Sheffield Teaching Hospitals NHS Foundation Trust

Chief Executive's Report

Board of Directors – 25 January 2022

1. Covid-19 Gold Commander Update

Gold Command and the Trust remains focussed on safely providing urgent and emergency services and planned elective care, the command structure remains in place. Given the longevity of the pandemic an increased focus on staff health and wellbeing remains in place. A verbal update will be provided in the meeting which will include an update on the most recent covid activity figures.

2. Integrated Performance Report

For the Integrated Performance Report (paper Cii), each Director will highlight the key issues for the Board of Directors for the reporting periods of October and November 2021.

3. Maternity Dashboard

The monthly reports for October and November are included at Appendix A and B which provide a rolling three month overview of Maternity Services' performance, which is benchmarked against a defined set of targets and provides assurance to the Board of Directors in relation to the tracking of the Trust's performance. This data is captured in the same format across the Local Maternity and Neonatal System (LMNS) enabling a comparison of performance across the Trusts within the LMNS to identify areas for improvement either by individual trusts or as an LMNS system. The October report was considered by the Healthcare Governance Committee on Monday 20 December 2021 and the November report considered by the Trust Executive Group on Wednesday 19 January 2022.

4. Covid-19 Inquiry – Document Preservation Notice

In May 2021, the Prime Minister announced that the Government would establish a Statutory Public Inquiry into the Government and public sector response to the Covid-19 pandemic. The full scope of the Inquiry will be confirmed when its terms of reference are published, however, the broad aim of the inquiry will be to establish facts, identify key issues and learn lessons for the future.

It is important that STH engage with the Inquiry openly and transparently. The Inquiry will provide an opportunity for learning and to demonstrate the extraordinary work of the NHS throughout the course of the Covid-19 pandemic.

In December 2021 the Prime Minister announced that Baroness Heather Hallet had been appointed as Chair of the Inquiry which is expected to begin in Spring 2022. In preparation for the Inquiry an STH Covid-19 Inquiry Oversight Group has been established and will be taking actions to ensure that the Trust is in the best possible position to engage with the Inquiry. As a first step a Document Preservation Notice has been issued to all Bronze Commands asking staff to retain all potentially relevant material.

Further updates will be provided once the draft Terms of Reference are published by the Inquiry team.

5. Mental Health Strategy

The need to develop our care for patients with mental health and mental capacity issues has become increasingly apparent through challenges experienced in our day-to-day provision of care. There is also an increasing regulatory focus on this area. In response, a new Mental Health Strategy for the 2022-5 period has been developed based upon three principles:

- Supporting patients to achieve the best mental health possible for them and provide the person-centred care they need when they are challenged with mental health problems and illness.
- Recognising and responding to these needs with understanding, kindness, and skill to promote the mental wellbeing and safety of people in our care without discrimination.
- Fostering an integrated approach to care that gives equal attention to the mental health needs of patients alongside their physical needs and supports continuity of care and collaboration across mental health pathways.

This strategy recognises that STH cares for a large number of patients with mental health issues, either as their primary problem or as a factor impacting on their health, and that our staff have to be able to deal with patients with mental health and mental capacity issues sensitively and effectively and recognising the requirements of the law and national guidelines. The detail of the strategy focuses on the quality of care and support given through an engaged mental health culture and appropriately trained staff working through the right clinical processes, safety and governance arrangements and in collaboration with other organisations and stakeholders. A detailed implementation plan will be developed and overseen by the Mental Health Steering Group and implemented through the newly-developed STH Mental Health Team. The strategy is included at Appendix C.

6. Vaccination as a Condition of Deployment (VCOD) Regulations

On 6 January 2022, the Government made new legislation, approved by Parliament, which amended the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On 14 January 2022, NHS England and Improvement provided guidance on the implementation of the Vaccination as a Condition of Deployment (VCOD) regulations.

The regulations provide that the registered person can only deploy or otherwise engage a person for the purposes of the provision of a CQC-regulated activity, in which they have direct, face to face contact with patients and service users, if the person provides evidence that they have been vaccinated with a complete course (presently defined as first and second dose) of an approved COVID-19 vaccine. This is subject to specific exemptions and conditions. The requirements include front-line workers, as well as non-clinical workers not directly involved in patient care but who may have face to face contact with patients, including ancillary staff such as porters, domestics and receptionists. All such workers are described as being in scope.

The key implementation dates are:

- 6 January 2022 – a 12-week grace period between the regulations being made and coming into force, commenced. The Trust has established a Project Board and a process in advance of the guidance to ensure it was prepared for the new regulations, which included communication and engagement with staff to support them with the opportunity to obtain their vaccine.

- 3 February 2022 – this is the last date for workers in scope of the regulations to get their first dose of an authorised vaccine (unless exempt) so they can be fully vaccinated with a complete course by 1 April 2022. Under current vaccination guidance, eight weeks are required between the first and second vaccine dose. Staff who remain unvaccinated (excluding those who are exempt) will be invited to a formal meeting chaired by an appropriate manager, in which they are notified that a potential outcome of the meeting may be dismissal.

- 1 April 2022 regulations come into force from which point, the CQC have confirmed that they will use their existing assessment approach and enforce the government's policy.

The Trust will also need to consider the termination of employment of staff whose roles are in scope of the regulations and who refuse to be vaccinated in-line with the mandated timescales (excluding staff who are exempt) or decline to disclose their vaccination status. Any such termination should be undertaken lawfully, which requires that there be a proper reason for the dismissal and that a fair and reasonable procedure is followed.

Daily reports will be provided from the Project Board to Gold Command as the Trust responds to the guidance and implements the new regulations. The Trust's focus has always and will continue to be to ensure that all staff who are hesitant or decline are provided with every opportunity to obtain their vaccine. An opportunity will be provided to staff to discuss the vaccine with a senior clinical member of staff to ensure the decision is fully-informed as part of the process.

7. 2022/23 National Planning Guidance Update

National planning guidance was published on 24 December 2021. Key principles underpinning the planning priorities for 2022/23 include:

- Prioritising the support for the health and wellbeing of staff
- Need to accelerate plans to grow the workforce
- Embedding the learning from the pandemic including adopting new models of care
- Moving back to and beyond pre pandemic levels of productivity

No financial guidance has been formally issued except the 2022/23 National Tariff Payment System consultation. Various briefings and draft guidance signal a move to largely aligned incentive contracts whereby there is a fixed element for an agreed level of activity and a variable element to pick up variances, and a partial movement away from emergency Covid arrangements. Further technical and supporting guidance is expected alongside further detail of the planning process.

