Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Quality Report
2019-20

PROUD TO MAKE A DIFFERENCE
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Contents

1. Introduction

1.1 Statement on Quality from the Chief Executive

When 2019/2020 began none of us could have imagined that we would be reporting our performance in the context of the impact of a pandemic which has touched every part of the NHS and all our lives.

The response from our staff across all areas of the Trust has been nothing short of remarkable, both in terms of caring for patients with COVID19, but also the commitment to re-design many services to ensure those patients who needed urgent or emergency care continued to receive it through the outbreak where it was appropriate and safe to do so.

It was inevitable that COVID-19 would impact on our overall performance and achievement of our quality goals but I am pleased to report that there have still been significant developments and improvements in 2019/2020 which are set out in this report.

This Quality Report also outlines our priorities for 2020-21 along with areas where we need to continue to improve.

Ensuring our patients have good clinical outcomes and that our services are centred around them are two of the five main aims of the Trust and to achieve this we strive to do all we can to treat and care for people in a high quality, safe environment which both protects them from avoidable harm and improves their health.

Our drive for continual improvement is embodied within the Trust's Corporate Strategy 'Making a Difference' which is supported by a Quality Strategy and Governance Framework.

Our five aims

- Deliver the best clinical outcomes
- Provide patient centred services
- Employ caring and cared for staff
- Spend public money wisely
- Deliver excellent research, education and innovation

Our Proud values underpin these aims:

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

We also have robust processes in place across the Trust from Board to ward level to ensure we continually monitor clinical safety indicators and outcomes, taking action where issues are flagged or improvements can be made. Our management structure is purposely heavily clinician led and this informs and drives decision making and retains our focus on delivering safe and high quality care.

Our mortality rates and infection prevention metrics continue to be good.

Personalised, responsive and timely care is also important to those patients who are being referred for care which is why we have continued to sustain a strong performance against the 18 week referral to treatment time standards with our performance in the top quartile over the last two years at a national level. We have delivered this through a strong focus on systems, processes, governance and the implementation of national best practice.

Across a number of elective care pathways, service improvement work has continued to identify and remove unnecessary delays and improve the efficiency of care.

Whilst the last three months of the year were dominated by COVID-19, I would like to mention other developments, investments and performance achieved in 2019/20.

Growing demand resulted in even more patients being treated during the year for emergency and planned care compared to 2018/19. We treated around two per cent more inpatients and day cases as well as almost three per cent more outpatients. The number of attendances to our Accident and Emergency Department also increased by almost five per cent.

Delivering safe, high quality care in a timely way continued to be our main priority and we persisted in looking for opportunities to innovate and improve where possible to build on our strong foundations which, when reviewed by the Care Quality Commission in 2018 resulted in a rating of 'Good' overall with many 'Outstanding' features.

Across the five domains that the Care Quality Commission uses, we were rated as follows:

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

These ratings are a testament to all our staff who work hard to do the right thing for our over two million patient contacts every year in our hospitals and community services. In addition to the assessment by the Care Quality Commission, there are a number of indicators and national standards which provide important information about our performance during the year.

- We have continued to work hard so that the vast majority of our patients are seen within 18 weeks from the date their GP refers them for a hospital consultation and have consistently delivered the national 92 per cent standard. Our average waiting time from GP referral to treatment is approximately eight weeks.
- The percentage of patients waiting less than six weeks for a diagnostic test increased to over 99 per cent within the year.
- Whilst we did not consistently achieve the national standard of 95 per cent four hour waiting time standard in A&E, on average we did treat, discharge or admit almost nine out of ten patients (84 per cent) who came to the Accident and Emergency Department within the required four hour timeframe.
- We continued to focus on good infection control and prevention to ensure our patients are as safe as possible. We once again achieved positive ratings for our facilities cleanliness and invested in modernising wards and departments as part of an on-going programme. During 2019/20, we once again had a low level of MRSA bacteraemia cases (3) and the number of cases of C.difficile remained relatively low too.
- We met or exceeded the national standard for urgent cancer referrals being seen within two weeks. However, we underachieved for some of the subsequent treatment standards and we have been working hard throughout the year to address this despite significant growth in the demand for our cancer services.
- We were better than planned in terms of financial performance, despite the year being as challenging as ever.
- Patient surveys and Friends and Family Test feedback were consistently positive. We use this information to seek assurance about where we are getting things right, but more importantly to gain insight into where we may not be meeting patients' expectations and need to learn or change.

Our continuous drive for improvement has resulted in some important enhancements to

safety, clinical care, patient experience and our facilities. A small selection are outlined here.

