Programme *Note: National audit required 100 cases, STH submitted 105.* | Yes | 105% |
| **Respiratory Audits:** | | |
| a. Adult Respiratory Support Audit | Yes | Still data collecting |
| b. Smoking Cessation Audit- Maternity and Mental Health Services | | Audit still in development |
| Cleft Registry and Audit Network Database | NA | |
| **Women's and children's health** | | |
| Child Health Clinical Outcome Review Programme (NCEPOD) | NA | |
| **Maternal, Newborn and Infant Clinical Outcome Review Programme:** | | |
| Perinatal Mortality Surveillance and Confidential Enquiry | Yes | 100% |
| Maternal Mortality Surveillance and Confidential Enquiry | Yes | 100% |
| National Perinatal Mortality Review Tool | Yes | 100% |
| National Maternity and Perinatal Audit (NMPA) | Yes | 100% |
| National Neonatal Audit Programme (NNAP) | Yes | 100% |
| National Paediatric Diabetes Audit (NPDA) | NA | |
| Paediatric Intensive Care (PICA Net) | NA | |
| National Child Mortality Database | Yes | 100% |
| National Audit of Seizures and Epilepsies in Children and Young People | NA | |
| **Outcomes** | | |
| **Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD):** | | |
| Epilepsy | Yes | 100% |
| Transition from child to adult health services | Yes | 100% |
| Crohn's Disease | Yes | 100% |
| Community Acquired Pneumonia | Yes | 97% (data collection still open) |
| Testicular Torsion | Yes | 93% (data collection still open) |

*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.*

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## Supporting Statements

**The Trust did not participate in the following national audits:**

**RCEM Audit of Infection Control 2021/22**

Prospective data collection was not possible due to work demands. Unsuccessful attempts were made to run a year of data, making retrospective data collection then not possible. Infection control is continually monitored by the care group, it is a core project of the work Acute & Emergency Medicine (AEM) are doing around the CQC report publication and there is now a group within the senior nursing team. We will be participating in the RCEM Audit of Infection Control Audit 2022/23.

**Muscle Invasive Bladder Cancer Audit**

Due to ongoing service pressures and resource gaps, STH was unable to collect and submit data for this audit. This problem of support for audit data submission has been an ongoing concern for the directorate and recent clerical appointments have been made specifically to address data collection for national audits, which will reduce the likelihood of future failures to submit national data.

**National Ophthalmology Audit Database**

The Trust formally ceased participation in the National Ophthalmology Database (NOD) Audit in 2020 but continued with local data collection which commenced prior to joining the National Cataract Audit and has continued in parallel throughout the period of the NOD audit. A local report is produced annually and reviewed by the Ophthalmology Directorate. STHFT enters data for 100% of cataract patients onto Medisoft, an Electronic Medical Record (EMR).

The quality of delivery of this high-volume surgical activity in STHFT remains very good. This is confirmed by the posterior capsular rupture (PCR) complication rate which meets national standards.

**The Trust participated only in part in:**

**National Asthma Audit**

Due to limited resource to collect and submit data, the agreement between the STH Asthma team and the national team was that the Trust would aim to submit 10 patients per month so that a sample of our care is included in the national reports. Unfortunately, this was no longer possible from January 2023. Data was not submitted from this time due to further resource gaps.

Medical trainees have become involved in data collection and a plan is in place to retrospectively enter 10 patients per month from January 2023.

**National Vascular Registry (NVR)**

The Vascular Directorate have a current plan to improve case ascertainment.

A business plan has been submitted to appoint a dedicated NVR audit clerk/coordinator to help facilitate this, to support consultants to submit data and also to follow up any missing data for cases. As yet no appointment has been made.

**NHS England published statement for PROMS**

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data is still outstanding with no definitive date for completion. Therefore, NHS England has paused the current publication reporting series for PROMS currently. The Trust is looking at available local data, although not risk adjusted, to inform improvements.

The reports of 25 national clinical audits were reviewed by the provider in 2022/23 and STHFT intends to take actions to improve the quality of healthcare provided, examples of which are included as follows:

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**National Audit of Care at the End of Life (NACEL) 2022**

STHFT's 'National Audit of Care at the End of Life' results (2018-2021) identified an ongoing need to improve the delivery and documentation of personalised end of life care for patients and those important to them. Feedback from a stakeholder event in 2020 also highlighted the need for a document to provide prompts to aid staff in the delivery of care at the end of life. End of life care was agreed as a two-year quality objective for the Trust for 2021-2023 to improve documentation of care delivered in the last days of life.

Previously, medical staff documented in paper records, whilst nursing staff documented in the electronic patient record (Lorenzo). It was not possible to have one cohesive care planning document for use by the whole multidisciplinary team. Initially, an 'Individualised Plan of Care for Last Days of Life (IPoC) was developed for non-nursing clinical staff, and this was piloted across three wards in 2017/18, with a re-pilot in 2021. The results demonstrated improvement in documentation and the holistic care given to patients at the end of life.

Following feedback of the pilot, an extensive staff consultation took place and the 'Caring for Dying Patients: Personalised Plan of Care' (CfDP:PPC) was developed to replace the IPoC. This is currently a paper document with the intention to digitalise when medical staff move to documenting in the new electronic patient record planned for 2024. The CfDP:PPC was piloted and rolled out across the Trust in 2022 and this evaluated well. Staff training has also been made available to support the implementation of the CfDP:PPC.

NACEL 2022 has demonstrated improvement in the number of patients with an individualised plan of care which has risen from 36% in 2019 to 57% in 2022. This is likely due to the implementation of the CfDP:PPC documentation across STH. Compliance has increased in most aspects of assessment, care planning of treatments and symptom management.

The NACEL 2022 Case Note Review has demonstrated improvement in 43 of the 46 standards. At the time of the audit, the CfDP:PPC had not been fully implemented and so it is anticipated that the Trust will achieve improved compliance again in 2023. Although NACEL will not be running in 2023, STH has agreed to undertake a local audit, based on the national standards, to measure the impact of the CfDP:PPC document. The NACEL results from 2018 to 2022 can be seen detailed in the infographic on page 27.

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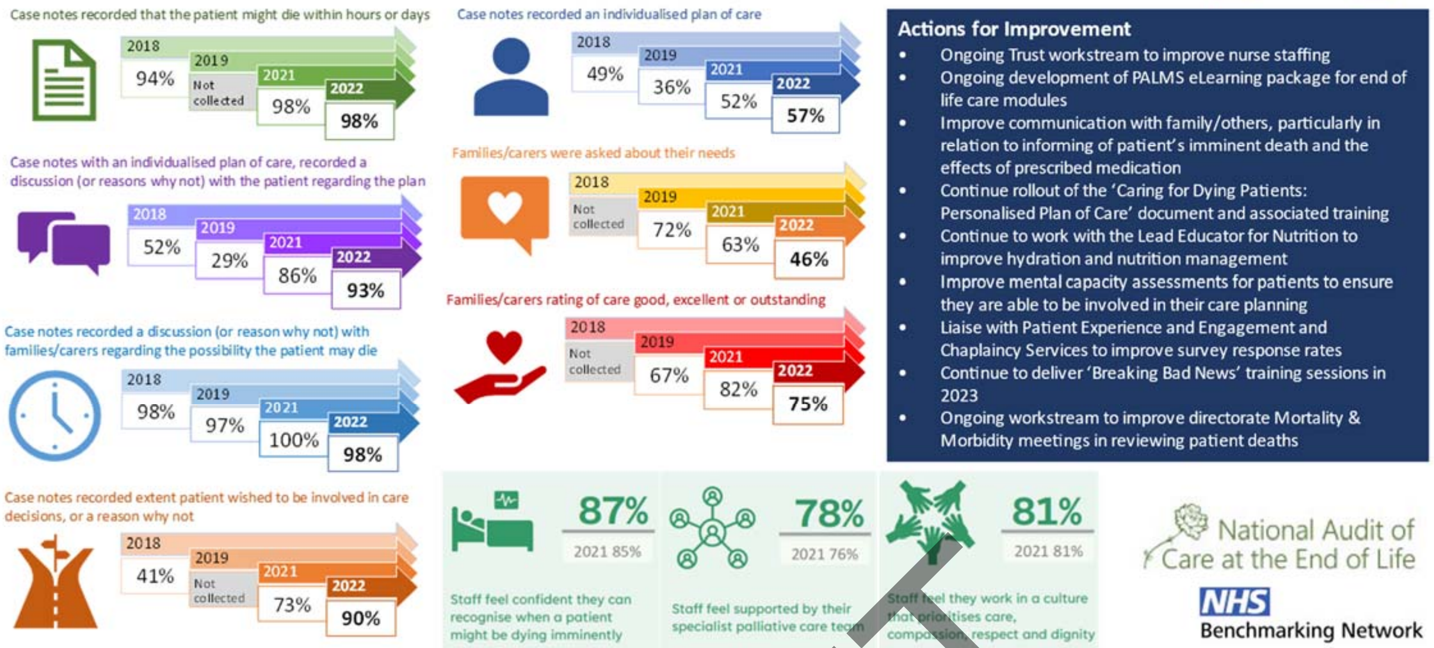
*Figure 2: National Audit of Care at the End of Life (NACEL) Results*

National Audit of Care at the End of Life

50 Case Note Reviews
24 Quality Surveys
213 Staff Surveys

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**National Pregnancy in Diabetes (NPID) Audit**
NPID, part of the National Diabetes Audit, measures the quality of antenatal care and pregnancy outcomes for women with pre gestational diabetes. It is intended to support local, regional and national quality improvement.

The audit measures relate to national standards, National Institute for Health and Clinical Excellence (NICE) Guideline 3 (NG3). The audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address the three key questions:

- Were women with diabetes adequately prepared for pregnancy?
- Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother?
- Were adverse neonatal outcomes minimised?

The STHFT project lead has reached out to GPs/Primary Care regarding change, resulting in improvement in STH compliance with the standards, which are in line with or better than national averages.

The following Trust actions have been implemented and involve Primary care as well as secondary care:

- Information prescription into SystmOne, the community electronic patient record – this will alert GPs to prescribe Folic Acid, inform maternity services and encourage women to book with the midwife by 10 weeks of pregnancy.
- Diabetes Specialist Midwives have been sending emails to Community Midwives (CMW) on a regular basis regarding early booking.
- A Reception Staff Pathway is available in all GP practices to refer women to be reviewed by CMW as soon as possible.
- The Booking Hub is aware that women with diabetes should be booked into Diabetes Antenatal Clinic within the first 10 weeks.
- Information leaflets and business cards are given to women immediately following birth to pre-conceptually plan for their next pregnancy.
- Safer Campaign Posters are displayed in GP surgeries and leaflets are available.
- The following changes to ICE reporting (the system which allows pathology and radiology results to be viewed) (each HbA1c, the

measure of blood sugar (glucose) attached to haemoglobin, reported on ICE will have the attached info below the result): Women (15 to 49 years) with Type 1 and Type 2 diabetes who are planning to become pregnant should be advised to:

1. Keep their HbA1c level below 48 mmol/mol.
2. To take 5mg/day folic acid in the pre-conception period.
3. Refer to Diabetes Pre-conception clinic.
4. If pregnant refer to diabetes antenatal clinic urgently to be seen before 10 weeks gestation.

- A local audit of preconception planning and care for women with type 1 and type 2 diabetes is currently taking place. The aim of the audit is to identify if women are receiving adequate preconception care and if the current pilot preconception clinic needs to be expanded.

**NCAPOP Falls and Fragility Fractures: Inpatient Falls Audit**

The National Audit of Inpatient Falls (NAIF) audits the delivery and quality of care for patients over 60 years of age who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales. NAIF reviews the care the patient has received before their fall as well as the post-fall care. The audit also looks for evidence of examination for other injuries for patients who are found to have a fracture, which is recommended by the National Institute for Health and Care Excellence's (NICE) clinical guideline CG161, and quality standard QS86.

The 2022 Annual Report focuses on patients who sustained an inpatient femoral fracture between 1 January and 31 December 2021. The number of femoral fracture numbers are small and subject to significant variation and will not give reassurance of good practice in fall prevention practice. Therefore, trusts are encouraged to focus on the process measures that are key performance indicators for this audit.

***NAIF Key Performance Indicators 2022***

- KPI 1: Participation in the audit.
- KPI 2: Checking for injury before moving from the floor.
- KPI 3: Moving the patient safely from the floor.
- KPI 4: Carrying out a prompt medical assessment after the fall.
- KPI 5: High-quality MFRA prior to the fall.

STHFT Prevention & Management of Inpatient Falls policy (2022) states every inpatient must have an initial Falls Risk Assessment completed as soon as is reasonably practical following admission, and in any event within twelve hours of admission. A positive response to any of the risk factors on the assessment tool, triggers the need to complete the Falls Prevention Care Plan Record, as soon as is reasonably practical using the electronic patient record. As a patient's condition can change rapidly, any staff attending to a patient should undertake a dynamic risk assessment when providing any care. This process involves identifying, measuring, and evaluating risk in real-time, while working.