The timelines will be shifted back to reflect the current focus on operational pressures with indicative planning deadlines of mid-March 2022 for draft plan submissions and end April 2022 for final plan submissions.

8. Board Visits - Out and About Programme

In November 2021, the Trust launched a scheduled programme of out and about visits for Board members to visit all Directorates, pairing both a Non-Executive and Executive Director. Due to the pandemic, operational pressures and restricted visiting on site, the visits are currently paused and the situation will be reviewed in mid-February.

However, in advance of the new restrictions the following visit took place during November 2021:

Diabetes and Endocrinology [John O'Kane and David Hughes]

- Strategic discussion held with staff around nurse staffing, vacancies and placements for student nurses.
- Ward Brearley 2 visited. This was a busy medical ward with a high proportion of patients medically fit for discharge. Some patients had a notably long length of stay.
- The impact of the Hadfield closure was noted. This had resulted in a number of relocations for the ward team over recent years.
- Observation of the Board Round demonstrated the value of the e-whiteboard as a tool and the role of Physicians Associates.

The visit was hosted by colleagues in the clinical area, Board members would like to extend their thanks to the individuals involved and the courtesy shown during the visit.

9. New Chief Executive Designate of the South Yorkshire integrated Care Board (SYICB)

Gavin Boyle has been appointed as the new Chief Executive designate of the SYICB. Gavin has over 30 years' experience of working within NHS organisations, holding a number of Board-level posts. I look forward to working with Gavin as he takes on his new duties.

10. Chief Executive – Sheffield Children's NHS Foundation Trust

I am pleased to report that Sheffield Children's NHS Foundation Trust announced the appointment of Ruth Brown as substantive Chief Executive on 8 December 2021. Ruth joined Sheffield Children's in 2017 and has been Executive Director of Strategy and Operations, Deputy CEO and most recently Acting CEO for the Trust.

11. Operations Director – Surgical Services

I am pleased to confirm that Caroline Turner has been appointed as Operations Director in Surgical Services. Caroline was previously the Deputy Operations Director in Surgical Services and has been covering as Interim Operations Director since October 2021.

12. South Yorkshire and Bassetlaw Integrated Care System (SY&B ICS)

To note, due to the need to focus on operational pressures, a report from the Chief Executive of SY&B ICS has not been produced. A report will be included in the next Public Board Meeting in March 2022.

Pearse Butler and Gavin Boyle recently wrote to the Trust to explain the delays to the implementation of the Health and Social Care Act due to the need to focus on the operational challenges across the health and care system. This letter can be found at Appendix D.

13. Sheffield Health and Care Partnership

There is no overview report to share for the Sheffield Health and Care Partnership this month. The regular monthly report will resume in February 2022.

Kirsten Major
Chief Executive
25 January 2022

Appendix A

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE

20 DECEMBER 2021

Subject	Maternity Dashboard
Supporting TEG Member	Chris Morley, Chief Nurse
Authors	Ms Fiona Kew, Clinical Director Marie Reid, Midwifery Director Leanne Likaj, Deputy Head of Midwifery
Status[1]	D

PURPOSE OF THE REPORT

To provide the Healthcare Governance Committee with the Maternity Dashboard containing data from October 2021.

KEY POINTS

The report:

- The Local Maternity and Neonatal System (LMNS) Maternity Dashboard, has recently been redesigned following feedback to source data directly from Maternity Services Data Set submissions and to refine some of the thresholds and metrics.
- Provide an overview of Maternity Services' performance benchmarked against a defined set of targets.
- This report provides the detail for October 2021.
- Benchmarking takes place regionally through the LMNS and nationally through the North East and Yorkshire (NE&Y) Regional Perinatal Quality Oversight Group.

IMPLICATIONS[2]

		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓

RECOMMENDATIONS

For the Healthcare Governance Committee to be assured that the Trust utilises a Maternity Dashboard to monitor and track its own performance, make improvements and compare performance at STH with other Trusts within the LMNS.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	8 December 2021	
Healthcare Governance Committee	20 December 2021	

1 Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

2 Against the five aims of the STHFT Corporate Strategy 2017-20

Introduction

The Maternity Dashboard provides a monthly overview of the Maternity Services' performance against a defined set of targets and safety indicators. These targets are taken from national recommendations, Saving Babies Lives version two (SBL V2), NHS Digital Hospital Episodes Statistics (HES) and Healthcare Quality Improvement Programme (HQIP) National Maternity and Perinatal Audit (NMPA).

The indicators shown in Table 1 below are from the LMNS dashboard. Where there is a target specified, the figures are in Green if we are meeting the target and Red if we are not.

Maternity services data is collected in the Jessop Wing Maternity Information System (JMIS) throughout the maternity pathway and this data is submitted nationally as part of the Maternity Services Data Set submissions (MSDS).

Midwifery staffing levels are monitored using Birth rate Plus Acuity tool and this is benchmarked against the National Institute for Health and Care Excellence (NICE) (2015) Safe midwifery staffing for maternity settings. This NICE (2015) document recommends the use of a midwifery red flag event as a warning sign that something may be wrong with midwifery staffing.

The STHFT team will collaborate with the LMNS to ensure that the RAG rating and reporting is benchmarked appropriately. To monitor trends over time, there are a series of charts demonstrating the data over a slightly longer period.

The LMNS Maternity Dashboard, has recently been redesigned following feedback to source data directly from Maternity Services Data Set submissions and to refine some of the thresholds and metrics. Data in tables 1 & 2 are now presented in this new format.

Exception report against red KPI ratings for October 2021

Caesarean Sections

The number of caesarean sections (CS) is higher than the recommended target of 13% for elective CS and 17% for emergency CS. However, this needs to be taken in context with the complexity of case mix at the Jessop Wing and the continued national focus to fully support women's birth choice.

Caesarean section rate targets are based on England HES data for 2019/20 with no variation given for tertiary centres. Benchmarking in a previous report highlighted that the Trust's CS rate was not at significant variation with other maternity units within the Yorkshire and Humber region. The Shelford Group is currently benchmarking CS rates across its members including STH using the Robson Group criteria. The Robson Group criteria classifies all deliveries into one of ten groups using five parameters: obstetric history, onset of labour, fetal lie, number of neonates, and gestational age. Use of the Robson Group criteria allows standardised comparisons of data across organisations and timepoints and identifies the factors driving changes in caesarean section rates.