A new toolkit supporting the safeguarding of children and young people who miss healthcare appointments, often for reasons beyond their control, was launched by the British Dental Association after being piloted by our community and special care dentistry experts. The 'was not brought' toolkit aims to encourage healthcare professionals to consider the child's perspective when they are not brought for healthcare appointments, including dental appointments.

A new pathway was introduced by our emergency care and palliative care teams in partnership with GPs to enable patients nearing the end of life and who arrived at the emergency department to be supported to return to their preferred place of death, which is often their home rather than be admitted to hospital. The pathway includes a 'comfort box' that contains items such as syringe drivers, incontinence pads and mouth care equipment.

The problems of knife crime across the UK's cities are well documented and so we spent time with NHS colleagues in Glasgow to learn how they had played a part in achieving a reduction in the number of young people whose involvement resulted in injury or, sadly, death. As a result of this we worked together with the local Violence Reduction Unit and Sheffield Hospitals Charity to become the first NHS Trust in England to appoint Emergency Department (ED) Navigators. The aim of their role is to work with people affected by violence that come into ED and to guide them to the support they need to make positive changes and lifestyle choices.

We opened an ambulatory care room providing specialist care for patients with respiratory conditions at the Northern General Hospital. The room provides a range of diagnostic procedures and dedicated recovery area, for respiratory and hepatology patients who may previously have had to stay in hospital for treatment. Being treated in the ambulatory facility means they are able to return home more quickly and enjoy a better quality of life, while reducing unnecessary hospital admissions.

Many more examples of improvements made throughout the year are featured on our website www.sth.nhs.uk .

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

This included the continuation of a £30 million theatre refurbishment project at the Royal Hallamshire Hospital and work to install new public and patient lifts. We built two new wards at the Northern General Hospital as well as completing several ward refurbishments. We were very excited to begin planning for a multi-million pound development of Weston Park Cancer Centre, including a new research facility supported by our partner the University of Sheffield. We opened a new walkway which now links Weston Park with Jessop Wing and the Hallamshire Hospital which will make it much easier to transfer patients and be a more pleasant experience for staff travelling between the sites. We also opened a new Brachytherapy Unit and Aseptic Unit to support cancer care.

We completed a new Hyper Acute Stroke Unit at the Hallamshire Hospital along with a new musculoskeletal hub to improve the facilities and care pathway for patients with musculoskeletal conditions. We also opened a new video telemetry unit helping to diagnose patients with suspected epilepsy and sleep and movement disorders.

In total we have invested over £45 million in our facilities and equipment throughout the year.

On top of these developments we continued to invest in IT systems to enhance clinical safety, efficiency and patient experience. During 2019/20 we began to plan for the procurement of a fully comprehensive Electronic Patient Record, which we see as an essential requirement for the Trust to achieve its goal of being paperless. However this had to be paused due to the COVID-19 outbreak and will resume during 2020/21.

It was exceptionally pleasing that national and local survey results consistently showed that the majority of our patients and staff would recommend the Trust as a place to receive care and to work. Our staff also won a number of quality and safety awards throughout the year.

Ensuring the people who work across our hospital and community services are supported, valued and given the opportunity to develop is so important if we are to expect them to deliver the best possible care to patients. That is why we continued to implement our People Strategy which sets out our vision and plans to ensure Sheffield Teaching Hospitals is a 'brilliant place to work' as well as a brilliant place to receive care. We particularly focused on equality and diversity over the last 12 months and created a dedicated Programme Board with a number of hugely enthusiastic staff networks to support this work. The People Strategy also focuses on how we recruit and retain the workforce we need for the future and how we can best support staff health and wellbeing. We are particularly proud to have developed a professional development programme for our administrative colleagues whose work underpins all of our clinical services.

During the last 12 months we have continued to encourage more of our staff to be actively engaged and involved in decisions, setting the future direction of the organisation. We are committed to continuing this important work because we believe our staff are key to the delivery of excellent patient care. It is very important that we value everyone who works in the organisation and the efforts they go to every day to make a difference to our patients.

We also continue to work with the South Yorkshire and Bassetlaw Integrated Care System (ICS) and Sheffield Accountable Care Partnership (ACP). These collaborative structures bring together health and social care organisations across the region and across Sheffield respectively to plan and deliver services jointly better tailored to the needs of the local population. During the year both of these partnerships strengthened and a number of work streams are in place aimed at improving health outcomes and population health.

In summary, we have had a unprecedented year but which once again demonstrated that our ability to innovate, adapt and respond to opportunities and challenges. This has placed us in a good position to deliver safe and high quality care to our patients. We have continued to ensure we create a positive and personal place to work for our staff and we remain at the heart of shaping health and social care with our NHS and other partners. Our continued focus on education and research underpins our curiosity to improve continually.