The Trust is committed to improving patient safety and reduction of harm due to inpatients falls for all our patients in our care. This work has included:

- Improving staff understanding and compliance in relation to STH Prevention & Management of Inpatient Falls policy (2022) by:
  - Reviewing and updating Falls Risk Assessment (FRA) on Lorenzo in line with NICE CG 161 recommendations.
  - Promoting the undertaking/documentation of lying and standing blood pressure for all patients over 65 as routine practice on admission to hospital.
  - Promoting the undertaking and documentation of Medication Review in relation to patient risk of falls.
  - Promoting the undertaking of Safety Huddles 7 days per week.
  - Promote capacity for undertaking of walking aid assessment within 24 hours of identified patient need.

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- Falls Risk Assessment, the Falls Prevention Care Plan and the Moving & Handling Assessment are reviewed and updated when:
  - there is a change in the patient's condition which could affect their mobility risk of falls.
  - on transfer to another location.
  - following a fall.
  - as a minimum, on a weekly basis.
- A Lead Educator for falls prevention has been appointed.

**Local Clinical Audits**

The reports of 161 local clinical audits were reviewed by STHFT in 2022/23. An example of improvements to the quality of healthcare provided can be found below:

**An audit to determine whether the nutrition screening and care pathway is followed on Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU)**

The Sentinel Stroke National Audit Programme (SSNAP) includes measurement of referral to a dietician for patients at high risk of malnutrition. A local audit was carried out to assure that screening at admission and weekly thereafter (as per guidelines), is taking place. The audit looked at screening within 48 hours of admission, weight score being repeated weekly, and referrals to the dietician.

The results found that the percentage completion of the MUST (Malnutrition Universal Screening Tool) over the periods audited were high although dietetic referrals initiated following the assessment were variable. This suggests that, in addition to using the MUST, alternative methods of ensuring appropriate referrals are required, such as dietetic attendance at board rounds and multidisciplinary team meetings (MDTs). In addition, weekly weight recordings were variable. Attendance at MDTs and the use of the e-Whiteboard is now embedded into practice. The wards complete the Hydration and Nutrition Assurance Toolkit (HANAT) audit which incorporates a review of the use of MUST. An improvement workplan is in progress to:

- Promote weekly weight recordings and for this to become consistent practice.
- Engage with nutrition link workers and dietician to improve communication.
- Hold discussions with staff to identify and understand barriers and agree solutions to address.

Improvements will be evidenced within the SSNAP.

**Procedural Marking Policy Audit**

Following two Never Events (wrong site surgery relating to procedural marking) in 2022, and following a CQC visit in 2021, an audit against the Trust's Procedural Marking Policy was initiated.

All patients entering theatres across the Trust were audited in July 2022 and again in October 2022. Following the first audit, an improvement plan was implemented which included zero admission to theatres for any unmarked site for surgery and the revision of Support Worker competencies, to include not taking patients to theatres if the surgical site is not appropriately marked. Improvement has been demonstrated in three of the four standards re-measured in the second round of audit:

- 93% of procedural marks are made prior to the patient entering the procedural room (76% in the first audit).
- 86% of procedural marks contain an arrow to the surgical site (72% in the first audit).
- 71% of procedural marks are still visible after draping (66% in the first audit).

A re-audit is scheduled to be undertaken in October 2023 to review progress.

**Optimising medication for patients with heart failure with reduced ejection fraction (HFrEF)**

This local audit was commissioned by the Trust's Clinical Effectiveness Committee following the publication of the National Heart Failure Audit Report (2019-2020). The national audit found that the Trust did not meet the target for discharge on triple therapy with three disease modifying drugs for heart failure with reduced ejection fraction. A

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local audit project then identified the reasons why patients were not discharged on triple therapy.

The results evidenced that whilst the Trust has a lower percentage of patients on triple therapy when compared to the national average, there were good clinical reasons for not being given the combination. Frailty, low blood pressure and kidney dysfunction were the prominent reasons limiting initiation. Therefore, decisions to not initiate triple therapy were justified. In addition, a rise in prescription rates for beta blockers and mineralocorticoid receptor antagonists (MRAs) can be seen in the subsequent year. In conclusion, the audit provided the Trust with excellent data on the clinical reasons why individual patients cannot and should not be on triple therapy and reassurance on the results of the national audit.

**Trustwide DNACPR Re-audit 2022**

A national report from CQC in March 2021 found worrying variation in people's experiences of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the Covid-19 pandemic. Whilst there were some examples of good practice, the CQC also heard from people who were not properly involved in decisions or were unaware that such an important decision about their care had been made.

In its interim report, the CQC made it clear that all care providers must assure themselves that any DNACPR decisions have been made appropriately, in discussion with the person and in line with legal requirements and best practice. These shortfalls in governance must be addressed if providers are to assure themselves that decisions were, and are, being made on an individual basis, and in line with the person's wishes and human rights. STHFT introduced an annual Trustwide audit of DNACPR processes against the DNACPR Policy as part of its Trust Clinical Audit Programme. The 2021 and 2022 audit outcomes and improvement plan are detailed below.

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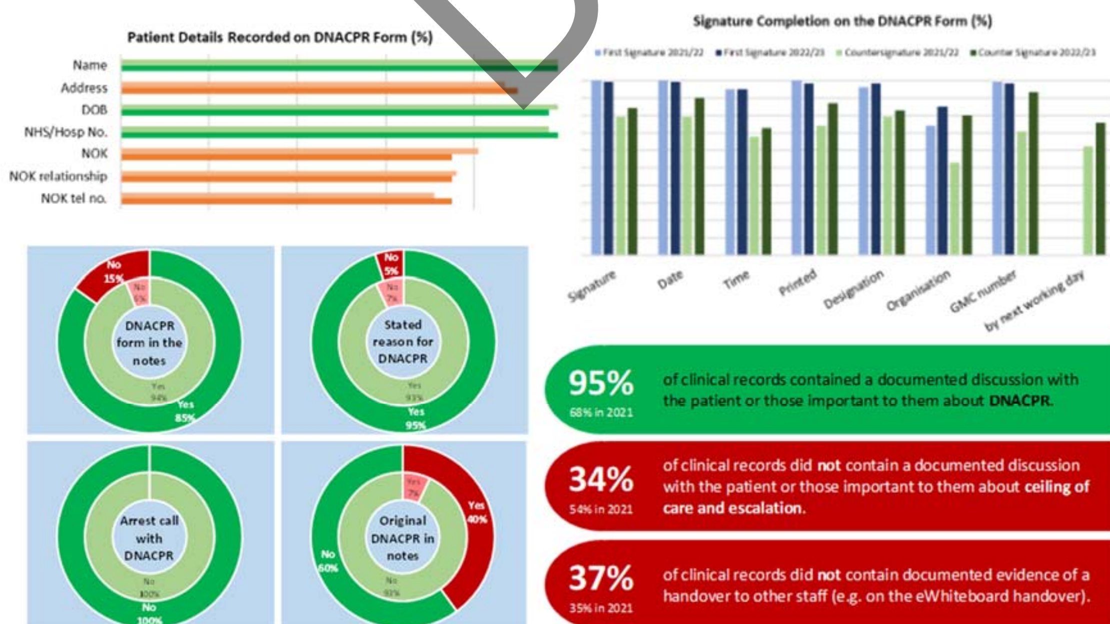
*Figure 3: Trustwide DNACPR Audit Results*

## Trustwide DNACPR Re-Audit 2022




*Inner circle = 2021, Outer circle = 2022*

**14** directorates

**95** cases audited

**Actions for Improvement**

- Education in relation to completion of the DNACPR section of the discharge summary.
- Education in relation to discussions around DNACPR, ceiling of care and escalation and recording of the discussions in the patient's notes.
- Education in relation to what to do with the DNACPR forms on discharge.
- Consider alternative methods of filing the DNACPR form in the patient's clinical record, i.e. plastic wallet.
- Introduce DNACPR into safety huddles, i.e. identifying those patients with a DNACPR in place.

## c. Clinical research and innovation

### Recruitment to trials

The number of patients receiving NHS Services provided or subcontracted by STHFT in 2022/23 that were recruited to studies during that period to participate in the National Institute of Health Research portfolio research trials was 6722.

### Patient and Public Involvement and Engagement

Despite the inevitable challenges of the previous few years during and post-pandemic, we have seen the Trust adapt and develop its patient and public involvement and engagement activity to ensure that our research has meaningfully involved relevant people for optimal patient benefit. Whilst there is the option to move back to face-to-face meetings, public involvement in research has mostly remained in the virtual world largely due to preference of the public contributors themselves. As one of the former test bed sites of the UK Standards for Public Involvement, we are committed to carrying out our activities using the standards as a guide. As such, several of the well-established public involvement groups have trialled hybrid meetings to ensure people have choice and flexibility in their opportunities to get involved. Researchers are increasingly enabled to include people who may only have the opportunity to be involved virtually, yet some do report challenges in meaningful involvement with online only or hybrid meetings.

Undoubtedly, there have been greater opportunities for us post-pandemic in giving both the public and researchers more options for involvement, and in increasing our engagement with communities who we have not engaged with in the past. However, we are striving to work in a way that people are not excluded for a myriad of reasons including accessibility to digital technology and language barriers, and we are committed to ensuring our research is relevant and thus more likely to benefit the target population. Our involvement in the regional Ethnic Minority Research Inclusion group is key in ensuring we are building meaningful relationships with our local communities and can increase the levels of participation of people from ethnic minorities in our research.

So that we can ensure public trust in the research we do, it is vital that the public voice is included in decision making. In early 2023, representatives from our public involvement groups were involved in our research and innovation strategy development workshop which involved staff from across the Trust and local universities as well as other stakeholders from across the region. Notably, this year we have recently restarted bi-annual meetings with the coordinators and chairs of our public involvement groups, and separately with public involvement leads of NIHR infrastructures at STH. These forums are crucial in ensuring we can identify and offer training and guidance for public contributors, discuss best practice and work collaboratively with the public to continually adapt and improve our involvement and engagement activities.

### Events

We have continued to get involved with national campaigns including those to promote careers in research that are available, as well as sharing updates about health and care research and the vital contribution made by the public involved in research.

Although event activities were restricted during the pandemic, we have shown over the previous few years how we can still meaningfully engage with our staff and our local communities using digital and virtual methods. However, the return to in person events has enabled us to engage with a more diverse audience as we have additional methods of communication available to us.

Building on the successes of our virtual events for International Clinical Trials Day, for 2022, we held an in-person event with an expert panel discussion that highlighted the invaluable contributions that patients and members of the public make to the development of healthcare treatments and interventions. Importantly, progress and opportunities to ensure health

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research is fully inclusive and representative were emphasised.

### Training and Support

With the COVID19 pandemic preventing face to face events going ahead, opportunities for the Clinical Research and Innovation Office to deliver established training was limited for several years and we continued to direct both our researchers and members of the public involved in research to online resources and training where relevant. However, more recently, we began working with colleagues across the region to identify priorities for training in public involvement for researchers, with a view to develop and offer this training face to face in 2023. We also get involved in delivering research training to junior doctors and allied health professionals and contribute to a local youth engagement programme designed to introduce young people in the health sector.

The Trust is a key a partner on the Equity in Doctoral Education through Partnership and Innovation (EDEPI) programme with Sheffield Hallam University (SHU). The programme is funded by Research England – part of UK Research and Innovation (UKRI) – and the Office for Students; it is a partnership that not only involves Sheffield Hallam University but operates across NHS Trusts and Universities in Nottingham and Liverpool and Sheffield Children's Hospital. Therefore, our involvement in the programme not only improves access to doctoral education for NHS staff from racially minoritised groups, but also involves collaboration with other Trusts and Universities, providing regular opportunity to learn from each other on how we can develop employees from racially minoritised groups. The scheme is designed to be fully committed to providing equity in access to doctoral education; potential candidates are required to have an undergraduate degree and demonstrate the competency to be able to undertake a PhD through the transferable skills that they have gained working within the NHS. A Masters degree and/or previous research experience are not a part of the eligibility, therefore the Trust are encouraging applications from STH staff from racially minoritised groups with ideas of how they could improve patient care.

Towards the end of 2022, two members of staff at STH were offered a place on the programme and will commence their PhD study in 2023. STH provides funding for the successful candidates for one day a week of their salary to complete the PhD part-time over five years, and Sheffield Hallam University waive the tuition fees and provide academic supervision and guidance. The application and selection process are running again in 2023 with a further three places available on the programme, demonstrating our continued commitment to creating opportunities for staff from racially minoritised groups, and aligning with the Trust's core equality objectives for developing employees.