Massive obstetric haemorrhage

There are different ways of calculating massive obstetric haemorrhage rates. Using the National Maternity and Perinatal Audit definition, the rate is calculated from the population of women who gave birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks and have a post-partum haemorrhage (PPH) of greater than 1500mls. The STH massive obstetric haemorrhage rate using this criterium remains above the target taken from the 2017 audit of 2.9% or less, at 4.2%.

The Yorkshire and Humber Maternity Dashboard calculates the rate from the population of all women who give birth and have a PPH of greater than 1500mls.

Below is a data comparison table using the Yorkshire and Humber Maternity Dashboard definition with units primarily from Yorkshire and the Humber but including Newcastle. These data are from Q2 (Jul-Sep) 2021 as this is the latest information available to us currently.

Trust	Massive Obstetric Haemorrhage rate. (Target < 2.9%)
Sheffield Teaching Hospitals NHS Foundation Trust	5.30%
Barnsley Hospital NHS Foundation Trust	3.00%
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	2.50%
The Rotherham NHS Foundation Trust	2.50%
Hull University Teaching Hospitals NHS Trust	4.30%
Northern Lincolnshire and Goole NHS Foundation Trust	3.30%
York Teaching Hospital NHS Foundation Trust	3.90%
Airedale NHS Foundation Trust	2.40%
Bradford Teaching Hospitals NHS Foundation Trust	3.60%
Calderdale and Huddersfield NHS Foundation Trust	2.40%
Harrogate and District NHS Foundation Trust	4.40%
Leeds Teaching Hospitals NHS Trust	5.40%
Mid Yorkshire Hospitals NHS Trust	4.10%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	4.20%

A series of interventions have been put in place to improve the accuracy of the measurement of blood loss. Under buttock drapes with a measuring pouch have been introduced for all deliveries in lithotomy position, scales to weigh swabs have been purchased and put in every delivery room, a flow chart has been created for accurate measurement of blood loss and the theatre team have been educated regarding marking the suction machine when all liquor has been sucked out at caesarean section. This is helping with more contemporaneous measurement of PPH, which is important in facilitating effective intervention when excessive blood loss is first recognised. Further audit work and improvements are planned over coming months.

In addition, the Trust is working in collaboration with the LMNS to standardise measurement and recording of peri-partum blood loss across Yorkshire and Humber. This work stream is now being taken forward by the Maternity Safety Learning Network (MSLN). Initial scoping work has begun around the standardisation of individual processes and guidelines.

Healthcare Safety Investigation Bureau (HSIB) referrals

During October one case relating to an early neonatal death was reportable to HSIB. Once the HSIB investigation is complete the outcome will be reported to the Board of Directors.

Term admissions to Neonatal Intensive Care Unit (NICU)

In Oct 2021 inborn term admissions to the NNU at the Jessop Wing was above the national target of <5% for the first time since July 2020. There were 31 term admissions born in the Jessop Wing in total, with 4 excluded from the ATAIN review (admitted for congenital anomalies).

All the admissions have been reviewed by the ATAIN team and 10 have been classified as avoidable according to the LMNS classification code. Our normal trajectory is between 2-5 avoidable admissions each month.

- 2 x requiring phototherapy
- 2 x due to unavailability of Transitional Care service because of staffing issues
- 1 x hypoxic brain damage
- 1 x observation
- 2 x raised lactate
- 2 x hypothermia (one also associated with hypoglycaemia)

On reviewing the 17 unavoidable cases, the ATAIN team highlighted an increase this month in babies being admitted with respiratory problems relating to presumed sepsis. The review identified no clinical care issues within this cohort of babies.

The increase in admissions above the 5% target is assessed to be due to a combination of unusual factors and is expected to return (and remain) below 5% in future months. The fact that Transitional Care was closed has contributed towards this, but the 5% target would still have been breached in October had it remained open. Transitional care is currently open.

Ten Steps to Safety – Maternity Incentive Scheme Compliance

A Maternity Incentive Scheme task and finish group has commenced regular meetings to monitor compliance with all ten safety standards. A detailed progress report will be included in the quarter 2 Maternity Safety Report.

Pre-Term Birth Rates

Factors that influence pre-term birth rate figures are Public Health initiatives, all of which are standards for Trusts to achieve through Saving Babies Lives V2 and are monitored through the Maternity Incentive Scheme standards.

Summary

The dashboard will enable oversight by the Board of Directors and the LMNS of themes and trends in maternity outcomes for STHFT.

References

Donna Ockenden (2020) Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. Accessed on 30/04/21 at https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

Healthcare Quality Improvement Programme (HQIP) (2020) - National Maternity and Perinatal Audit (NMPA). Accessed on 30/04/21 at https://www.hqip.org.uk/a-z-of-nca/maternity-perinatal-audit/#.YIvmSJBYaUk

National Maternity Review (2016) Better Births. Improving outcomes for maternity services in England.

NHS Digital (2020) NHS Maternity Statistics, England 2019-20. Accessed on 30/04/21 at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2019-20

NHS England (2019) Saving Babies' Lives Care Bundle Version 2. Accessed on 30/04/21 at https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

NHS England (2020) Implementing a revised perinatal quality surveillance model. Accessed on 30/04/21 at https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

National Institute for Health and Care Excellence (NICE) (2015) Safe midwifery staffing for maternity settings. Accessed on 30/04/21 at https://www.nice.org.uk/guidance/ng4

Online Publication: www.who.int/reproductivehealth/publications/maternal_perinatal_health/robson-classification

Yorkshire and Humber Maternity Dashboard – Core Indicators April –June 2021/22

Table 1. LMNS KPIs

KPI	Detail	Target	August	September	October
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	5.87%	3.85%	4.2%
Smoking at time of delivery		6%	7.41%	9.57%	8.7%
3rd & 4th degree tear	SVD (unassisted)		1.09%	2.64%	2.0%
	Instrumental (assisted)		0.43%	0.61%	1.3%
	Total	3.5%	1.52%	2.64%	3.3%
Caesarean Section rate	Elective	13%	16.30%	13.72%	15.3%
	Emergency	17%	19.26%	18.05%	23.5%
Early Deliveries	Deliveries before 27 weeks gestation		0.43%	0.49%	0.53%
	Deliveries before 37 weeks gestation		8.48%	8.47%	8.68%
Percentage of women placed on CoC pathway		35% (March 21)	0%	0%	0% *
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	0%	0%	0% *
	Area of deprivation	75%	0%	0%	0% *
CoC DQ - Overall DQ	Proportion of women with all data items recorded that are required for the continuity of carer placement measure	80%	0%	0%	0% *
Term admissions to NICU		< 5%	4.37%	3.23%	5.93%
Stillbirths			1	3	2
Serious Incidents			2	0	1
Never Events			0	0	0