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

1.2 Introduction from the Medical Director

Quality Reports enable NHS Foundation Trusts to be held to account by the public, as well as providing useful information for current and future patients. This Quality Report is an attempt to convey an honest, open and accurate assessment of the quality of care patients received during 2019/20 at Sheffield Teaching Hospitals NHS Foundation Trust.

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

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

As a Trust, we have considered carefully which quality improvement priorities we should adopt for 2020/21. As with previous Quality Reports, the quality improvement priorities have been developed in collaboration with Governors and with representatives from NHS Sheffield Clinical Commissioning Group and Healthwatch Sheffield.

In developing this year's Quality Report we have taken into account the comments and opinions of internal and external parties on the 2018/19 Report. The proposed quality improvement priorities for 2020/21 were agreed in November 2019 by the Trust Executive Group, on behalf of the Board of Directors. The final draft of the Quality Report was sent to external partner organisations for comments in September 2020 in readiness for the revised publishing deadline of 15 December 2020.

Dr David Hughes
Medical Director

2. Priorities for Improvement

This section describes progress against the priorities for improvement during 2019/20 and provides an update on progress in relation to improvement priorities from previous years. In addition, priorities for 2020/21 are outlined, along with an explanation of the process for their selection.

2.1 Priorities for Improvement 2019/20

Reduce the number of referrals logged on Lorenzo after 30 days of receipt in order to reduce delays in patient journeys

Background

The aim of the objective was to ensure patients do not face unnecessary delays at two stages of the patient journey. Firstly, the recording of received paper referrals onto the patient administration system, and secondly, the clinical review and allocation of these paper referrals to the correct service.

Achievements against objective

Achievements are described below. We consider that overall the objective was *partly achieved.*

Following the establishment of the quality objective two key changes were made. Firstly the threshold for the cases requiring investigation was reduced to 20 days in the first instance, with a view to further reductions over time. Secondly the reasons for delays were analysed in a number of apparently poor performing areas.

The findings from the investigations revealed the following two main causes:

- A large number of the apparent delays were not actually delays. They reflected patient pathways where patient activity was added to the main patient administration system retrospectively, to ensure payment to the Trust for the activity carried out, however this was after the patient had been seen and treated in a timely manner. The preferred solution to this problem is to use electronic automation to ensure actions carried out in parallel systems are automatically synchronised daily with the Patient Administration System cutting out the delay. Whilst the Trust has a piece of technology believed to be is capable of achieving this automation, the developer post that supports it has been vacant. This post is now filled and the work will be commissioned from the IT department in 2020.
- Issues relating to processes in some departments. Where this was identified meetings were held to review their processes and set in place action plans to address the delays. This work is on-going and will continue to be overseen by the Electronic Referral System (ERS) Programme Board.

Over the last 12 months the number of patients facing a delays in the recording of their referrals has reduced by just under 1/3 (1178) with a further 1/3 reduction possible from the automation solution. Work relating to the delays in clinical review and allocation of referrals to the correct service has not made the same level of progress so this will be a continuing focus for the ERS Programme Board during 2020/21.

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

Background

It is well recognised that within healthcare a wealth of data is collected and analysed on a regular basis. Review of this data however is often retrospective and provides only a look back on what has already happened. Whilst such retrospective data is helpful in enabling predictions of expected future activity, or

guidance on actions that can be taken with an aim to improve future care, treatment and experiences, an ability to obtain a more 'real time' understanding of issues would allow for early preventative action.

Achievement against the objective

Achievements are described below. We consider that overall the objective was *achieved.*

The Trust has undertaken a scoping exercise to better understand what real time metrics are already available and in use across the organisation and how these can be supported by any additional tools. The work has involved the following:

- a mapping exercise of key systems and safety data currently available allowing proactive monitoring of emerging risk.
- exploring principles to be used to trigger a 'deep dive' review of areas where data indicate an emerging theme.
- a multi-disciplinary staff consultation on the use of an interactive web based tool to gather real time staff feedback.

In addition the Trust has successfully introduced electronic recording of patients' clinical observations in all inpatient wards across the Trust. This enables immediate identification of any areas with patients who are triggering on the National Early Warning Score and require clinical support and escalation.

Work on completing the final report with recommendations was paused during COVID-19. This has now recommenced and will be produced during September 2020. Following approval of the report, actions to take forward the recommendations will be agreed with implementation commencing in October 2020.

Evaluate new inpatient and outpatient patient letters, consulting widely with patients, including those from seldom heard or hard to reach groups.

Background

As part of the Quality Improvement priorities for the Trust, it has been identified that there is a need to ensure all outpatient and inpatient letters are fit for purpose. The focus has been on improving the letters to ensure that they are clear and understandable, and meet the needs of patients and national good practice guidelines.