The innovative Nurse, Midwifery and Allied Health Professional Research Internship Programme was launched in 2021, with four interns graduating from the scheme in June 2022. The initial scheme was a partnership between the National Institute for Health and Care Research (NIHR) Sheffield Biomedical Research Centre, STHFT and the Sheffield Clinical Academic Training Programme.

The research internship programme is pitched at STH front line nurses, midwives and allied health professionals who are clinically curious, and who may want to consider dipping their toes into the world of clinical research with a view to possibly pursuing a clinical academic career in the future, such as applying for a pre-doctoral, doctoral or post-doctoral fellowship.

The programme is designed to support individuals with research capability building, such as enabling them to be more research aware with an ultimate aspiration to support and encourage their development as potential future research leaders. This tailored programme enables individuals to develop specific research-related skills and knowledge to equip them for their own research development, from in-house projects to NIHR Integrated Clinical Academic pathways application support.

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Importantly, it offers the post-holders a one day per week secondment, with clinical academic mentorship, to pursue a small research project pertinent to both their professional background and to their clinical area of work. The award buys one day of the post-holder's time to enable research capacity by providing funds to their clinical area for backfill.

This success has seen the programme receive further funding for a 2022/23 cohort; the partnership for the second cohort is between the NIHR Sheffield Clinical Research Facility, STHFT and Sheffield Hospitals Charity. Not only has the scheme been extended but has now grown to 12 Internships which began in September 2022. The interns have all successfully developed project proposals with their supervisory teams and have begun collecting data in preparation for presenting their findings at the graduation ceremony in September 2023.

### Innovation

The Clinical Research & Innovation Office, on behalf of the Trust, has partnered with Leeds Teaching Hospitals, and hospitals in Barcelona Spain, Vall Hebron and Germans Trias, to build an exchange programme for healthcare professional-intrapreneurs working in the NHS, and the Spanish equivalent. This Healthcare Entrepreneur Exchange Programme (HEEP) is the first structured programme of this sort. It is an opportunity for fostering collaborations and open innovation between two healthcare systems that have repeatedly proven to be some of the best in the world. The programme will empower grassroots innovators in order to develop the healthcare solutions of the future.

Tailored training sessions covering topics relating to developing a business case and developing a pitch for the healthcare solution along with personal mentorship was provided to help shortlisted teams to develop bespoke innovation and leadership skills. They then pitched their ideas at a Dragons Den in April. The winners will visit Barcelona for a few days in May with a reciprocal visit from our Spanish colleagues in June.

### Communications

Using well-established links, we continue to promote and share the many successes of researchers at the Trust via Trust Communications. Opportunities for staff to submit research and innovation success stories for regional and national awards are disseminated widely to ensure colleagues get the recognition deserved for their endeavours. We actively engage with national campaigns to promote the available roles, opportunities and successes that can come from a career in research.

The visible impact that research has had on clinical care and rapid development of vaccines through the recent pandemic is evident. As such, it is vital that opportunities to promote us as a research active Trust are shared widely. This year saw the initiation of a research and innovation newsletter for all nurses and midwives, as well as research newsletters in many Directorates and Care Groups across the Trust, including those previously not represented.

In recognition of the important contribution that all health professionals make to care at the Trust, and to ensure that opportunities for embedding research in their careers are visible for all disciplines, this year has seen the development of web pages specifically for health professionals such as nurses, midwives, allied health professionals and healthcare scientists. These are designed for people at any stage of their career and who may be just becoming aware of research, all the way through to those already research active and wishing to become a clinical academic.

Acting on feedback received from participants in our NIHR portfolio research is vital to ensure we continue to improve the way in which we design, deliver and disseminate high quality research. We have been focusing on improving the extent to which participants receive the results of studies they have taken part in, as well as ensuring we communicate these findings to the wider public. One such example of best practice has been a virtual event led by the Principal Investigator for

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study participants at the end of a clinical trial to share the study findings.

### Staff Engagement

The Trust remains committed to raising awareness of research across the Trust and increasing staff engagement with research. Testament to this has been the restart of relatively new initiatives such as Research Cafés that had been put on hold due to the pandemic; these have recommenced and have now been implemented in new Directorates, with structured plans in place to deliver these cafés across sites, broadening disease areas covered as well as highlighting the variety of roles available to staff involved in research.

To increase awareness of research and the difference it makes to patients and their care, the Clinical Research Facility has seconded a member of staff to a research awareness role where they have arranged and delivered sessions Trust-wide to nurses and Allied Health Professionals. This has given members of staff knowledge of research taking place in their clinical area, how they can support patients on trials and how they can further engage with Trust research.

Close working between the Clinical Research & Innovation Office and Trust Communications team, ensures relevant opportunities for all staff to be involved in research are disseminated widely and via targeted means. Additionally, within Directorates, additional resource has enabled production and distribution of regular staff newsletters highlighting achievements, successes, and opportunities for staff.

### Annual Surveys

The Participant in Research Experience Survey asks participants of NIHR portfolio research about their experience of taking part in research. We use this data to continue to improve how our studies are designed and carried out. The data collection period for 2022/23 has just finished and will be analysed in due course, so here we report on feedback from 2021/22. A total of 322 respondents from 12 studies completed the Participant in Research Experience Survey across STHFT in the year 2021/22. This placed us third in Yorkshire and Humber, and we exceeded our target set by the Clinical Research Network (257 for 2021/22) for the second year in a row. We continued to be able to offer a digital version of the PRES as well as a paper version which gives participants additional flexibility and has had a positive impact, with just under half of respondents completing the survey online. For 75% of respondents, it was the first study they had taken part in (3% less than 2020/21) and 91% would take part in research again (5% less than 2020/21). Participants gave plenty of very positive feedback based on their own experience, and staff were regularly praised by participants. In addition to the many positive comments about staff and the efficiency of the research trials, we did receive information about areas where we could improve in future, mainly around ensuring that participants are informed whether and how they will receive the results of the study.

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

During 2022/23 STHFT had to participate in 12 national CQUIN schemes and four NHSE specialised CQUIN schemes. The income received by the Trust during 2022/23 included a value in the baseline that would have been linked to achievement of CQUIN.

## e. Care Quality Commission (CQC)

STHFT is required to register with the CQC, and its current registration status is fully registered. STHFT has the following conditions on the registration:

- Implement an effective system for managing and responding to patient risk to ensure all mothers and babies who attend Jessop Wing are cared for in a safe and effective manner and in line with national guidance.
- Operate an effective clinical escalation system to ensure every woman attending the Jessop Wing is triaged, assessed and streamlined by appropriately skilled and qualified staff.

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- Implement an effective risk and governance system on Jessop Wing which ensures that:
    - There is oversight at service, division and board level in the management of the maternity services.
    - There are effective quality assurance systems in place to support the delivery of safe and quality care.
    - Risk and occurrence of incidents are properly identified and managed, to include an effective system of recording actions taken and ensuring learning from any incidents.
    - Serious incidents are reflected and reported correctly in line with national guidance and adequately investigated.
    - Ensuring learning is shared from the investigation.
    - Incident grading is reviewed to ensure it is accurate and in line with national guidance.

- Implement an effective system on Jessop Wing to ensure that medical and midwifery staff have the qualifications, competence, skills and experience to care for and meet the needs of women and babies safely within all areas of the Maternity Services including any area where women are waiting to be seen. Training must include, but is not limited to, cardiotocograph (CTG) interpretation, to include Dawes Redman, and use of auscultation and multidisciplinary emergency skills training.

### Full Inspection

From 20 to 22 September 2022, CQC carried out an unannounced inspection of the urgent and emergency, maternity, medical and surgical services provided by the Trust in response to the requirements outlined following the previous inspection in 2021. All key lines of enquiry in the core services were inspected, including urgent and emergency care at the Northern General Hospital, medical wards (including services for older people) and surgery at the Royal Hallamshire and Northern General Hospitals and maternity services at the Jessop Maternity Wing.

In addition, the CQC sought assurance that the trust had taken action to comply with the Warning Notice served under Section 29A of the Health and Social Care Act following the last inspection which advised the trust to make significant improvements to the quality of healthcare provided and the well-led specific areas of concerns also identified in the Warning Notice.

The Trust's Inspection Report was published on 22 December 2022 with the Trust achieving an overall rating of 'Requires Improvement'. There were no areas rated 'inadequate' and many of the individual key lines of enquiry or site ratings had improved since the 2021 inspection. The Trust-wide ratings are detailed on page 25.

*Figure 4: CQC Ratings 2021 and 2022*

| | 2021 | 2022 |
|---|---|---|
| Safe | Inadequate | Requires Improvement |
| Effective | Requires Improvement | Good |
| Caring | Requires Improvement | Good |
| Responsive | Requires Improvement | Requires Improvement |
| Well-led | Requires Improvement | Requires Improvement |
| Overall rating | Requires Improvement | Requires Improvement |

In response to the CQC Inspection Report, a high-level action plan was developed by the Trust covering all 'must do' requirements and 'should do' recommendations. The approved high-level action plan was submitted to CQC on 26 January 2023 with a number of improvements now embedded with other improvements continuing to progress. The implementation of the actions is overseen by the Trust Executive Group and the Quality Committee.

The Trust has provided regular updates on the improvement work in response to the CQC inspection report to the monthly Quality Board, chaired by NHS England, as well as the NHS England Board to Board meeting in January 2023.

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## Maternity and Midwifery Services

Following the two-day inspection by CQC of the Trust's Maternity and Midwifery Services in March 2021, a detailed action plan was developed to address the areas of concern highlighted by the CQC.

During 2022/23, the Trust has continued to provide a monthly update to CQC on this action plan along with reports written to provide assurance to the senior leadership team and/or Trust Board to demonstrate compliance with the conditions. This includes the monthly Maternity and Neonatal Safety Report which contains the Maternity Dashboard and an update of training compliance figures.

## f. Data quality

STHFT submitted records during 2022/23 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.
- 100% for outpatient care.
- 99.7% for Accident and Emergency Care.

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

- 100% for admitted patient care.
- 100% for outpatient care.
- 100% for Accident and Emergency Care.

STHFT was not subject to a Payment by Results audit process during 2022/23. STHFT continues with the following programmes to improve its data quality. A number of the normal activities were severely disrupted during 2022/23 but:

- The Data Quality Team continue providing support to the organisation and consistently driving forward a coordinated Data Quality agenda across the organisation.
- The reporting dashboards to support improvement to Data Quality, including the Administrative Patient Safety Dashboard, Breaks in Process and Administrative Safety Huddles is well established within the organisation evidenced through the quarterly reviews with each Care Group.
- The Data Quality Steering Group, chaired by the Assistant Chief Executive, continues to maintain oversight of data quality, and continues to support data quality improvement across the organisation. Regular review of the workplan is in place to target the areas of greatest risk.
- The Trust continues to undertake a range of discreet projects where data quality has been identified as requiring improvement such as clinical coding, new national datasets and review of existing data submissions.

The Data Security & Protection Toolkit assessment has been collated and submitted in full for the submission in March 2023.

## g. Patient safety alerts

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

The following are examples of actions taken and changes made as a result of Patient Safety Alerts:

- Potassium permanganate removed as a stock supply from all areas and provided on a named patient basis only.
- All areas without piped oxygen identified and a standard operating procedure developed and implemented to manage patients who require oxygen in these locations to reduce risks associated with use of oxygen cylinders.
- All affected Phillips ventilators withdrawn, alternative ventilators purchased, and training on the replacement equipment and consumables provided.