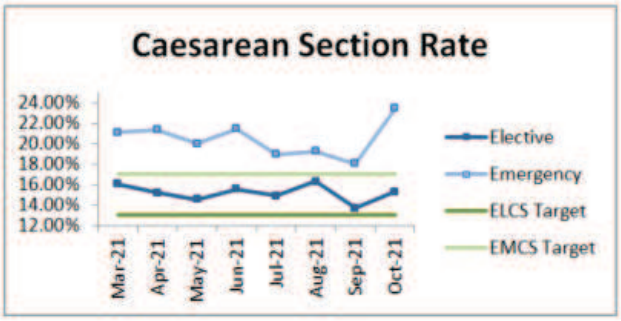
** Please note that with Continuity Of Carer (CoC) suspended, all related figures are expected to be 0%*

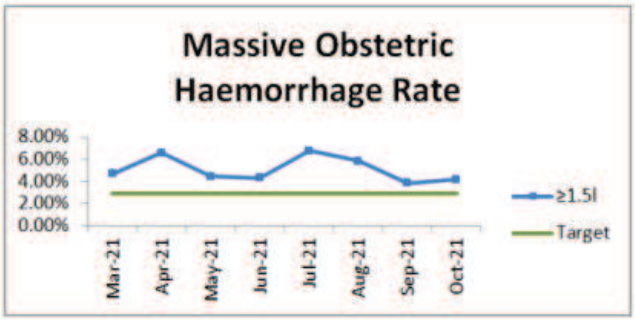
Table 2 – Other LMNS Indicators (October data)

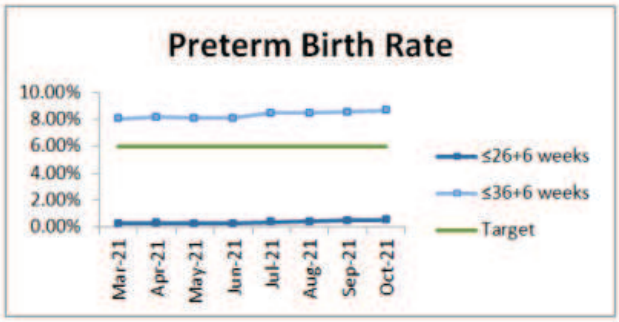
Indicator	Data
Unactioned Datix / Open > 30 days	237
HSIB Cases	1
HIE cases (2 or 3)	0
Neonatal Deaths (Early / Late)	2
Notification to ENS	0
Maternal Mortality (direct / indirect)	0
MW to birth ratio	1:30/1:26 total
Vacancy rate (MW)	4.8% (total) 8% clinical
LW co-ordinator supernumerary (%)	100%

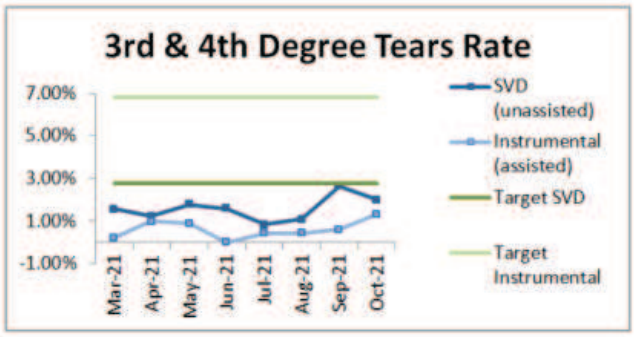
Please note there are no directly comparable data for previous months as indicators have been changed.

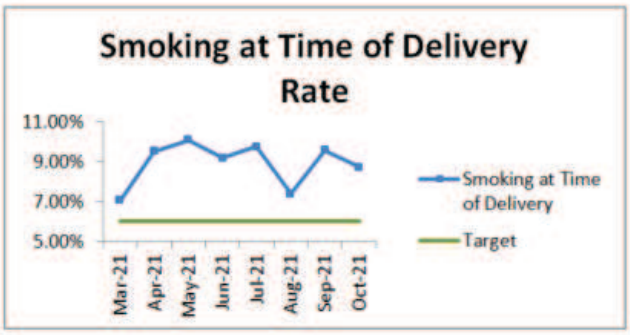
Charts of selected KPIs

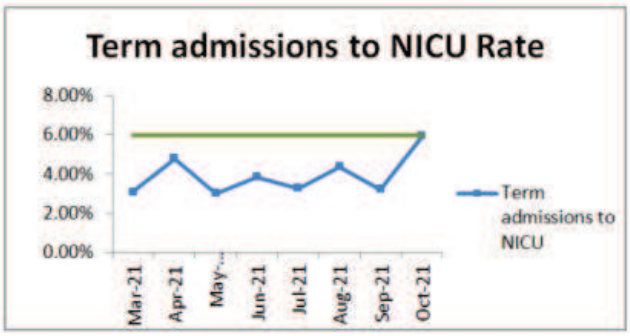












Appendix B

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE TRUST EXECUTIVE GROUP

19 JANUARY 2022

Subject	Maternity Dashboard November 2021
Supporting TEG Member	Chris Morley, Chief Nurse
Authors	Fiona Kew, Clinical Director Marie Reid, Midwifery Director Sue Gregory, Operations Director
Status[1]	D

PURPOSE OF THE REPORT

To provide the Trust Executive Group with the Maternity Dashboard containing data from November 2021.

KEY POINTS

The report:

- Provide an overview of Maternity Services' performance benchmarked against a defined set of targets.
- This report provides the detail for November 2021.
- This month's report has a shorter narrative due to operational pressures
- The report has been produced after the Healthcare Governance Committee, so will go straight to the Board without being reviewed at Healthcare Governance.

IMPLICATIONS[2]

		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓

RECOMMENDATIONS

For the Trust Executive Group to receive the Maternity Dashboard for November 2021 and to debate the performance benchmarked against the thresholds.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	19 January 2022	Y
Board of Directors	25 January 2022	

1 Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

2 Against the five aims of the STHFT Corporate Strategy 2017-20

Introduction

The Maternity Dashboard provides a monthly overview of the Maternity Services' performance against a defined set of targets and safety indicators. These targets are taken from national recommendations, Saving Babies Lives version two (SBL V2), NHS Digital Hospital Episodes Statistics (HES) and Healthcare Quality Improvement Programme (HQIP) National Maternity and Perinatal Audit (NMPA).