Achievement against the objective

Achievements are described below. We consider that overall the objective was *partly achieved.*

The Trust has worked over the last year to:

- Review all the appointment letters to patients currently held within the Trust's Electronic Patient Record system (EPR).
- Review and amend the existing content of our letters to ensure that they are:
  - Professional and compassionate
  - Easy to understand
  - Incorporating national requirements, include pictures and symbols
  - Incorporating Accessibility Standard Guidance to make it clear that letters are available in Braille, large print and encouraging patients to ask for any other method of communication that they might need.
- Understand the EPR System potential to support the required improvements to the presentation of the letters.
- Hold patient forums to obtain feedback and suggestions for content and improvements to the letters and to review proposed replacement letters.
- Produce standardised letter templates as agreed at the patient forums.
- Commence a roll out programme across the Trust to replace existing letters.

In addition, the Trust has undertaken to:

- Establish a change control process for any requests for additional appointment

letters to ensure that all letter content is in line with the new standardised requirements and layout.

- Establish an Accessible Information Standards Group to review the process for supporting patients who require information in non-standard formats.

To measure the success of the new letter, an evaluation of the new format commenced in March 2020 which included consulting widely with patients, to ensure the Trust has achieved its objective. Positive feedback was received however the evaluation was paused due to COVID-19, and as a result the number of responses was low. Work to review feedback received has now started and improvements to the letter content will be made to ensure patient need is met. Final sign-off will be sought from the Change Control Board by the end of August 2020 to commence the process of converting all letters to the new format.

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

Background

The Trust is committed to delivering high quality customer care across all services. We have previously developed a set of customer service standards for administrative and clerical staff and it was agreed to also develop a toolkit to improve customer care in inpatient areas. The toolkit will promote the best practice from across the Trust to improve the patient experience in inpatient areas.

Achievement against the objective

Achievements are described below. We consider that overall the objective was *achieved.*

During 2019/20 the project has progressed to agreed timescales and included:

- A review of patient experience feedback from inpatient areas across the Trust.
- A series of observational visits, interviews with patients, visitors and staff from three wards identified as exemplars in customer care.
- Discussions with the Podiatry Service regarding the Customer Services Excellence Award held by the service.
- Scoping of currently available in-house customer care training available to clinical staff.
- Scoping of customer care training available in leadership packages and through Organisational Development and discussion with the Leadership Development Team to further incorporate customer services within training programmes.
- Review of national guidance, toolkits and self-assessment checklists relating to customer care.

A toolkit has been developed which provides an overview of customer services, self-assessment tools, how to access patient feedback and training available to staff.

2.2 Update on progress against previous priorities for improvement

Mortality Rates

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Another mortality indicator is the Hospital Standardised Mortality Ratio (HSMR). The SHMI includes all deaths which occurred in hospital or within 30 days of discharge, while the HSMR includes 56 diagnoses which account for around 80 per cent of in hospital deaths. Another difference between these two indicators is that the case-mix adjustment variables differ between the SHMI and the HSMR. For example, the HSMR includes an adjustment for palliative care whereas the SHMI does not.

The Trust's SHMI remains in the 'as expected' range (0.997 for October 2018 - September 2019) and the monthly HSMR figures since April 2019 have also been within the 'as expected' range. During 2019/20 the Trust's HSMR for the rolling average period December 2018 to November 2019, was showing as 'higher than expected' (106.7) which was unusual given the history of the Trust's mortality ratios. Discussions have been on-going with Dr Foster Intelligence, who collect and publish the data, to understand the change. Some issues have been identified with the source data and remedial action has been taken to address these. Work will continue during 2020/21 to ensure the correct risk adjustments are being included in the calculation of 'expected' deaths. We will continue to scrutinise both mortality indicators to identify any variations and to inform our on-going quality and safety work. This work is now being overseen by the Mortality Governance Committee.

2.3 Priorities for Improvement 2020/21

This section describes the Quality Improvement Priorities that have been adopted for 2020/21.

To ensure the Trust is constantly moving forward to improve our patient experience and care, new Quality Objectives are selected each year.

Following agreement last year, three Quality Objectives for 2020/21 have been agreed by the Quality Board in conjunction with patients, clinicians, governors and Healthwatch Sheffield. These were approved by the Trust Executive Group, on behalf of the Trust's Board of Directors, in November 2019.

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

The objectives for 2020/21 are as follows:

Safety

- Further improve the recognition and timeliness of the management of deteriorating patients leading to improved patient care and outcomes.

Patient Experience

- Complete an end to end review of the complaints process to identify areas of good practice and areas for further improvement.