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*Figure 5: Patient Safety Alerts*

| Reference | Title | Issued | Deadline (action complete) | Open/ Closed |
|---|---|---|---|---|
| NatPSA/2022/ 005/UKHSA | Contamination Of Hygiene Products with Pseudomonas Aeruginosa | 24/06/2022 | 01/07/2022 | Closed |
| NatPSA/2022/ 005/UKHSA | Contamination of hygiene products with Pseudomonas aeruginosa | 07/07/2022 | 15/07/2022 | Closed |
| NatPSA/2022/ 003/NHSPS | Inadvertent oral administration of potassium permanganate | 05/04/2022 | 04/10/2022 | Closed |
| NatPSA/2023/ 003/MHRA | Nidek Eyecee Preloaded and Eyecee One Crystal Preloaded Intraocular Lenses (Iols): Risk of Increased Intraocular Pressure | 01/02/2023 | 16/02/2023 | Closed |
| NatPSA/2022/ 004/MHRA | Novorapid Pumpcart In the Roche Accu-Chek Inight Insulin Pump: Risk of Insulin Leakage Causing Hyperglycaemia and Diabetic Ketoacidosis | 26/05/2022 | 26/11/2022 | Closed |
| NatPSA/2022/ 009/MHRA | Prenoxad 1mg/Ml Solution for Injection in A Pre-Filled Syringe, Macarthys Laboratories, (Aurum Pharmaceuticals Ltd), Caution Due to Potential Needles in Sealed Kits | 10/11/2022 | 17/11/2022 | Closed |
| NatPSA/2022/ 007/MHRA | Recall Of Mexiletine Hydrochloride 50mg, 100mg and 200mg Hard Capsules, Clinigen Healthcare Ltd Due to A Potential of Underdosing And/Or Overdosing | 04/08/2022 | 12/08/2022 | Closed |
| NatPSA/2022/ 008/MHRA | Recall Of Targocid 200mg Powder for Solution for Injection/Infusion or Oral Solution, Aventis Pharma Limited T/A Sonofi, Due to The Presence of Bacterial Endotoxins | 21/10/2022 | 26/10/2022 | Closed |
| NatPSA/2022/ 006/DHSC | Shortage Of Alteplase and Tenecteplase Injections | 03/08/2022 | 10/08/2022 | Closed |
| NatPSA/2023/ 002/CMU | Supply Of Licensed and Unlicensed Epidural Infusion Bags | 23/01/2023 | 27/01/2023 | Closed |
| NatPSA/2022/ 002/MHRA-U | UPDATED 03/05/22 Philips Health Systems V60, V60 Plus and V680 ventilators – potential unexpected shutdown leading to complete loss of ventilation | 03/05/2022 | 31/05/2022 | Closed |
| NatPSA/2023/ 001/NHSPS | Use Of Oxygen Cylinders Where Patients Do Not Have Access to Medical Gas Pipeline Systems | 10/01/2023 | 20/01/2023 | Closed |

## NHS Staff Survey

The response rate to the 2022 survey from STH staff was 39% which whilst an improvement on the previous year, was below the national average for our benchmarking group of Acute/Combined Acute and Community Trusts (44%).

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*Figure 6: Response rate to the NHS Staff Survey – Staff involvement*

| 2020/21 | | 2021/22 | | 2022/23 | |
|---|---|---|---|---|---|
| Trust | National Average | Trust | National Average | Trust | National Average |
| 42% | 45% | 38% | 50.1% | 39% | 44% |

*Figure 7: Staff survey results*

| | 2020/21 | | 2021/22 | | 2022/23 | |
|---|---|---|---|---|---|---|
| | Trust | Benchmark group | Trust | Benchmark group | Trust | Benchmark group |
| We are compassionate and inclusive | | | 7.2 | 7.2 | 7..2 | 7.2 |
| We are recognised and rewarded | | | 5.8 | 5.8 | 5.7 | 5.7 |
| We each have a voice that counts | | | 6.7 | 6.7 | 6.6 | 6.6 |
| We are safe and healthy | | | 5.9 | 5.9 | 5.9 | 5.9 |
| We are always learning | | | 5.2 | 5.2 | 5.3 | 5.4 |
| We work flexibly | | | 5.8 | 5.9 | 5.8 | 6.0 |
| We are a team | | | 6.5 | 6.6 | 6.5 | 6.6 |
| Staff engagement | 7.0 | 7.0 | 6.7 | 6.8 | 6.7 | 6.8 |
| Morale | 6.2 | 6.0 | 5.8 | 5.7 | 5.7 | 5.7 |

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As in 2021, the 2022 NHS Staff Survey was once again benchmarked in line with the NHS People promise. There is a theme for each of the 7 elements of the NHS People Promise plus the Staff Engagement and Morale retained from previous years. As in previous years each theme is scored out of 10. Each of the themes has been broken down into sub-theme scores.

The trust was **average** for our benchmarking group (i.e. Acute/Acute and Community trusts) for five themes:

- We are compassionate and inclusive.
- We are recognised and rewarded.
- We each have a voice that counts.
- We are safe and healthy.
- Morale.

The trust scored **below average** for four of the themes:

- We are always learning.
- We work flexibly.
- We are a team.
- Staff engagement.

The only statistically significant improvements were in *We are always learning* and *We are a team* and the two statistically significant deteriorations were in *We are recognised and rewarded* and *Morale*.

As in 2021, the highest score overall was achieved in *We are compassionate and inclusive* (7.2) and the lowest in *We are always learning* (5.2) which showed an improvement despite being below average.

The percentage of staff who would recommend the Trust to friends and family as a place to be treated remains above the benchmark average at 68.3% (down from 76.3% in 2021). The percentage of staff recommending the Trust as a place to work dropped to 56.5% which was average for the benchmark group (down from 62.3% in 2022).

Each directorate will use their 2022 staff survey results to update their staff survey plans for 2022/23. We also continue to use the National Quarterly Pulse survey to ensure we get more regular feedback from staff on their staff experience.

The newly launched People strategy based on the seven themes of the People promise will also lead to improvements in staff experience.

We continue to recognise the great work that individuals and teams carry out by nominating staff for national awards and through our Thank You awards which were able to return at an event at City Hall in November 2022. Over 600 staff

also received a long service award at a ceremony earlier on the same day.

The Trust's reward programme for colleagues has continued to be expanded, which includes salary sacrifice options and staff discounts. This remains one of the most comprehensive packages in the NHS.

This year we have also introduced several initiatives to support staff who may be struggling with the cost of living such as the popular 'inflation busting 'meal deals' and Wagestream a salary advance app.

We have also worked to continue to support staff Health and Wellbeing by extending the service offered by our Employee Assistance Programme provider Vivup to cover staff family members (over the age of 16 living in their household). We have continued to support the creation and maintenance of CALM rooms across the Trust funded by Sheffield Hospitals Charity and now have 70 CALM rooms and three Breathing Spaces in the Chapels.

We continue to work towards a positive culture of wellbeing with the introduction of Wellbeing champions with approximately 200 recruited and trained across the trust. We have also launched a programme of Professional Nurse advocates to proactively support nursing staff sessions for staff from all disciplines to discuss difficult emotional and social issues arising from delivering healthcare.

To further support the positive culture, regular Wellbeing Conversations are being encouraged and are included in the annual appraisal process as a minimum. Schwartz rounds which provide a safe space for staff to reflect on the emotional impact of health care are now offered trust wide approximately monthly.

This year we have established new Health and Wellbeing and Staff Engagement SharePoint sites making it easier for colleagues to access information about wellbeing support and staff discounts from home or on their mobiles.

The Promoting and Valuing Difference work stream of the Trust's People Strategy oversees the progress being made against the metrics within both the NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

A copy of the Trusts' data matched against both the WRES and the WDES metrics and associated Action Plans can be found on our internet site. Our WRES and WDES data has highlighted the areas where we need to take further action to improve the experiences of our Black, Asian and ethnic minority and disabled colleagues. The Trusts' Equality, Diversity and Inclusion (EDI) Team works in collaboration with our four Staff Network Groups which offer peer support, advice and guidance and act as a voice for the organisation on issues that impact on women, Black, Asian and ethnic minority, disabled, and lesbian, gay, bisexual and trans (LGBTQ+) colleagues.

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*Figure 8: Work Race Quality Standard (WRES)*

| WRES Metric | Metric Description | Ethnic Group | 2020 | 2021 | 2022 | Improvement | Representative Target | National 2021 |
|---|---|---|---|---|---|---|---|---|
| Metric 1 | Percentage of BME staff in Bands 8-9, VSM (including Executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce | BME Staff in Post | 14.07% | 14.80% | 17.56 % | 🟢 | 19% | 22.4% |
| | | BME 8a + & VSM | 5.38% | 6.12% | 6.88% | 🟢 | 13% | - |
| Metric 2 | Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts | White | 1.24 | 1.33 | 1.35 | 🔴 | 1.00 | 1.61 |
| Metric 3 | Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process | BME | 0.95 | 1.31 | 1.16 | 🟢 | 1.00 | 1.14 |
| Metric 4 | Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff | White | 1.03 | 0.99 | 0.81 | 🟢 | 1.00 | 1.14 |
| Metric 5 | KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | White | 21.1% | 20.4% | 23.9% | 🔴 | 0% | 25.9% |
| | | BME | 23.6% | 21.0% | 26.7% | 🔴 | 0% | 28.9% |
| Metric 6 | KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | White | 18.6% | 18.5% | 20.4% | 🔴 | 0% | 23.2% |
| | | BME | 22.4% | 26.8% | 28.6% | 🔴 | 0% | 28.8% |
| Metric 7 | KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion | White | 89.2% | 90.0% | 59.0% | 🔴 | 100% | 87.3% |
| | | BME | 73.2% | 72.9% | 41.4% | 🔴 | 100% | 69.2% |
| Metric 8 | Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team | White | 4.7% | 4.9% | 5.9% | 🔴 | 0% | 6.2% |
| | | BME | 12.6% | 14.1% | 18.3% | 🔴 | 0% | 16.7% |
| Metric 9 | Percentage of BME Board membership | White | 86% | 86% | 81% | 🟢 | 81% | 82.4% |
| | | Unknown | 14% | 7% | 13% | 🔴 | 0% | 5.0% |
| | | BME | 0% | 7% | 6% | 🔴 | 19% | 12.6% |

🟢 change in a positive direction

🔴 change in a negative direction

⚫ no change

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*Figure 9: Workforce Disability Equality Standard (WDES)*

| WDES Metric | Metric Description | Disability Group | 2020 | 2021 | 2022 | Improvement |
|---|---|---|---|---|---|---|
| Metric 1 | Percentage of Disabled staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of Disabled staff in the overall workforce | Disabled Staff in Post | 3.71% | 3.92% | 4.53% | 🟢 |
| | | Disabled 8a+ & VSM | 1.62% | 2.26% | 3.25% | 🟢 |
| Metric 2 | Relative likelihood of Disabled staff compared to non-disabled being appointed from shortlisting across all posts | Non-disabled | 1.31 | 1.15 | 1.09 | 🟢 |
| Metric 3 | Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure | Disabled | 4.75 | 0.00 | 0.00 | ⚫ |
| Metric 4 | a. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public | Disabled | 25.5% | 24.6% | 29.5% | 🔴 |
| | | Non-disabled | 20.1% | 19.0% | 22.4% | 🔴 |
| | ii.Managers | Disabled | 12.6% | 14.1% | 14.3% | 🔴 |
| | | Non-disabled | 6.8% | 6.5% | 7.7% | 🔴 |
| | iii. Other colleagues | Disabled | 21.5% | 22.1% | 24.5% | 🔴 |
| | | Non-disabled | 13.1% | 12.7% | 14.9% | 🔴 |
| | b. Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | Disabled | 48.6% | 51.4% | 45.5% | 🔴 |
| | | Non-disabled | 41.9% | 44.9% | 43.5% | 🔴 |
| Metric 5 | Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion | Disabled | 82.0% | 83.5% | 51.7% | 🔴 |
| | | Non-disabled | 89.3% | 89.4% | 58.2% | 🔴 |
| Metric 6 | Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | Disabled | 33.9% | 31.7% | 32.0% | 🔴 |
| | | Non-disabled | 19.8% | 21.9% | 21.9% | ⚫ |
| Metric 7 | Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work | Disabled | 42.9% | 39.8% | 36.0% | 🔴 |
| | | Non-disabled | 53.0% | 51.2% | 43.8% | 🔴 |
| Metric 8 | Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work | Disabled | 78.9% | 79.3% | 74.7% | 🔴 |
| Metric 9 | a. The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation | Organisation | 7 | 7 | 6.7 | 🔴 |
| | | Disabled | 6.7 | 6.6 | 6.4 | 🔴 |
| | | Non-disabled | 7.1 | 7.1 | 6.9 | 🔴 |
| Metric 10 | Percentage difference between the organisations Board voting membership and its overall workforce By voting membership of the Board | Disabled | 0% | 13% | 12% | 🔴 |
| | | Non-disabled | 79% | 67% | 69% | 🔴 |
| | | Unknown | 21% | 20% | 19% | 🟢 |
| | By voting membership of the Board | Disabled | 0% | 13% | 12% | 🔴 |
| | | Non-disabled | 79% | 67% | 69% | 🔴 |
| | | Unknown | 21% | 20% | 19% | 🟢 |
| | By Executive membership of the Board | Disabled | 0% | 0% | 0% | ⚫ |
| | | Non-disabled | 71% | 88% | 100% | 🔴 |
| | | Unknown | 29% | 13% | 0% | 🟢 |

🟢 change in a positive direction

🔴 change in a negative direction

⚫ no change

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## h. Equality, Diversity and Inclusion

The Trust has a strong governance framework in place which includes a dedicated Equality, Diversity and Inclusion (EDI) Board that oversees the development and implementation of our strategic approach and work to embed best practice across all areas of the organisation, to benefit both patients and our workforce. The EDI Board has a diverse and broad membership that includes senior leaders, service managers and representatives of the Trust's four Staff Network Groups. It reports to the Trust Executive Group and to both the People and Quality Committees.

The Trust is continuing to implement its Equality, Diversity and Inclusion (EDI) Strategy (2021-2025), which reflects the organisational commitment to being an inclusive organisation. Our aim is to be a Trust that values its workforce and supports them to bring their whole selves to work and an organisation where our patients can easily access high quality services that are personalised to meet their needs.