The indicators shown in Table 1 below are from the LMNS dashboard. Where there is a target specified, the figures are highlighted Green if we are meeting the target and Red if we are not.

Maternity services data is collected in the Jessop Wing Maternity Information System (JMIS) throughout the maternity pathway and this data is submitted nationally as part of the Maternity Services Data Set submissions (MSDS).

The STHFT team will collaborate with the LMNS to ensure that the RAG rating and reporting is benchmarked appropriately. In addition, further work will be undertaken to ensure that the dashboard used by STH, reports the metrics that the Trust recognise as relevant, and use both target levels and benchmarking to monitor performance as well as meeting the needs of external stakeholders.

To monitor trends over time, there are a series of charts demonstrating the data over a slightly longer period.

Issues to note for November 2021

Caesarean Sections

The number of caesarean sections (CS) is higher than the recommended target of 13% for elective CS and 17% for emergency CS. However, this needs to be taken in context with the complexity of case mix at the Jessop Wing and the continued national focus to fully support women's birth choice.

Caesarean section rate targets are based on England HES data for 2019/20 with no variation given for tertiary centres. Benchmarking in a previous report highlighted that the Trust's CS rate was not at significant variation with other maternity units within the Yorkshire and Humber region.

Massive obstetric haemorrhage

The massive obstetric haemorrhage rate continues to hover around 5% (defined as blood loss greater than 1500mls peripartum) for all deliveries. The national target is 2.9% for women who gave birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks. Comparative data is also problematic because measurement of PPH is inconsistent between units. The Maternity Safety Learning Network has commenced work on standardisation of measurement.

As described in a previous report work continues to reduce the rate. An audit of the use of oxytocics, medication used in the management of the third stage of labour (to deliver the placenta after the baby is born), is currently underway and will report shortly. This will inform our prevention and active management of haemorrhage.

Term admissions to Neonatal Intensive Care Unit (NICU)

In October 2021 inborn term admissions to the Neonatal Unit at the Jessop Wing was above the national target of <5%. For November inborn term admissions to the Neonatal Unit was again below the national target at 2%.

Summary

The dashboard will enable oversight by the Board of Directors and the LMNS of themes and trends in maternity outcomes for STHFT.

Table 1 - LMNS KPIs

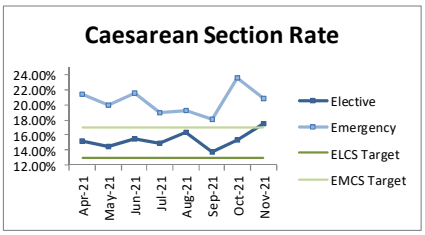
KPI	Detail	Target	September	October	November
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	**3.85%**	**4.2%**	**5.2%**
Smoking at time of delivery		6%	**9.57%**	**8.7%**	**9.3%**
3rd & 4th degree tear	SVD (unassisted)		2.64%	2.0%	1.2%
	Instrumental (assisted)		0.61%	1.3%	0.5%
	Total	3.5%	**2.64%**	**3.3%**	**1.6%**
Caesarean Section rate	Elective	13%	**13.72%**	**15.3%**	**17.5%**
	Emergency	17%	**18.05%**	**23.5%**	**20.8%**
Early Deliveries	Deliveries before 27 weeks gestation		0.49%	0.53%	0.6%
	Deliveries before 37 weeks gestation		8.47%	8.68%	8.8%
Percentage of women placed on CoC pathway		35% (March 21)	**0%**	**0%**	**0% ***
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	**0%**	**0%**	**0% ***
	Area of deprivation	75%	**0%**	**0%**	**0% ***
CoC DQ - Overall DQ	Proportion of women with all data items recorded that are required for the continuity of carer placement measure	80%	**0%**	**0%**	**0% ***
Term admissions to NICU		< 5%	**3.23%**	**5.93%**	**2%**
Stillbirths			3	2	0
Serious Incidents			0	1	2
Never Events			0	0	0

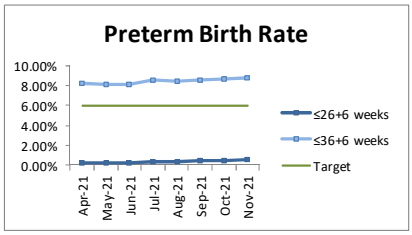
** Please note that with Continuity Of Carer (CoC) suspended, all related figures are expected to be 0%*

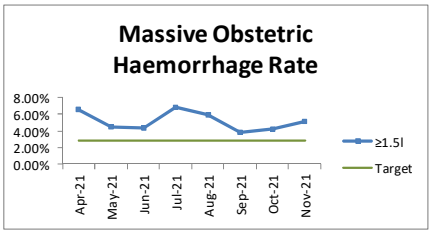
Table 2 – Other LMNS Indicators (November data)

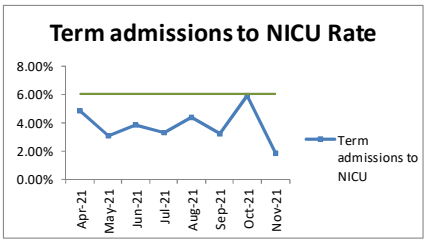
Indicator	Data
Unactioned Datix / Open > 30 days	259
HSIB Cases	0
HIE cases (2 or 3)	0
Neonatal Deaths (Early / Late)	4/0
Notification to ENS	0
Maternal Mortality (direct / indirect)	1 indirect death reported (DoD 2/8/20 but trust not notified until Nov 21)
MW to birth ratio	1:30/1:26 total
Vacancy rate (MW)	4.8% (total) 8% clinical
LW co-ordinator supernumerary (%)	100%