Effectiveness

- Further reduce the number of outpatient appointments cancelled by the Trust.

COVID-19 has necessitated a redesign of our outpatient service and a substantial shift to virtual (non face to face) consultations. This objective is now deemed inappropriate and has been amended. The key priority for our outpatient improvement work during 2020/21 will be to return to 90% pre-COVID outpatient activity, in line with NHSE guidance.

These three Quality Objectives span the domains within the Trust's Quality Strategy of patient safety, clinical effectiveness and patient experience.

How did we choose these priorities?

Discussions and meeting through the Trust's Quality Board which includes Healthwatch representative, Trust governors, clinicians, managers, and members of the Trust Executive Group and senior management team.

Consideration also included the priorities identified by patients and staff during the Quality Strategy consultation.

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

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

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

2020/21 Objectives

Safety

Improve the recognition and timeliness of the management of deteriorating patients leading to improved patient care and outcomes

Objective breakdown:

This is a one year objective.

The purpose of this objective is to create a Trust-wide dashboard that would give an understanding of where and when patients are deteriorating, and guide improvement work to support the timely management of the deteriorating patient.

Work will involve:

- Ensuring observations from inpatient and acute assessments are recorded electronically.
- Developing a dashboard to better understand our deteriorating patients.
- Establishing a defined and consistent response to deterioration of patients as defined by NEWS2 scores.

Objective output/metrics:

The primary output will be completion of the full Trust-wide implementation of electronic observations within the E-whiteboard, and the development of ward level dashboards to better understand our deteriorating patients.

Patient Experience

Complete an end to end review of the complaints process to identify areas of good practice and areas for further improvement.

Objective breakdown:

This is a one year objective.

The purpose of this objective is to agree changes to the complaints process to ensure a process which provides a personal approach, seeks to resolve concerns and restore trust, and drives improvements to services.

Work will involve:

- Undertaking a baseline staff survey and, through a number of different approaches, completing a 'check and challenge' of the current complaints process.
- Implementing a new complainant satisfaction survey to focus on a small number of critical measures of the process from the perspective of the complainant.
- Finalising and implementing proposals for a new process, based around core principles to ensure a personal approach with a focus on resolution and improvement.
- Agree an implementation plan to operationalise the new process. This will include putting in place new ways of working, agreeing new measures of performance, and delivering scheduled complaints training sessions for directorates to commence implementation of the new approach at local level.

Objective output/metrics:

At least 50% of complaint responses will identify, at sign-off stage, the nub of the complaint and the expectations of the complainant from the complaints process along with clear, auditable actions where appropriate.

Improved feedback from patients / families about the complaints process and more complaints resolved quickly and informally.

Effectiveness

Further reduce the number of outpatient appointments cancelled by the Trust.

As explained above, this objective is now deemed inappropriate and has been amended. The key priority for our outpatient improvement work during 2020/21 will be to return to 90% pre-COVID outpatient activity, in line with NHSE guidance.

2.4 Statements of assurance from the Board

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

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

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

a. Services provided

During 2019/20, Sheffield Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 74[1] relevant health services. Sheffield Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 74 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 100 per cent of the total income generated from the provision of relevant health services by Sheffield Teaching Hospitals NHS Foundation Trust for 2019/20.

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

b. Clinical audit

During 2019/20, 62 national clinical audits and 2 national confidential enquiries covered relevant health services that Sheffield Teaching Hospital NHS Foundation Trust provides.

During that period Sheffield Teaching Hospital NHS Foundation Trust participated in 100 per cent of national clinical audits and national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate. The national clinical audits and national confidential enquiries that Sheffield Teaching Hospital NHS Foundation Trust was eligible to participate in during 2019/20 are documented in the table below. The national clinical audits the Trust has not participated in are detailed later in the section.

The national clinical audits and national confidential enquiries that Sheffield Teaching Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

[1] Defined as specialities provided on an out-patient basis

Fig: Audit and confidential enquiries

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
Acute care		
Case Mix Programme (CMP)	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Major Trauma Audit	Yes	100%*
National Emergency Laparotomy Audit (NELA)	Yes	99%
National Joint Registry (NJR)	Yes	98.8%
National Neurosurgery Audit Programme	Yes	100%
National Ophthalmology Audit	Yes	100%
Nephrectomy audit	Yes	50%
Percutaneous Nephrolithotomy (PCNL)	Yes	88%
Cystectomy	Yes	35%
National Bariatric Surgery (NBSR)	Yes	100%
Stress Urinary Incontinence Audit	Yes	63%
Radical Prostatectomy Audit	Yes	55%
Mandatory Surveillance of Bloodstream infections and clostridium difficile infection	Yes	100%
National Audit of Seizure Management in Hospitals (NASH3)	Yes	100%
National Smoking Cessation Audit	Yes	50%
Perioperative Quality Improvement Programme (PQIP)	Yes	9.6% - See Supporting Statements
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) Summer 2019 data collection	No	See Supporting Statements
Society for Acute Medicine's Benchmarking Audit (SAMBA) Winter data collection	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD):		
Dysphagia in Parkinson's Disease	Yes	83%
Out of hospital cardiac arrest	Yes	87%
Child Health Clinical Outcome Review Programme:		
Long term ventilation in children, young people and young adults	Yes	85%
Blood and transplant		
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
National Comparative Audit of the Medical Use of Blood (red cells)	Yes	100%