The EDI Strategy is built around the themes within the NHS Equality Delivery System (EDS2022), which looks at issues such as patient access, outcomes and experience and also workforce and leadership diversity. The strategy shows some of what has been achieved to date and also identifies what we are focussing on achieving going forward. It is supported by an annual Implementation Plan that is flexible and adaptable to ensure that it contains the real priorities for action. It also shows how the Trust will meet its statutory obligations under the Equality Act 2010, the NHS Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Accessible Information Standard (AIS).

We have continued to focus on developing new and innovative approaches to building confidence and capability in relation to good EDI practice across all areas of the Trust. Our achievements over the past year have included:

- Supported the launch of the Sheffield Race Equality Commission Report and activity to embed the actions from it.
- Completed our Reciprocal Mentoring Programme, where members of the Trust's leadership team are paired with members of our Staff Network Groups to provide a sharing of lived experience and strategies for success. It has been decided to continue with this programme due to the positive feedback from participants and will run three cohorts per year for the next 3 years.
- Supported the embedding of our Race Equality Charter through the delivery of CPD funded 'Becoming an Inclusive Leader' training for all managers and leaders.
- Promoted our EDI Training Directory, encouraging colleagues to access the full complement of EDI learning and development available on our PALMS e-learning platform.
- Developed and delivered a range of bespoke training and interventions to support teams tackling difficult issues, including on understanding trans and gender diversity, understanding microaggressions and others; procured a supplied to deliver a bespoke Board EDI Development Programme.
- Continued collaborative working with our partners across the city, region and system through the Sheffield Health Care Partnership (HCP), the Yorkshire and Humber Regional EDI Leads, the South Yorkshire Integrated Care Board (ICB) EDI Leads network and the Shelford Group EDI Leads.
- Produced the EDI Data Dashboard which, once launched and communicated across the Trust, will provide access to live, anonymised patient and workforce diversity data which we will be used by service areas and decision makers to better understand the profile of who users our services / our workforce and how we can ensure we meet their needs.
- Invested in our network of Workplace Dyslexia Assessors, we now have 35 trained individuals undertaking this role in addition to their day job and have further developed the service being offered; a recent survey indicated that 100% of those who responded felt that they had benefitted from the service

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and that it had made a positive difference to their working lives.

- Produced an interactive Inclusion Calendar in collaboration with the Staff Network Groups and Chaplaincy and celebrated a number of dates with a wide range of communications and activities throughout the year, including marking World AIDS Day, International Women's Day, Holocaust Memorial Day, International Day for the Elimination of Racial Discrimination, Autism Awareness Day, Ramadan and many other key dates.
- Made mandatory the requirement for a diverse and inclusive recruitment process for all and 8+ roles and Consultant roles.
- Published our Workforce Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) metrics and created separate action plans for each which are actively managed and monitored.
- Produced and published our annual Gender Pay Gap data and report.
- Achieve a Top 100 ranking in our second Stonewall Workplace Equality Index (WEI) submission and received a Gold Award for our Bi and Trans inclusion work.
- Continued to embed our approach to Equality Impact Assessments (EIAs) by making it a key part of policy development and ensuring that all key decisions, changes and proposals are supported by a Rapid EIA.
- Created a new Equal Opportunities Policy that covers both workforce and our patients which sets out how we will be fair, inclusive and non-discriminatory in all that we do.
- Created a new Workplace Reasonable Adjustments Policy and Passport to support our colleagues with a disability/ies and/or long-term condition/s.
- Continued to make conversations around EDI easy to have within team settings through embedding the 'Conversation Corners' approach in all our LEAD Managers Briefings.
- Continued to ensure that EDI considerations are a key focus in our service improvement programmes and that Rapid EIAs are undertaken at every opportunity.
- Worked with two service areas – Maternity and Emergency Department – to complete our EDS2022 review for 2022/23; the focus of this was on service user access, outcome and experience.
- Chosen to participate in the NHS Employers Diversity in Health and Care Partners Programme; attending 4 modules designed to support the development of best EDI practice.
- Developed and launched the Trust's PROUD Behaviours, linked directly to the PROUD Values, for both colleagues and patients.
- Launched the See Me First badge and campaign which focuses on putting the patient at the centre of everything we do.
- Continued to roll out the Rainbow badge initiative to show our continued support and allegiance to our LGBTQ+ workforce and patients.

The Trust is continually seeking to improve its engagement and involvement of our colleagues, our patients and the wider community in everything that we do. We want to understand people's experiences, which will be both positive and negative, so that we are self-aware and understand what we are getting right, what we are getting wrong and how we can improve.

### i. Annual patient surveys

Seeking and acting on patient feedback is a high priority, and the Trust continues to undertake a wide range of patient feedback initiatives regarding the services they provide, these include:

- The national patient survey programme which provides the Trust with high level patient experience feedback relating to the care they have received. Following each national survey, an action plan is developed which is signed off at the Patient Experience and Engagement Group (PEEG) and either monitored at PEEG or local Governance meetings.
- The Friends and Family Test which provides a snapshot of a patient's experience and gives patients and carers the chance to easily provide feedback at any point in their journey. Each month the top themes identified are reported to PEEG and regular 'deep dives' are

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completed to provide more granular data on the themes and inform improvement actions.

Survey work during 2022/23 included participation in the National Survey Programme for cancer care, maternity services, urgent and emergency care, and inpatients. The results for the 2022 Maternity Survey have been published and national results, including comparative scores, will be available during 2023 for the National Cancer Patient Experience Survey, the Urgent and Emergency Care Survey and the National Inpatient Survey.

During 2022/23, the Care Quality Commission published results from the National Adult Inpatient Survey (2021), the National Cancer Patient Experience Survey (2021) and National Maternity Survey (2022).

### National Adult Inpatient Survey 2021

The National Inpatient Survey 2021 was carried out across 134 acute and specialised NHS trusts in England. All adult patients (aged 16 and over) who had spent at least one night in hospital during November 2021 and were not admitted to maternity or psychiatric units were eligible to be surveyed. For the 2021 survey, STH increased the sample of patients, with a total sample of 2401 patients, from which 896 responses were received, equating to a 37% response rate. This compares to a national response rate of 39.5%. As some trusts did not increase their sample size, the CQC analysis only includes response from the original sample size of 1250, to ensure accurate and fair trust comparison. Therefore 442 patient responses have been included in the Trust's position for national reporting.

Compared to other trusts participating in the National Inpatient Survey, this Trust scored 'about the same' as other trusts on most questions and scored 'better' than other trusts on two questions; 'During your time in hospital, did you get enough to drink?' and 'Did you have confidence and trust in the doctors treating you?'

In terms of the question relating to overall experience, the Trust score of 8.4 was ranked 'about the same' as the national average.

### National Cancer Patient Experience Survey 2021

The National Cancer Survey 2021 was carried out across 134 NHS trusts and included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2021. A total of 1,862 eligible patients from the Trust were sent a survey, and 1,051 were returned, giving a response rate of 56% (national response rate of 55%).

The Trust scored 9.0 for the overall average rating of care which is slightly higher than both the Trust's 2020 score of 8.9 and the 2021 national average score of 8.9.

The questions with the lowest scores from patients have been reviewed and an action plan developed by the teams providing care for patients with cancer to improve services for patients.

### National Maternity Survey 2022

The 2022 survey of women's experiences of maternity services involved 121 NHS Trusts in England. Women were eligible for the survey if they had a live birth during February 2022, were aged 16 years or older, and gave birth in a hospital, birth centre, maternity unit, or at home. A total of 419 eligible patients from this Trust were invited to take part in the survey and 205 completed the survey giving a response rate of 49% (national response rate 47%).

The Trust scored 'worse' than most trusts for eight questions, 'somewhat worse' than most trusts for eight questions and scored 'about the same' as other trusts for the remaining 35 questions.

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The Trust performed 'worse' than other trusts for the questions:

- During your antenatal check-ups, did your midwives ask you about your mental health?
- On the day you left hospital, was your discharge delayed for any reason?
- Thinking about your postnatal care, were you involved in decisions about your care?
- Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?
- Did the midwife or midwifery tram that your saw or spoke to take your personal circumstances into account when giving you advice?
- Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?
- Were you given information about any changes you might experience to your mental health after having your baby?
- Were you given information about your own physical recovery after the birth?

The Trust performed 'somewhat worse' than other trusts for the questions:

- During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?
- Did you have confidence and trust in the staff caring for you during your antenatal care?
- Thinking about your antenatal care, were you treated with respect and dignity?
- At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?
- Thinking about your care during labour and birth, were you involved in decisions about your care?
- If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?
- Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
- Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

In response to this survey and the themes arising from Maternity FFT (below) the service has developed an action plan which includes actions to:

- Improve staffing:
  - Increase midwifery staffing levels in line with Birth Rate Plus assessment.
  - Expand roles of midwifery support workers to complement the role of qualified midwives.
- Improve experience and ensure patients feel treated with respect and dignity:
  - Implement What Matters to You & Civility Saves Lives in Maternity Services
  - Roll-out of Trust PROUD behaviours framework.
- Improve access to information:
  - Creation of Jessop Wing website and inclusion of i-decide tool to inform women of their choices in pregnancy and birth.
  - Implement end-to-end Maternity Information System
- Ensure women with specific needs are supported:
  - Review of use and accessibility of interpreting service in Jessop Wing.
  - Ensure staff aware of Health Passports for women with learning difficulties or autism.

### 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; 'Overall, how was your experience of our service' with a six-point scale, ranging from 'very good' to 'very poor'. The definition of positive and negative scores are in line with national guidance and therefore the positive score is based on responses of 'Very good' and 'Good'. The negative score is based on a response of 'Poor' and 'Very poor'. 'Don't know' or 'neither good nor poor' don't count towards a

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positive or negative score but are included in the denominator.

The Trust also asks a follow-up question to understand why patients have selected their rating.

During 2022/23, the overall positive score across all services was 91%. This is above the National score of 90%**.

FFT responses are collected through postcards, text and interactive voice messaging, and online responses which are supported in some areas by the use of ward iPads.  Postcards are also available in 'Easy read' and alternative language versions for patients who have alternative communication needs and would like to give feedback.

FFT results are monitored through monthly reports. Wards and departments are able to access patient comments relevant to their area via an online patient experience portal.

The Trust is committed to maintaining good positive scores for FFT to ensure a positive patient experience in all services. Therefore, the Trust works to a positive score target for inpatients of 95%, maternity services of 95%, community services of 90% and outpatient services of 94%. The Trust's internal target for A&E was adjusted from 86% to 77% in October 2022 to align the internal target with the national average FFT positive score for A&E. Positive scores are monitored and reported on a quarterly basis in the Integrated Quality Report and on a monthly basis through the Patient Experience and Engagement Group (PEEG), which escalates trends or concerns to the Patient Experience and Engagement Committee and takes relevant actions to improve the Trust's FFT position.

The scores across all areas of FFT comparing with 2021/22 are detailed below.

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*Figure 10: Scores for FFT**

| FFT Area | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|
| | Sheffield Teaching Hospitals NHS Foundation Trust | | National | | Sheffield Teaching Hospitals NHS Foundation Trust | | National | |
| | Positive Score | Negative Score | Positive Score | Negative Score | Positive Score | Negative Score | Positive Score | Negative Score |
| Inpatient | 91% | 5% | 94% | 3% | 92% | 4% | 92%** | 3%** |
| Outpatient | 94% | 3% | 93% | 3% | 94% | 3% | 93%** | 3%** |
| Maternity | 80% | 14% | 92% | 4% | 88% | 7% | 90%** | 4%** |
| Community | 91% | 3% | 94% | 3% | 93% | 3% | 93%** | 4%** |
| A&E | 77% | 15% | 78% | 14% | 81% | 12% | 76%** | 16%** |

** The national position currently consists of FFT data for the 12-month period of March 2022-February 2023 as the national data for March 2023 is not yet published. This is expected to be available in May 2023.

## j. Complaints

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

All contacts received by the PALS are assessed to see if they can be dealt with quickly, for example by taking direct action, or by putting the enquirer in touch with an appropriate member of staff. This course of action is agreed with the patient and the enquiry is recorded as a concern (informal complaint). During 2022/23, we received 2,854 informal concerns which we were able to respond to quickly.

If the concern or issue cannot be dealt with informally or if the enquirer remains concerned, the issue is categorised as a formal complaint and processed accordingly. During 2022/23 1224 formal complaints were received. The number of formal complaints received by the Trust has increased overall by 10.4%. This increase reflects the decrease received last year, largely due to the nationwide pause in the complaint process in 2020/21 due to the COVID-19 Pandemic.

A monthly breakdown of formal complaints and concerns received during 2022/23 is provided below.

Of the formal complaints closed during 2022/23 721 (61%) were upheld or partially upheld by the Trust.