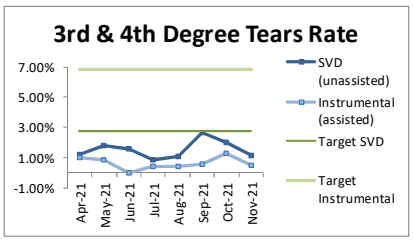
Charts of selected KPIs

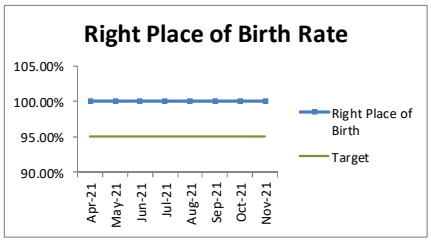


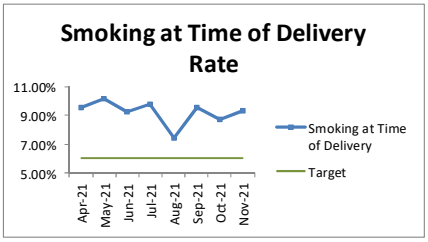












Sheffield Teaching Hospitals
NHS Foundation Trust

Mental Health Strategy 2022 - 2025

Reference Number	Version	Status	Executive Lead(s) Name and Job Title	Author(s) Name and Job Title	
419	3	Current	David Hughes, Medical Director (Development)	Mark Cobb CD Lead for Mental Health	
Approval Body		Mental Health Steering Group		**Date Approved**	23/08/2021
Ratified by		Trust Executive Group Board of Directors		**Date Ratified**	10/11/2021 14/12/2021
Date Issued		18/12/2021		**Review Date**	01/01/2025
Contact for Review Name and Job Title: Mark Cobb, CD Lead for Mental Health					

Associated Documentation:

Trust Controlled Documents

Detention under the Mental Health Act: Policy and Procedures
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy
Policy for Providing Supportive Care to Patients whose Behaviour Challenges the Service (Adults)

Legal framework

Human Rights Act 1988
Mental Capacity Act (2005)
Mental Capacity (Amendment) Act 2019
Mental Health Act (1983)

External Documentation

Centre for Mental Health (2020) Mental health for all? The final report of the Commission for Equality in Mental Health
Centre for Mental health (2021) Covid-19 and the nation's mental health: Forecasting needs and risks in the UK
CQC (2020) Assessment of mental health services in acute trusts
King's Fund (2019) Outcomes for mental health services: What really matters?
NHS (2019) Mental Health Implementation Plan 2019/20 – 2023/24
NHS (2020) Advancing mental health inequalities strategy
Royal College of Emergency Medicine (2019) Mental Health in Emergency Departments: a toolkit for improving care
Sheffield ACP (2021) Mental Health, Learning Disability and Dementia Delivery Board: A Vision for Better Mental Health for Sheffield

For more information on this document please contact

Mark Cobb
CD Lead for Mental Health
Email: markcobb1@nhs.net

Version History

Version	Date Issued	Brief Summary of amendments	Owner's Name:
1	2018	New Strategy	Mark Cobb
2	2020	New Strategy	Mark Cobb
3	18/12/2021	New Strategy	Mark Cobb

Document Imprint

Executive Summary: Mental Health Strategy

Document Objectives:	To set out the key strategic objectives for the care of people in STH who have mental health needs
Group/Persons Consulted:	Mental Health Steering Group Patient and Healthcare Governance Liaison Mental Health Team
Monitoring Arrangements and Indicators:	This strategy will be monitored through the Mental Health Steering Group
Training Implications:	Specific training requirements to underpin this strategy are detailed in a Training Needs Analysis for mental health
Equality Impact Assessment:	Considered as making a positive impact
Resource implications:	
Intended Recipients:	All staff who may be involved in the care of people with mental health needs and the processes that support this.
Who should:-	
➢ be **aware** of the document and ➢ where to access it	Senior managers
➢ **understand** the document	Clinical Directors, Nurse Directors and Matrons
➢ have a **good working knowledge** of the document	Members of the Mental Health Steering Group

Table of Contents

Mental Health Strategy 2022 - 2025

1. WHAT IS GOOD MENTAL HEALTH

The World Health Organisation defines good mental health as "A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community." [1] The scope of this strategy covers all aspects of the mental health of our patients and incorporates the care of patients with learning disability and autism, patients with issues around mental capacity and patients with dementia.

2. WHY MENTAL HEALTH MATTERS TO STH

The mission of the Trust is to improve health and wellbeing, to support people to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives. Mental health is an integral part of health and therefore an integral part of the work of STH. For example, chronic physical and mental health conditions commonly co-exist and research suggests that these patients typically have a poorer health-related quality of life, worse clinical outcomes, and an increased risk of premature mortality than those who have physical conditions alone[2,3]. This strategy therefore recognises the complex interplay between mental and physical health and it does so against a background of rising prevalence of mental health issues in the population and what will most likely be a profound effect on mental health as a result of Covid-19[4]. The strategy also situates the response of STH within the wider 'system' and the mental health pathways our patients engage with, such as dementia care. We cannot achieve our ambitions for mental health without working collaboratively with others. Finally, staff mental health and wellbeing are equally important and are addressed within Staff Health and Wellbeing in the HR portfolio and through the Trust's People Strategy.

3. CURRENT PROVISION OF MENTAL HEALTH CARE

The CCG commissions a Liaison Mental Health service from Sheffield Health and Social Care Trust to work into STH to provide specialist assessment, treatment and advice. The Mental Health Team consists of Liaison Psychiatrists and Mental Health Nurses and for the period of this report they received 2,968 referrals from the Emergency Department and 2,882 referrals from hospital wards. The Liaison service is a member of the Psychiatric Liaison Accreditation Network (PLAN), a quality improvement and accreditation network for psychiatric liaison services in the UK.

4. A SNAPSHOT OF MENTAL HEALTH IN STH

The following snapshot is based on 12 months of data from 2020-2021 that gives attention to the most prominent and documented aspects of mental health in STH. There are on average 320 people per month who attend A&E with a recognised mental health presentation[5]. Almost one third of these people present with suicidal thoughts and nearly one quarter

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[1] World Health Organization (2004) *Promoting mental health: concepts, emerging evidence, practice.* Geneva: WHO

[2] Academy of Medical Sciences (2018) *Multimorbidity: a priority for global health research*

[3] Patel V, and Chatterji S. (2015) *Integrating mental health in care for noncommunicable diseases: An imperative for person-centered care*. Health Affairs, 34(9), pp. 1498–1505.

[4] O'Shea N (2021) *Covid-19 and the nation's mental health Forecasting needs and risks in the UK*. London: Centre for Mental Heath

[5] Source: SNOMED codes in ED records, 2020-2021

attend as a result of poisoning, with a further one in eight presenting with other forms of self-harm. One in six people present at A&E with behaviours of concern and behaviours that are a challenge for staff to manage and/or puts the person or others at risk. This includes people who are in a mental health crisis.