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
Cancer		
National Lung Cancer Audit (NLCA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Gastro-intestinal Cancer Programme:		
National Bowel Cancer Audit (NBOCA)	Yes	89%*
National Oesophago-gastric Cancer (NOGCA)	Yes	80%*
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%*
Adult Cardiac Surgery	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	88.14%
National Heart Failure Audit	Yes	100%*
National Audit of Cardiac Rehabilitation (NACR)	Yes	100%
National Vascular Registry		
National Carotid Interventions Audit	Yes	100%*
Abdominal Aortic Aneurysm (AAA)	Yes	100%*
Peripheral Vascular Surgery – Lower limb angioplasty/stenting	Yes	47%*
Peripheral Vascular Surgery – Lower limb bypass	Yes	79%*
Peripheral Vascular Surgery – Lower limb amputation	Yes	20%*
Long term conditions		
National Audit of Pulmonary Hypertension	Yes	100%*
UK Cystic Fibrosis Registry	Yes	100%
National Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	80%
UK Parkinson's Audit	Yes	100%
Adult Asthma and COPD (COPD) Audit Programme (NACAP):		
COPD	Yes	98%
Adult Asthma	Yes	7% - See Supporting Statements
Pulmonary Rehabilitation	Yes	67.8%
Inflammatory Bowel Disease (IBD) programme	Yes	See Supporting Statements
National Audit of Dementia: Spotlight audit on psychotropic medication	No	See Supporting Statements

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
National Diabetes Audits:		
National Diabetes Audit: Insulin Pump	Yes	100%
National Diabetes Foot care Audit	Yes	32.7%*
National Diabetes Inpatient Audit	Yes	100%
National Diabetes Inpatient Audit HARMS	Yes	100%
National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Audit - Adults	Yes	100%
Mental health		
Mental Health – Care in Emergency Departments	Yes	100%*
Older people		
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Assessing Cognitive Impairment in Older People/Care in Emergency Departments	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP):		
National Hip Fracture Database	Yes	104.2%**
National In Patient Falls	Yes	100%
Other		
Elective Surgery (National PROMs Programme)	Yes	Not published nationally to date'
National Audit of Care at the End of Life (NACEL)	Yes	100%
Women's and children's health		
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%

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 therefore final figures may change.*

*** case ascertainment is difficult to measure since the NHFD typically reports on more cases than are captured by alternative data sources HES and PEDW, which could leave "case ascertainment" figures of >100%. Instead we comment on the number of patients submitted to NHFD in the 2019 calendar year compared to the number of patients submitted to NHFD in 2018 calendar year*

Supporting statements

Society for Acute Medicine's Benchmarking Audit (SAMBA) Summer 2019 data

Data not submitted for Society for Acute Medicine's Benchmarking Audit (SAMBA) Summer 2019 due to lack of resource. A local data collection was carried out. The results will be benchmarked against the national results. The Trust did submit data to the Winter SAMBA.

National Audit of Dementia Spotlight Audit, Prescription of Psychotropic Medication

Data was not submitted, for the National Audit of Dementia Spotlight Audit, Psychotropic Medication, due to limited resource to collect data and meet the deadline for submission nationally. A local data collection carried out from August till October 2019 has shown that our compliance to the national standards was very good.

Adult Asthma

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. We will continue to enter 10 patients per month so that a sample of our care is included in the national reports.

IBD Registry

Resource to upload information to the IBD Registry has continued to be limited in 2019/20. The Directorate continue to look at ways to engage effectively with the IBD Registry project. This has included appointment of additional IBD specialist nurses and additional administrative time. COVID-19 has presented further clinical demands on the Directorate which has impacted their ability to submit data.

Perioperative Quality Improvement Programme (PQIP)

PQIP has confirmed that STH recruited 25 patients to the PQIP study in 2019/20. As the study is voluntary, an advisory target of 5 patients per week is set, but PQIP recognise that some sites will have more capacity to achieve this than others and recruiting lower numbers does not preclude a site from participating.