Where complainants remain unhappy with the Trust's response, they can refer to the Parliamentary and Health Service Ombudsman (PHSO) to get an independent and objective body to review their complaint. The PHSO investigate complaints made regarding Government departments and other public sector organisations and the NHS in England. During 2022/23 the Parliamentary and Health Service Ombudsman closed 4 cases regarding the Trust, 0 were upheld and 2 were partially upheld.

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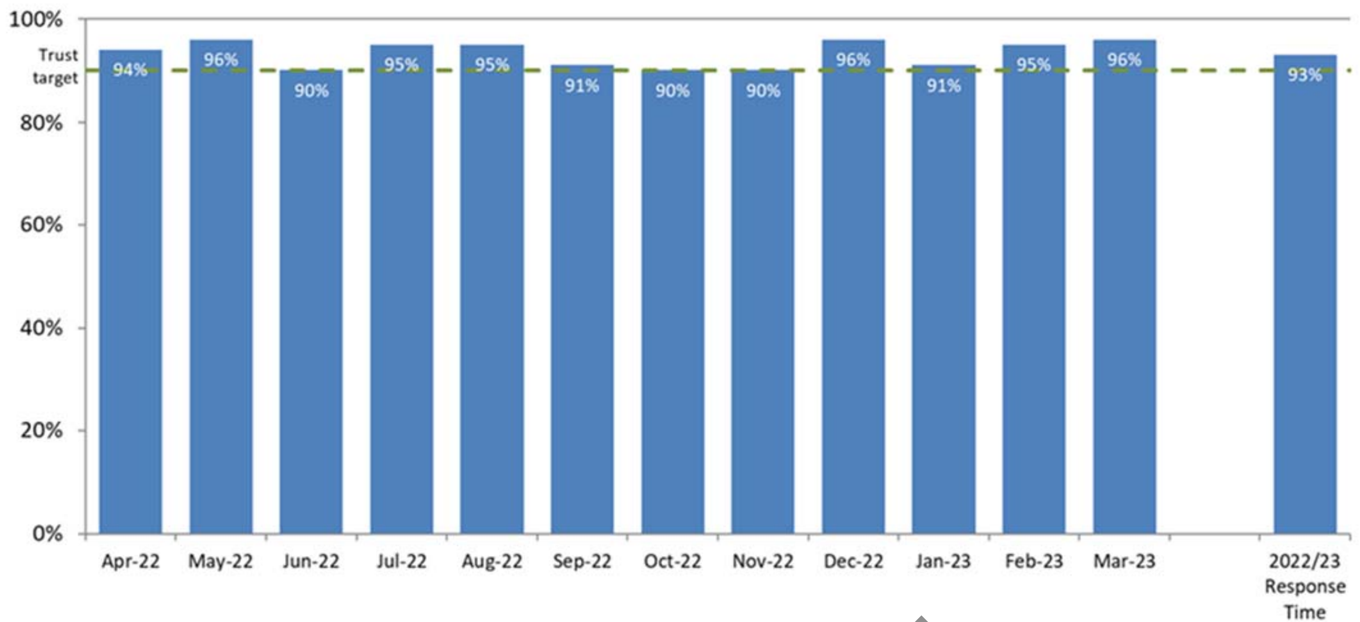
*Figure 11: Complaints received during 2021/22 by month*

| | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Feb | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New informal concerns received | 230 | 248 | 246 | 226 | 266 | 258 | 250 | 233 | 172 | 248 | 226 | 251 | 2854 |
| New formal complaints received | 98 | 125 | 93 | 91 | 114 | 109 | 121 | 114 | 65 | 90 | 110 | 94 | 1224 |
| **Total** | **328** | **373** | **339** | **317** | **380** | **367** | **371** | **347** | **237** | **338** | **336** | **345** | **4078** |

*Figure 12: Breakdown of complaints response times by month*




The complaint response time target is that at least 90% of complaints are closed within the agreed timescale. This target was achieved in 2022/23, with 93% being responded to in time, or with an extension.

Monthly complaints reports are produced for the Patient Experience and Engagement Group showing the number of formal complaints received and response times at directorate level. Open concerns (informal complaints) have also recently been added to this monthly report to ensure these are being followed up and responded to appropriately.

This reporting aims to ensure that the Trust is continually reviewing information, so that serious issues, emerging themes or areas where there is a notable increase in numbers of formal complaints and concerns, can be investigated and reviewed.

In April 2022, a review of the subjects used to record complaints was undertaken. Going forward it is anticipated the changes will help to provide more accurate and consistent data on themes and trends arising from complaints. Historically there were 29 Primary Subjects and 158 Sub-Subjects on Datix to record complaints. Many of these were duplicates and not consistently used, due to the subjective nature of how complaints are recorded. The change reduced the numbers to 20 Primary Subjects and 82 Sub-Subjects.

When presented as a percentage, complaints relating to 'Attitude' have increased by 1.7%. Complaints relating to 'Communication with patient' have increased by 2.4% however those relating to 'Communication with Relative/Carer' have decreased by 2.2%.  The Trust had previously seen an increase in those complaints during the pandemic, and this may have been attributed to relatives/carers not being able to visit.

Complaints about 'Waiting time for follow-up / routine appointment' and 'waiting for procedure' have seen biggest increases with 4.3% and 4.6% increases.  This is reflective of the effect of the Covid-10 pandemic and the backlog of clinical cases that was created with the reduced capacity over that time.

The Trust remains committed to learning from, and taking action as a result of, complaint investigations. In order to share learning the Patient Experience and Engagement Group receives regular presentations, on a rolling programme, from the Nurse Director of each Care Group. The presentation reviews in detail how a complaint was managed and demonstrates the reflective learning and improvements which have been implemented as a direct result of the complaint.

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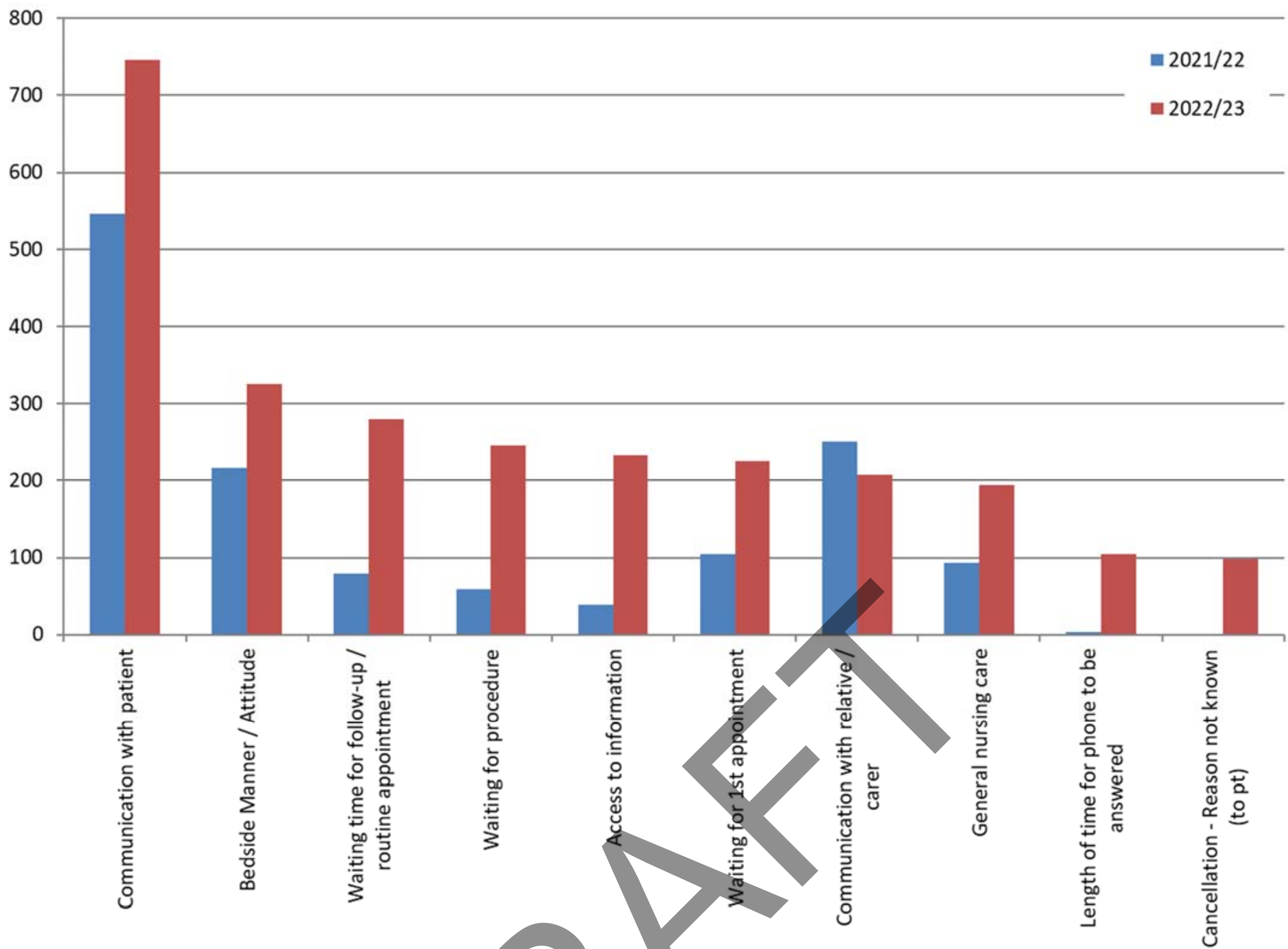
*Figure 13: Breakdown of complaints by theme*

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## k. Delivering same-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 2022/23.

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

The Trust received three Regulation 28 Reports during 2022/23 they are as follows:

1. On 25 April 2022 a Regulation 28 was issued concerning a patient who was born at Sheffield Jessop Wing on 3 April 2021. He was born premature at only 28 weeks and was very small even for his age. On 3 April 2021 an umbilical Venous Catheter was positioned in a sub optimal position and required review within 24 hours. The review was not documented or handed over and as a result was not completed. This resulted in his death on 5 April 2021.

The Coroner found the death was contributed to by neglect and issued a Regulation 28 Report due to the following concerns:

- The parents were not told about the consultant plan to review, reassess, and pull back the central line. Them knowing could have prompted that this was done.
- Although staffing was over national standards, the available skill mix could have created an additional burden on the consultant.
- The pink 'handover' sheets have been reviewed and redesigned to include more than the national requirements. There does not seem to be any consideration of whether the national form would meet the requirements of this unit and that less information may be preferable in these circumstances.

Evidence was heard regarding Jessop Wing having responsibility for the sickest and most premature babies in the region. Jessop Wing, however, cannot ask for support if required. There was evidence given of a buddy system and how the Jessop wing have tried to access support form colleagues directly. There are other neonatology consultants across the region who could provide remote assistance potentially.

2. On 26 April 2022 a Regulation 28 was issued concerning a patient who was born in Sheffield Jessop Wing on 6 August 2020. During the delivery clinical decisions resulted in a 23-minute delay and during this time her condition was not adequately monitored. She was born in a very poor condition and later died on the 9 August 2020.

   The Coroner found the death was contributed to by neglect and issued a Regulation 28 Report due to the following concerns:

   - The decision was made by the midwife present during delivery to move to an episiotomy, however this was delayed as another midwife who came to support suggested more position changes. This resulted in inadequate monitoring of foetal heart rate. Although the decision to seek support is not criticised, the Coroner concluded the subsequent lack of clarity regarding which midwife was the decision maker, resulted in a delay in undertaking the Episiotomy.
   - The decision to move the mother from consultant to midwife led care without consultation is concerning.
   - The lack of discussion with the mother about birthing options prior to labour and therefore lack of engagement with her is concerning.
   - The reference to 'normal birth' in the 'Born in Sheffield' documentation suggests encouragement of a natural birth to expectant mothers when they may prefer to explore other options such as caesarean section. Language is hugely important in terms of the experience individuals have when vulnerable.
   - There appears to be no safeguards in place for those not on continuous heart rate monitoring.

3. On 22 November 2022 a Regulation 28 was issued concerning a patient who was admitted to the Royal Hallamshire Hospital on 16 June 2022. During the admission the patient was receiving additional support from her own private care staff. She died following a fall in hospital after her care staff had left for the day.

   The Coroner found the death was as a result of an accident and issued a Regulation 28 Report due to the following concerns:

   - The patient was in receipt of care from her own care staff. These staff were not made aware of any of the risk assessment or care plans which were in place to support her. This put the patient at risk as her private carers were providing care contrary to what was indicated by the MDT responsible for her. Involvement in care planning of those supporting the patient would have made this a safer environment and the roles and responsibilities of those involved should have been made clear.

## m. Never Events

Never Events are defined by NHS England 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 2022/23, eight Never Events were declared. Seven occurred at the Trust and one occurred at Spire Claremont Hospital. Three were in relation to 'wrong site surgery', three related to a 'retained foreign object post procedure' and two were in relation to 'wrong implant/prosthesis'.