Patients admitted for medical or surgical care on inpatient wards can also have co-existing mental health needs. In the period of this report around 12% (24,382/192,239 admissions in 2020/21) of inpatients had a mental health condition identifiable with an ICD10[6] diagnostic code as detailed in the following table.

Condition	Number
Dementia & Delirium	5,454
Psychoactive substance use[7]	2003
Schizophrenia	720
Bipolar & depressive episodes	7,292
Anxiety & phobias	6,768
Eating disorder	218
Personality disorders	340
Learning disability	982
Autism & Asperger's syndrome	387
Attention Deficit Hyperactivity Disorder	133
Unspecified	85
Total	**24,382**

There were 126 patients treated in STH during 2020-2021 whilst detained under a section of the MHA as detailed in the table below. This is an increase of a third compared to the previous year.

	MHA Section			
Specialty	**2**	**3**	**5(2)**	**Total**
Burns Unit	0	0	1	1
Cardiothoracic Services	1	0	2	3
Communicable Diseases & Spec Med	2	0	4	6
Diabetes/Endocrinology	3	1	3	7
Emergency Department	1	1	0	2
Emergency Medicine	16	3	33	52
Gastroenterology/Hepatology	1	2	2	5
General Surgery	1	0	1	2
General Intensive Care Unit	0	0	2	2
Head and Neck Centre	5	1	4	10
Integrated Geriatric & Stroke Medicine	16	4	2	22

[6] Source. STH ICD10 coding for inpatients 2020-2021

	MHA Section			
Specialty	**2**	**3**	**5(2)**	**Total**
Obstetrics	1	0	0	1
Renal Services	0	0	1	1
Respiratory Medicine	3	1	3	7
Vascular	3	0	2	5
Total	**53**	**13**	**60**	**126**

5. EQUALITY AND HUMAN RIGHTS

People with mental health needs are the subject of societal fear, stigma and discrimination, and there are also profound inequalities across mental health care:

> "Some groups of people have far poorer mental health than others. In many cases, those same groups of people have less access to effective and relevant support for their mental health. And when they do get support, their experiences and outcomes are often poorer, in some circumstances causing harm. This 'triple barrier' on mental health inequality affects large numbers of people from different sections of the population."[8]

The NHS recognises that there is inequality in access, experience and outcomes across different groups who have mental health needs. The available evidence suggests that age, ethnicity, gender, sexual orientation, disability, and deprivation are related to the most pervasive and apparent mental health inequalities.[9] STH has a responsibility to ensure services meet the needs of people from all communities and are "…responsive to the strengths and needs of each individual and community's identity and culture."[10] Legislation underpins this responsibility with a public sector equality duty[11] and makes it unlawful for a public authority to act in a way which is incompatible with someone's human rights[12].

6. STH'S VISION FOR THE FUTURE

- ⇨ We will support patients to achieve the best mental health possible for them and provide the person-centred care they need when they are challenged with mental health problems and illness.

- ⇨ We will recognise and respond to these needs with understanding, kindness, and skill to promote the mental wellbeing and safety of people in our care without discrimination.

- ⇨ We will foster an integrated approach to care that gives equal attention to the mental health needs of patients alongside their physical needs and supports continuity of care and collaboration across mental health pathways.

[8] Centre for Mental Health (2020) *Commission for Equality in Mental Health*.
[9] NHS (2020) *Advancing mental health inequalities strategy*.
[10] National Collaborating Centre for Mental Health (2019) *Advancing Mental Health Equality*
[11] The Equality Act 2010 (Specific Duties) Regulations 2011
[12] Human Rights Act 1988

7. OUR AMBITIONS FOR CHANGE

This strategy sets out our ambitions for 2022 – 2025 and whilst it determines our work plans for this period we will remain responsive to national, regional and local initiatives and incorporate relevant actions where necessary. To develop this strategy we have built on our previous work, reviewed our learning from this period, and taken account of national plans and recommendations. The strategy is focussed on three key ambitions which are set out below along with their underpinning objectives:

1. Quality Care and Support

a. A positive and engaged mental health culture demonstrated through the values, beliefs and behaviours of the Trust and its staff.
b. Training to ensure staff have the relevant skills, knowledge and experience to recognise and respond to the mental health needs of their patients within the context of varied needs of different groups and populations, including intersecting factors.
c. Clinical practices and processes consistent with relevant NICE standards for mental health.
d. Access to effective treatment and support for populations with specific mental health needs (e.g. people with dementia, maternal mental health)
e. Signposting and referral of patients when previously untreated mental health issues are identified.
f. Timely access to liaison mental health, AMHPs and transfers of care to specialist mental health providers.

2. Safe and well governed

a. Identification of and safe care for patients who are at higher risk of self-harm and suicide
b. Provision of safe environments for the assessment and care of patients whose behaviour challenges or who are at higher risk of actions could result in harm or injury to the individual or another person.
c. Systems and practices that ensure compliance with mental health and other relevant legislation
d. Systems of learning to monitor, learn from and make improvements based on safety and quality data that includes patient feedback, the Mental Health Audit Programme, sentinel events and serious incidents, structured judgement reviews, the LeDeR programme and external reviewers' reports.
e. Adopt best practice in harm minimisation, conflict behaviour reduction and violence-prevention climates that take account of key influencing factors including patient characteristics, staff characteristics, the physical environment, and potential flashpoints.