Examples of Quality Improvement as a result of audit work

The reports of 31 national clinical audits were reviewed by the provider in 2019/20 and examples of the actions that Sheffield Teaching Hospital NHS Foundation Trust intends to take to improve the quality of healthcare provided are included below:

National Audit 1: National Emergency Laparotomy Audit (NELA)

National Emergency Laparotomy Audit (NELA) is a continuous data collection measuring the quality of care and outcomes for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers of emergency laparotomy.

NELA patients require prompt diagnosis and treatment of any sepsis or underlying disease, assessment of risk, provision of care according to risk, and access to theatre without delay. By analysing patient and surgical characteristics NELA can investigate processes of care and outcomes, and highlight if there is variation for any specific patient group (e.g. older patients) or for different operations performed. For patients, this means that they can be assured that providers are continually assessing whether their patients are receiving the best possible patient centred care. The audit seeks to address a number of standards including consultant surgeon and anaesthetist review prior to surgery, timely admission to theatre and discharge and future recovery.

- A NELA Steering Group has been established including key surgical, theatre, anaesthetic, nursing and Organisational Development members of staff
- NELA Quality improvement work was started in 2019
- A pre and post-op pathway devised by the NELA Steering Group was signed off by the Trust Executive Group (TEG) and launched in July 2019
- There is a recruitment plan for a NELA Specialist Nurse

The Quality Improvement work started at STH in 2019 has resulted in a much improved performance for Year 6 (patients who underwent an emergency laparotomy between 1 December 2018 and 30 November 2019).

For Financial Quarters 2 and 3 the Trust has achieved:

- Best Practice Tariff (the enhanced tariff will be paid if 80% of high risk patients have a consultant surgeon and consultant anaesthetist present during surgery and are admitted to critical care). STH achieved 85.2%
- 100% case ascertainment

Improvement is evident in the following areas, though it is accepted that case ascertainment previously was low and comparisons are therefore made with caution:

- Mortality rate
- Documented pre-operative risk assessment
- Frailty Assessment (over 70s)
- CT scan reported by Consultant Radiologist
- Patients requiring immediate surgery in theatre within 2 hours
- Theatre within six hours of decision to operate
- Consultant Surgeon present NELA pre-op risk of death ≥5%
- Consultant Anaesthetist present NELA pre-op risk of death ≥5%
- Critical care post-operatively

Booked NELA CT scans have shown an improved time to scan and report compared with those booked via the normal route, demonstrating that this part of the pathway has improved care. The Trust continues to look at ways to increase the number of patients over 70 years old receiving an assessment by an elderly medicine specialist.

The NELA Steering Group is working with the Emergency Department (ED) to implement updated ED guidance on NELA suitable patients in 2019 in collaboration with General Surgery and Critical Care. The guidance includes prescription of broad spectrum antibiotics for this patient group and is available on the Trust intranet.

Further areas for development being considered:

- Antibiotic order sets on the Trust Electronic Prescribing and Medicines Administration system (EPMA) are currently being developed.

Quality improvement work to ensure CT results are reported within a time frame that does not delay surgery and has low discrepancy rates.

National Audit 2: National Asthma and COPD Audit Programme - Adult asthma and COPD Organisational Audit Report 2019 (published March 2020)

The Northern General Hospital is fully compliant with the 7-day working key standards for this audit. This case study by Dr Rod Lawson was included in the national report.

Specialist 7 days a week respiratory service

- The Northern General Hospital aims to deliver a specialist, 7-day a week consultant-led respiratory service, maximising specialist nursing input.
- Patients are identified for specialist respiratory care by addition to a list on an electronic white board.
- Patients are triaged to the respiratory list from the emergency department (ED) or via the single point of access for community referrals.

- The white board also separately records general patient reviews, and reviews on the respiratory post take ward round (PTWR) delivered by consultant respiratory physicians.
- Usual review is on an acute medical unit (AMU) before transfer to a base respiratory ward, but reviews also occur at other locations (ED, clinical decision unit, non-respiratory base ward).
- A PTWR commences at 8am, 365 days per year, and sees all respiratory admissions from the last 24 hours not yet seen by a consultant.
- A 'hot take' after the PTWR, seeing new respiratory admissions and problem solving occurs until 7pm on weekdays.
- At the consultant PTWR, a green PTWR sheet, detailing the summary of investigations, diagnosis and clear management plan, is added to the paper patient record.