Learning from Serious Incidents and Never Events is shared through multiple forums within the Trust, including the Trust's Safety and Risk Forum, Management Board Briefing, relevant

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subject committees and via Trust-wide monthly safety messages from the Medical Director (Operations).

The Trust continues to work to strengthen learning opportunities and ensure improvements made are sustainable and embedded. Examples of ongoing actions that have been taken in response to Never Events include, but are not limited to, the continued roll out of the Inventory Management System, theatre culture survey work and audits to monitor compliance with procedural marking, surgical counts and procedural safety checklists.

### n. Duty of Candour

The Trust Incident Management Policy reflects the expectation in relation to Duty of Candour. This is supported by the Duty of Candour Policy that was published in August 2021. In June 2022 additional guidance was provided by the Care Quality Commission to provide further clarify as to what constitutes as a notifiable safety incident and Trust Policy has been updated accordingly. Duty of Candour training is provided via an e-learning resource.

All incidents, including those which trigger the Duty of Candour, are reported on Datix, the Trust's electronic incident management system. For the statutory Duty of Candour regulations to be considered, a patient safety incident has to be classed as an incident of moderate, major, or catastrophic severity. A trigger is then activated in Datix to prompt consideration whether Duty of Candour applies. During 2022/23, the number of incidents that met this criterion was 2022.

Of these 2022 incidents, 234 were related to hospital acquired COVID-19 and Duty of Candour has been completed in all cases with the exception of those where contact details for relevant next of kin could not be obtained.

Of the remaining 1,788 incidents, Duty of Candour was confirmed on the Datix record as being applicable to 1,098 cases. Of the remaining 690 incidents, Duty of Candour was recorded to be not applicable in 555 cases and a rationale was provided in all but 8 of these. There is no clear record on Datix whether Duty of Candour is applicable for the remaining 135 incidents. A review of the discrepant cases is underway. In addition, an audit tool to review Duty of Candour compliance is under development and will be undertaken at agreed intervals to provide assurance that appropriate decisions regarding Duty of Candour are being taken in line with national guidance.

This data highlights that there has been a 106% increase in the number of incidents reported to meet the Duty of Candour criteria from the previous year. This demonstrates a continuing increase in the understanding of the Duty of Candour regulations.

### o. Safeguarding

The Trust is one of a number of agencies who report to and support the obligations of the Sheffield Safeguarding Partnership for Children, Young People and Adults. The Statutory Safeguarding Partners consist of Sheffield City Council, South Yorkshire Police, and NHS South Yorkshire Integrated Care Board (ICB) Sheffield Place.

The Partnership Executive Board leads and holds all other partner agencies to account to ensure that children and adults at risk are protected from all forms of abuse, neglect or exploitation.

The Trust is represented at all external Safeguarding Partnership. multi-agency safeguarding and domestic abuse meetings and forums by members of the Trust Safeguarding Team.

The Trust provides various levels of mandatory safeguarding training to staff as required by the Safeguarding Intercollegiate Competency Frameworks for adults and children.

The Trust has a number of safeguarding policies, guidance documents and processes in place to support staff to identify and report all types of abuse of patients, carers, family members, visitors or staff.

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The Trust holds a quarterly Safeguarding Assurance Group meeting and produces an Annual Safeguarding Report for the Trust Executive Group via the Quality and Safety Executive Committee and the Committee.

Key Performance Indicators for safeguarding adults and children are submitted quarterly to the ICB Sheffield Place.

Mandatory quarterly reports are submitted to NHS improvement (NHSI) in respect of cases of Female Genital Mutilation identified by services in STHFT, and for Prevent training compliance and Prevent referrals made by the Trust.

The Trust's Safeguarding Team supports staff to identify and respond to both adults and children who are subject to domestic violence and abuse, working in particularly close collaboration with the Emergency Department and the Jessop Wing maternity services Vulnerabilities Team, and in liaison with external agencies.

The Trust Safeguarding Team has recruited to and supports a network of Safeguarding Champions across the organisation to offer local additional advice and assistance to front line staff to recognise and respond to abuse or neglect.

### p. Seven-day services

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 the Forum's recommendations, including full implementation of the clinical standards. In 2016, NHS England requested that hospital Trusts measure performance on four priority clinical standards.

The four priority clinical standards are:

- Standard 2: Time to initial consultant review from admission into hospital
- Standard 5: Access to diagnostics
- Standard 6: Access to consultant-led interventions
- Standard 8: On-going daily consultant-directed review

The Seven Day Service audit was postponed during 2020/21, 2021/22 and 2022/23 and therefore there is no audit data to present. The Organisation will approve the process for the Annual Board Assurance Report for 2023/24.

### q. Learning from deaths

The Trust is committed to learning from all patient deaths. During 2022/23, 2,914 patients died whilst an inpatient at the Trust. 166 patients died in the Accident and Emergency Department. The following number of deaths occurred in each quarter of the reporting period:

- 639 in the quarter 1
- 692 in the quarter 2
- 816 in the quarter 3
- 767 in the quarter 4

During 2022/23, 3,131 deaths were reviewed by a Medical Examiner. 179 cases have been referred for a Structured Judgement Review (SJR) case record review, most via the Medical Examiner system. 109 SJRs have been completed (61% of those referred) and five rejected.

The number of deaths in each quarter for which a SJR case record review was referred:

- 57 in the first quarter
- 44 in the second quarter
- 43 in the third quarter
- 35 in the fourth quarter

*Data correct as of 25 April 2023*

All but one of the 35 neonatal deaths have received a case record review, the equivalent of an SJR. The latest death is scheduled for review on 26 April.

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Deaths subject to an SI investigation are being managed in line with Trust Incident Management processes. Between 1 April 2022 and 31 March 2023, 11 cases were judged by the Serious Incident Group to be more likely than not to have been due to problems in the care provided to the patient.

Where an SJR is scored as 'poor' or 'very poor' by two independent reviewers, the directorate is requested to review the case and either declare an SI to the Serious Incident Group or complete context around the care and an action plan for review at Mortality Governance Committee. Regardless of outcome, all SJR summaries are sent to relevant Directorates for discussion at speciality Mortality and Morbidity meetings where local actions can be agreed and progressed.

Regular feedback from specialty Mortality and Morbidity Meetings to the Mortality Governance Group has been introduced during 2022/23 and work is ongoing to improve the way learning is shared. Analysis of SJR data is being done so that trends can be identified and fed into improvement work.

### r. Staff who speak up

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

We encourage staff to raise their concerns through conversations with supervisors and line managers so that they can be resolved as quickly possible. They can also raise their concerns within their line management structure but if they feel unable to do this, we have a Lead Freedom to Speak Up Guardian supported by eight voluntary Freedom to Speak Up Guardians who staff can speak to. The Guardians are supported by a number of trained Freedom to Speak Up Champions across the organisation. The contact details for the Guardians and Champions can be found on the Human Resources intranet page and are publicised on posters across the organisation. Staff may also raise concerns through a dedicated email address where they will be picked up and supported by a Guardian throughout the Freedom to Speak Up process.

The two main policies which support staff in doing this are: the Freedom to Speak Up Policy and the Acceptable Behaviour at Work Policy.

There are regular communications to Trust employees about the Freedom to Speak Up process and all staff raising concerns through this route receive feedback via the Guardian / Champion who they raised their concern with and/or the investigating manager. We will also seek feedback from concern raisers at the end of the process to allow us to learn and improve.

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

### s. Rota gaps

There continue to be significant challenges in filling medical rotas. There are gaps on rotas due to lack of trainees allocated by Health Education England. The Trust has a very successful internal locum bank, with which around 90% of Trust doctors in training are registered, and this provides a cohort of doctors familiar with the Trust, its processes, procedures, and IT systems who can be asked to fill gaps . The Trust also continues to appoint non-training grade posts to support longer term gaps on rotas.

A well-established Hospital Out of Hours service is in place at both campuses and makes efficient use of the out of hours workforce, allocating tasks to the most appropriate staff member, some of whom are non-medical.

Several non-medical staff have been appointed to undertake tasks traditionally carried out by doctors, including Advanced Clinical Practitioners, and Physicians' Associates. Although Physicians Associates cannot prescribe medication or order radiological investigations, and whilst plans are emerging nationally to address this, the relevant legislation is unlikely to become law during the next year.

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# Part 3

## Quality performance information 2022/23

*This section presents the Trust priorities which are encompassed in the mandated indicators that the organisation is required to report and have been agreed by the Board of Directors. The indicators include:*

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

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## Quality Performance Information

| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| **The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust for the reporting period.** | 1.00<br>Banding:<br>as expected | 0.98<br>Banding:<br>as expected | 1.00<br>Banding:<br>as expected |
| National Average: 1.00<br>Highest performing Trust score: 0.72<br>Lowest performing Trust score: 1.22<br>*(Figures for December 2021 – November 2022)* | 1.00<br>Banding:<br>as expected | 1.00<br>Banding:<br>as expected | 1.00<br>Banding:<br>as expected |
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. | 34% | 40% | 38% |
| National average: 40%<br>Highest trust score: 66%<br>Lowest trust score: 13%<br>*(Figures for December 2021 – November 2022)* | | | |

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 (published 13th April 2022).

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

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

Sheffield Teaching Hospitals NHS Foundation Trust has taken action to optimise this coding rate, and so the quality of its services by implementing a business-as-usual process relating to palliative care coding. This process ensures all activity is captured by validating clinical coding against the Palliative Care Services own contact report and an Information Services User Report. The validation work is undertaken monthly. As a result of this, in 2021/22 the Trust rate of palliative care coding increased markedly to 40%, in line with the national average. The rate decreased slightly to 38% in 2022/23, still well above the 2020/21 level and the Trust is committed to continuing the validation process in 2023/24.

| **Patient Reported Outcome Measures (PROMs)** | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| The Trust's EQ5D patient reported outcome measures scores for: | | | |
| (i) Hip replacement surgery primary | | | |
| Trust score: | * | ** | ** |
| National average: | 0.472 | ** | ** |
| Highest score: | 0.574 | ** | ** |
| Lowest score: | 0.393 | ** | ** |
| (ii) Hip replacement surgery revision | | | |
| Trust score: | * | ** | ** |
| National average: | 0.336 | ** | ** |
| Highest score: | 0.413 | ** | ** |
| Lowest score: | 0.253 | ** | ** |
| (iii) Knee replacement surgery primary | | | |

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| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
| --- | --- | --- | --- |
| Trust score:<br>National average:<br>Highest score:<br>Lowest score: | *<br>0.315<br>0.403<br>0.181 | **<br>**<br>**<br>** | **<br>**<br>**<br>** |
| (iv) Knee replacement surgery revision | | | |
| Trust score:<br>National average:<br>Highest score:<br>Lowest score: | *<br>0.299<br>0.230<br>0.207 | **<br>**<br>**<br>** | **<br>**<br>**<br>** |

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

** Denotes data not yet released. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. NHS England have paused the current publication reporting series for PROMS at this time. Therefore, the Trust is looking at available local data although not risk adjusted to inform improvements.