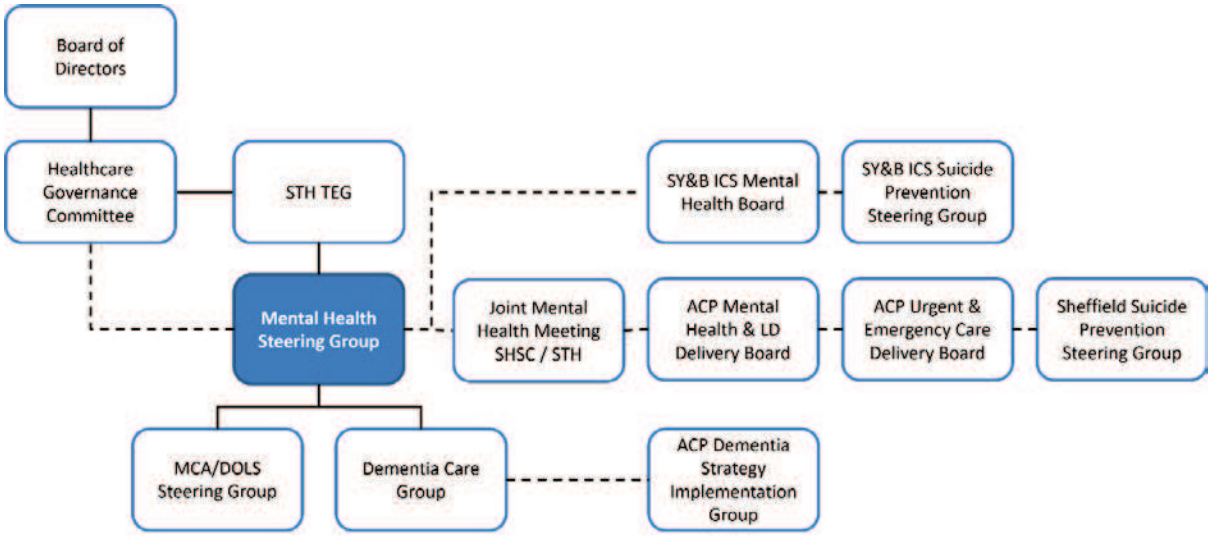
3. Collaboration and partnerships

a. Involvement of people with experience of mental health issues in STH and those who represent them including communities and groups who experience mental health inequalities.
b. Participation in the development of city-wide pathways (e.g. eating disorders, IAPT LTC)
c. Active role in relevant mental health developments and decision making at ACP and ICS level
d. Collaborate effectively with other services involved in mental health including SCH and the Police.
e. Integrated governance arrangements to support the quality and safety of liaison mental health.

8. IMPLEMENTATION PLAN

To achieve the priorities set out above a detailed implementation plan will be developed to support their delivery over the period of the Strategy and will include processes for monitoring progress and outcomes. The Implementation Plan will be overseen by the Mental Health Steering Group.

9. GOVERNANCE



10. RAPID EQUALITY IMPACT ANALYSIS

	- Is there a potential or actual negative impact associated with this policy on people or individuals who share a 'protected characteristic'? i.e. does this policy directly or indirectly discriminate? - Can this policy be used to promote equality between people who share a protected characteristic and people who do not	**NOTES** changes/additions/ further information or advice needed
RACE	The available evidence suggests that age, ethnicity, gender, sexual orientation, disability, and deprivation are related to the most pervasive and apparent mental health inequalities (NHS 2020, Advancing Mental Health Equalities Strategy). This policy includes a recognition of inequalities and strategic aims to advance equalities in access, experience and outcomes for those groups at risk of, or already experiencing, inequalities and ensuring our services meet their needs.	
SEX **(I.E. MALE / FEMALE)**		
GENDER REASSIGNMENT		
DISABILITY(including consideration of the impact on carers of a disabled person)		
RELIGION OR BELIEF		
SEXUAL ORIENTATION		
AGE		
PREGNANCY or MATERNITY		
	Does this Written Policy or Guidance impact on the following areas?	**NOTES** changes/additions/ further information or advice needed
HUMAN RIGHTS i.e. **Fairness** **Respect**	Mental health care and treatment engages a range of	

Equality **Dignity** **Autonomy**	human rights. People with mental health conditions are vulnerable to violations of these rights as they may at times be less able than others to safeguard their own interests. This policy will make a contribution to protecting and promoting their human rights by improving the ability and accountability of the Trust and its staff in fulfilling the rights of people with mental health needs	
SOCIAL DEPRIVATION / TACKLING HEALTH INEQUALITY		

South Yorkshire and Bassetlaw Integrated Care System

Appendix D

South Yorkshire & Bassetlaw Integrated Care System
722 Prince of Wales Road
Sheffield, S9 4EU
Programme Office: 0114 3051905

22nd December 2022

Dear colleagues

Delay to the implementation of the Health and Social Care Act

Clearly Omicron is having a significant impact both nationally and locally, which has meant we have had to adapt some of our usual activity as we focus on handling the operational challenges across our health and care system including delivering the vaccination programme and our surge planning.

You may have seen reports in the HSJ and wider media, suggesting that the implementation of the Health and Social Care Act will be delayed for three months from the 1 April until 1 July 2022. We expect further information alongside the planning guidance, which will be published shortly.

Whilst we await the guidance, we wanted to assure you that any delay does not change our direction. All the work you have put in to-date means that we are in an excellent position moving to statutory arrangements. We have:

- A long history of working together and strong relationships across South Yorkshire and Bassetlaw
- Operating models of partnership working in our Places and Collaborative and Alliances that are well established.
- Made great progress on establishing NHS South Yorkshire and its Board.
- Provided certainty to staff on their future within these arrangements and have begun the recruitment process to appoint to the Board
- A clear and robust approach to organisational transition, which can be flexible to cope with any delay.

Through our design and transition work we have been risk-assessing the impact of any possible delay and we are very confident that any change to the go-live date is manageable. Any confirmed delays will no doubt introduce additional complexities into our transition work, which we will be working through as this become necessary through over the coming weeks.

If there is more time, we will use it well to deepen our preparations and support you with the work you are already doing to develop more integrated services in our Places and in our Provider Collaboratives and Alliances. We will work together to develop a shared sense of our purpose, focusing on the values and behaviours, which will underpin and shape our new organisation and our ICS. We will continue to build on the strong foundations that already exit but also seize the opportunity that system working offers to improve the lives of those we serve, tackle health inequalities and improve population health.

We remain of the view that the proposals set out in the Bill offer us the opportunity, in partnership with our local authorities, primary care, NHS provider organisations, the voluntary sector and others to create an environment where we can listen to our communities and work together in a joined up way to meet their needs. Covid-19 has demonstrated what can be achieved when systems pull together but it has also brought into sharp focus the health and inequalities that exist in our communities. Establishing the Integrated Care System on a statutory footing provides the best ever opportunity to address unfair, avoidable and systematic differences in the opportunity for all our citizens to live healthily and well. We think that's worth getting excited about!

Finally, it is due to the exceptional commitment, dedication and professionalism of all our staff that the transition to new arrangements is being achieved alongside the unprecedented and sustained operational pressures on the health and care system caused by this pandemic. We would like to take this opportunity to acknowledge this and thank you for your continued leadership and all that you are doing.

Our best wishes for the festive season and for new beginnings in 2022.

Yours sincerely,

Pearse Butler
Chair
South Yorkshire & Bassetlaw Integrated Care System

Chair Designate
NHS South Yorkshire Integrated Care Board

Gavin Boyle
Chief Executive Designate
South Yorkshire, Integrated Care Board