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

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.

| | | | |
| --- | --- | --- | --- |
| **Readmissions** | | | |
| The percentage of patients aged: 0 to 15; and | 0% | 0% | 0% |
| 16 or over, readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.<br><br>These data are a snapshot at the time the report is run and may change as live systems are updated. Due to these, figures reported for previous years may change. | 12.25% | 12.52% | 13.51 |
| *Comparative data is not available* | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is taken from the Trust's Patient Administration System, Lorenzo. | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and through this the quality of its services, by raising any specific concerns with the individual specialty in order to allow a timely response. | | | |
| **Responsiveness to personal needs of patients** | 94% | 95% | ** |
| The Trust's responsiveness to the personal needs of its patients during the reporting period.<br><br>**The National Adult Inpatient 2022 Survey Takes place in January – April 2023 from a sample of patients who were inpatients during December 2022. Data from the Survey Contractor, Picker, is expected to be available in May 2023 with CQC results expected to follow in August 2023.<br><br>The data below is from the 2021 survey published in 2022. | | | |

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| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| The Trust score is made up of the following:<br>Did you get enough help from staff to eat your meals? – 88%<br>Do you think the hospital staff did everything they could to help control your pain? – 98%<br>Were you treated with respect and dignity? – 98%<br><br>National average: 93% (this is based on the average scores across all NHS trusts who are contracted with Picker.) | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by National CQC Survey Contractor. | | | |
| **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. | 95.12% | 95.01% | 93.00% |
| *Comparative data is not available* | | | |
| Sheffield Teaching Hospital NHS Foundation Trust considers that this data is as described as the data is taken directly from the Trust's Electronic Patient Record. | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and through this the quality of its services, by utilising developing IT clinical systems and completing Speciality Specific update of Thrombosis Prevention Guideline | | | |
| **Rate of Clostridium Difficile** | | | |
| **Hospital Onset/Healthcare Associated cases**<br>The rate per 100,000 bed days of Hospital Onset/Healthcare Associated cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period.<br>The rates are as stated in Apr 2023 on the UK Health Security Agency HCAI database which uses KH03 occupied overnight beds per 100,000 as a denominator for this parameter. | 27.21<br>(105 cases) | 26.80<br>(119 cases) | 26.35<br>(117 cases) |
| Community Onset/Healthcare Associated cases<br>The rate per 100,000 bed days of Community Onset/Healthcare Associated cases community associated cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period.<br>Community Onset cases presenting within 28 days of discharge, have been included in the objectives allocated to trusts since 2019/20. How these will be taken into account nationally as regards published rates is, as yet, unknown. The rates are calculated from data as stated in Apr 2023 on the UK Health Security Agency HCAI database using KHO3 occupied overnight beds per 100,000 as denominator for this parameter. Please note the rates quoted for 2020/21 and 2012/22 are updated rates, as currently published on the aforementioned HCAI database, and differ from those quoted in previous year's Quality Reports. The data quoted in previous reports was as stated on the HCAI database at the time of writing. | 10.44<br>(44 cases) | 7.41<br>(36 cases) | 10.70<br>(52 cases) |

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| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Position against national objective<br><br>During 2021/22 there have been a) 117 C.difficile Hospital Onset/Healthcare Associated episodes detected and b) 52 C.difficile Community Onset/Healthcare associated episodes detected within the Trust; total of 169. The national objective allocated to the Trust for 2022/23 was 149. This objective was therefore not achieved. | | | |
| Root cause analysis<br><br>Hospital Onset/Healthcare Associated episodes have a root cause analysis undertaken to identify if there has been any possible lapse in care. As of 1st Apr 2023, 12.5% of cases where an RCA has been completed, have been highlighted as possibly having a lapse in care. This is similar to 2019/20 (9.2%) and 2020/21 (10.2%), 2021/22 (8.4%) and actions continue to be taken to address the issues identified in these RCAs. | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by UK Health Security Agency.<br><br>Sheffield Teaching Hospitals NHS Foundation Trust continues to take a range of actions to improve this rate, and through this the quality of its services, by having a dedicated plan as part of its Infection Prevention and Control Programme to continue to reduce the rate of C.difficile experienced by patients admitted to the Trust. | | | |
| **Percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer** | | | |
| **Urgent GP referral for suspected cancer** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 61.8% | 60.8% | 45.6% |
| National Standard | 85% | 85% | 85% |
| **NHS Cancer Screening Service referral** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 60.0% | 65% | 40.2% |
| National Standard | 90% | 90% | 90% |
| *Data Source: Open Exeter National Cancer Waiting Times Database* | | | |
| **Rate of patient safety incidents** | | | |
| The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | 21,292 | 25,077 | Not available |
| **Number of incidents reported** | | | |
| Rate of incidents reported per 1000 bed days.<br><br>**Incident reporting rate data for the financial year 2022/23 is not available from the National Reporting and Learning System (NRLS) until September 2023. | 51.09 | 56.5 | ** |
| **The number and percentage of patient safety incidents that resulted in severe harm or death** | 216 (1.0%) | 112 (0.5%) | Not available |

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| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust encourages reporting of all incidents and although total numbers of incidents reported decreased between in 2020/2021 from the previous year, the rate of incidents reported per 1000 bed days has increased. This is reflective of a reduction in elective activity at the outset of the COVID-19 pandemic but demonstrates a continually improving safety culture. | | | |
| **Maximum six week wait for diagnostic procedures** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement. | 69.94% | 81.01% | 72.27 |
| National Standard | 99% | 99% | 99% |
| **Accident and Emergency maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 85.89% | 73.66% | 74.13% |
| National Standard | 95% | 95% | 95% |
| **MRSA blood stream infections** | | | |
| Hospital Onset bacteraemia cases in Sheffield Teaching Hospitals NHS Foundation Trust | 3 | 0 | 2 |
| Sheffield Teaching Hospitals NHS Foundation Trust threshold for Hospital Onset episodes. | 0 | 0 | 0 |
| **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 | 80.30% | 81.76% | 73.25% |
| 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 | 75.94% | 77.51% | 68.07% |
| National Standard | 92% | 92% | 92% |
| **Patients who require admission who waited less than 18 weeks from referral to hospital treatment** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 72.06% | 70.68% | 64.29% |
| National Standard | 90% | 90% | 90% |
| **Never Events (Count)** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement<br>* 1 of the 8 incidents for 2022/23 occurred at Spire Claremont Hospital | 3 | 6 | 8* |
| **Certification against compliance with requirements regarding access to healthcare for people with a learning disability** | | | |

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| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? | Yes | Yes | Yes |
| Does the NHS Foundation Trust provide readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to encourage representation of people with learning disabilities and their family carers? | Yes | Yes | Yes |
| Does the NHS Foundation Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? | Yes | Yes | Yes |
| **Data Completeness for Community Services** | | | |
| **Referral to treatment information:** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 53.14% | 61.42% | 60.80% |
| National Standard | 50% | 50% | 50% |
| **Referral information:** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 100% | 100% | 100% |
| National Standard | 50% | 50% | 50% |
| **Treatment activity information:** | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust achievement | 100% | 100% | 100% |
| National Standard | 50% | 50% | 50% |
| **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. | 84.0% | 76.2% | 68.3% |
| National average: Combined Acute/ Acute and Community Trusts – 61.9 %<br>Highest performing Trust score:(Combined Acute/ Acute and Community Trusts): 86.4%<br>Lowest performing trust score: (Combined Acute / Acute and Community Trusts): 39.2% | | | |
| Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the national CQC survey contractor. | | | |

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| Prescribed Information | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|
| Sheffield Teaching Hospitals NHS Foundation Trust continues to work to improve this percentage by involving staff in service improvements and redesign, through seeking staff views via both the full census NHS staff survey, the Quarterly NHSI People Pulse, utilising our Microsystems Academy approach and through the People Promise retention work.<br><br>Although there has been a decline in Trust performance over the past three years, this is in line with a national trend and the Trust remains better than the national average. | | | |
| **Friends and Family Test – Positive Score (patients who have scored either two 'Good', or one 'Very Good')**<br><br>The percentage of patients who attended the Trust during the reporting period who scored either two for 'Good' or one for 'Very Good', when asked for their overall experience of the service.<br><br>Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by Healthcare Communications and reported by NHS England.<br><br>Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and through this, the quality of its services:<br>• A monthly report is circulated across the Trust informing staff of scores and the number of responses, as well as enabling them to review the comments that patients have made about their experience.<br>• Monthly FFT scores are compared with the 12-month Trust score as well as the 12-month national score to monitor performance.<br>• FFT is monitored on a monthly basis through the Patient Experience and Engagement Group (PEEG)*, which escalates trends or concerns to the Patient Experience and Engagement Committee and takes relevant actions to improve the Trust's FFT position.<br>• Focused work has been completed in lower scoring areas to identify improvement actions. These have included actions being put in place to increase response rates in areas with very low response numbers, actions taken to improve sleep quality in areas where noise at night was identified as an issue and providing staff with training on how to have difficult conversations.<br><br>* In 2022, a new structure for oversight of Patient Experience was implemented constituting of a strategic senior-level Patient Experience and Engagement Committee chaired by the Chief Nurse and an operational Patient Experience and Engagement Group chaired by the Deputy Chief Nurse. | All areas<br>93%<br><br>Inpatient<br>93%<br><br>A&E<br>85%<br><br>Maternity<br>88%<br><br>Outpatient<br>94%<br><br>Community<br>93% | All areas<br>90%<br><br>Inpatient<br>91%<br><br>A&E<br>77%<br><br>Maternity<br>80 %<br><br>Outpatient<br>94%<br><br>Community<br>91% | All areas<br>91%<br><br>Inpatient<br>92%<br><br>A&E<br>81%<br><br>Maternity<br>88%<br><br>Outpatient<br>94%<br><br>Community<br>93% |

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# Part 4

## Statements from our Partners on the Quality Report

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# Statement on Behalf of NHS South Yorkshire Integrated Care Board

South Yorkshire
Integrated Care Board

TO BE ADDED

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# Statement from the Chair of Sheffield City Council's Health Scrutiny Sub-Committee

TO BE ADDED

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# Statement on Behalf of Healthwatch Sheffield

TO BE ADDED

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# Statement from Trust Governor Involvement in the Quality Report Steering Group

TO BE ADDED

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# 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.

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 2022/23.

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 2022 to March 2023
- Papers relating to quality reported to the Board over the period April 2022 to March 2023
- Feedback from NHS South Yorkshire Integrated Care Board dated XX
- Feedback from Governors XX
- Feedback from local Healthwatch organisations dated XX
- Feedback from Sheffield City Council's Health Scrutiny Sub-Committee dated XX
- The latest national patient surveys, dated July 2022 (Cancer), September 2022 (Adult Inpatient), January 2023 (Maternity)
- The latest national staff survey published March 2023

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

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

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

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

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

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

By order of the Board of Directors

| | |
|---|---|
| **SIGNATURE TO BE ADDED** | **SIGNATURE TO BE ADDED** |
| **Annette Laban** | **Kirsten Major** |
| Chair | Chief Executive |
| DATE TO BE ADDED | DATE TO BE ADDED |

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# Part 5

## Glossary

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**The table below provides a glossary of abbreviations and acronyms**

| | |
|---|---|
| ACP | Accountable Care Partnership |
| AI | Artificial Intelligence |
| AIS | Accessible Information Standard |
| BRC | Sheffield Biomedical Research Centre |
| CCG | Clinical Commissioning Group |
| CMP | Case Mix Programme |
| CPD | Continuing Professional Development |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality Improvement |
| CTG | Cardiotocograph |
| DNACPR | Do Not Attempt Cardiac Pulmonary Resuscitation |
| EDEPI | Equity in Doctoral Education through Partnership and Innovation |
| EDI | Equality, Diversity and Inclusion |
| EDS2 | NHS Equality Delivery System |
| EIAs | Equality Impact Assessments |
| EMR | Electronic Medical Record |
| EoLC | End of Life Care |
| FFFAP | Falls and Fragility Fractures Audit Programme |
| FFT | Friends and Family Test |
| HEEP | Healthcare Entrepreneur Exchange Programme |
| IBD | Inflammatory Bowel Disease |
| ICS | Integrated Care System |
| IOLs | Intra-ocular lens |
| KPIs | Key Performance Indicators |
| LD | Learning Disabilities |
| LeDeR | Learning Disability Mortality Review Programme |
| LGBTQ+ | Lesbian, Gay, Bisexual, Transgender, Queer or Questioning |
| MINAP | Myocardial Ischaemia National Audit Project |
| NABCOP | National Audit of Breast Cancer in Older Patients |
| NACEL | National Audit of Care at the End of Life |
| NBOCA | National Bowel Cancer Audit |
| NCAA | National Cardiac Arrest Audit |
| NCEPOD | National Confidential Enquiry into Patient Outcome and Death |
| NCHDA | National Congenital Heart Disease Audit |
| NEIAA | National Early Inflammatory Arthritis Audit |
| NELA | National Emergency Laparotomy Audit |
| NEWS2 | National Early Warning Score |
| NHSI | NHS Improvement |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health and Care Research |
| NJR | National Joint Registry |

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| | |
|---|---|
| NLCA | National Lung Cancer Audit |
| NMPA | National Maternity and Perinatal Audit |
| NNAP | National Neonatal Audit Programme |
| NOGCA | National Oesophago-Gastric Cancer Audit |
| NPCA | National Prostate Cancer Audit |
| NPDA | National Paediatric Diabetes Audit |
| NRLS | National Reporting and Learning System |
| OHCAO | Out-of-Hospital Cardiac Arrest Outcomes |
| PALS | Patient Access and Liaison Service |
| PCI | National Audit of Percutaneous Coronary Interventions |
| PCR | Posterior Capsular Rupture |
| PICA | Paediatric Intensive Care |
| POMH | Prescribing Observatory for Mental Health |
| PROMs | Patient Report Outcome Measures |
| ReSPECT | Recommended Summary Plan for Emergency Care and Treatment |
| SDEC | Same Day Emergency Care |
| SHMI | Summary Hospital-Level Mortality Indicator |
| SHOT | Serious Hazards of Transfusion Scheme |
| SI | Serious Incident |
| SJR | Structured Judgement Review |
| SMR | Spinal Muscular Atrophy |
| SSNAP | Sentinel Stroke National Audit programme |
| TARN | The Trauma Audit & Research Network |
| TTP | Thrombotic Thrombocytopenic Purpura |
| VTE | Venous Thromboembolism |
| WDES | Workforce Disability Equality Standard |
| WEI | Workplace Equality Index |
| WRES | Workforce Race Equality Standard |

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