For patients with COPD

- Admissions with (or likely to have) COPD are identified daily from the electronic white board by COPD specialist nurses, 365 days per year.
- Patients are reviewed on the same day by specialist nurses who check diagnosis, review treatment, check inhaler technique, provide education, refer to smoking cessation /pulmonary rehabilitation / community respiratory / mental health teams and triage to early supported discharge. Repeat visits are provided as required.
- The nursing team complete a single page pro forma, added to the notes alongside the consultant PTWR plan including lung function, historical oxygen saturations and appropriate input post discharge.
- Electronic notes are also made on SystemOne, shareable with the community team who may receive referrals, and are visible to two-thirds of Sheffield GPs.
- A weekly multidisciplinary team (MDT) meeting (between hospital and community team colleagues) reviews patients from this process.

For patients with asthma

- Asthma nurse specialists review the electronic white board twice daily during week days and visit patients identified as being admitted with asthma.
- Nurses carry out a review of diagnosis and management which includes a review of concordance and inhaler technique.
- Patient education is undertaken with advice about the need for early primary care review; all patients reviewed are supplied with an Asthma UK action plan. Complex patients with asthma are discussed at the weekly Asthma MDT.

National Audit 3: National Neonatal Audit Programme (NNAP) 2018

The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high-quality care measured against standards from the RCPCH (Royal College of Paediatrics and Child Health). The programme is wide ranging covering aspects of care from medication given to the mother before delivery to 2-year follow-up of babies. It includes neonatal outcomes as well as issues such as communication with parents of babies on the neonatal unit.

The Jessop Wing results show an improvement for all standards compared to 2017, some of the significant results were:

- 71% (93/131) babies born at less than 32 weeks admitted to the neonatal unit had their first measured temperature of 36.5-37.5°C within an hour of birth. This is significant as cold babies have an increased risk of complications.
- In 98.2% (536/546) cases there was a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission.
- 85% (23/27) of babies had documentation of 2-year follow-up.

Resulting actions:

- The Jessop Wing has undertaken a number of linked projects which assess these issues in more detail.
- The thermoregulation guideline is being updated in relation to the thermal care of preterm babies across the gestational ages to reflect changes in practice resulting from continuous audit and exception reporting over the last 2 years. Hypothermia is also a recognised contributing cause of admission of term babies to the NNU and is monitored through the ATAIN project (Avoiding Term Admissions into Neonatal Unit).
- Written documentation to be given to families on discharge with a 2-year follow-up appointment date on it is being produced.
- Actions have been taken to look at ways of supporting the retention of nursing staff completing additional training.

In summary the Jessop Wing results show improvements in many areas of care. Robust action plans are in place to further improve care and include more detailed local audits.

Confidential Enquiries

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

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

Local Clinical Audits

The reports of 90 local clinical audits were reviewed by the provider in 2019/20 and Sheffield Teaching Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit 1: Re-audit of adherence to NICE TA 339 for Omalizumab for previously treated chronic spontaneous urticarial

Urticaria is defined as “a condition characterised by development of wheals (hives), angioedema or both” and further classified as acute (<6 weeks) or chronic (>6 weeks). Urticaria can develop in response to known or unknown precipitants and can be inducible. Initial treatment for chronic spontaneous urticaria is long acting anti-histamines, when these treatments fail despite optimisation, Omalizumab is considered.

The aim of the audit was to ensure that all patients on Omalizumab for spontaneous urticaria adhere to the NICE guidance for implementation, review and cessation. The objectives of the audit were:

- To ensure greater awareness of and adherence to the current NICE guidance.
- To ensure patients are not unnecessarily started on or continued on a therapy with potentially harmful side effects.
- To improve efficiency of the service provided.

The first audit demonstrated full compliance with the standards. The limitation was that a small sample size was used. Actions were implemented to improve the information available on the internal database recording the use of Omalizumab. In addition, a pro forma was designed detailing the NICE criteria to enable staff to easily document compliance with the guideline and this is included in the patient record.

The re-audit also showed full compliance and demonstrates that the Trust are safely prescribing and monitoring the use of Omalizumab for previously treated chronic spontaneous urticaria as per NICE guidance.

Local Audit 2: Re-audit of documentation and actions when children are not brought for paediatric dentistry appointments at Charles Clifford Dental Hospital

Children's missed healthcare appointments are a safeguarding concern and should be followed up. Previous departmental and Trust audits have shown deficiencies in documentation when children are not brought for appointments. Although an increase in information sharing was demonstrated in previous audits, there was still room for improvement in terms of follow up measures. On-going discussion with Named Professionals for Safeguarding Children and with the Paediatric Liaison Nurse has identified, in cases of concern, uncertainty around dentists' decision-making and action planning, specifically whether dentists have reviewed the records and assessed the risk to the child. Furthermore, NICE CG89 suggests neglect should be considered if NHS dental treatment is not sought, compromising the wellbeing of the child.

The aim to identify whether dentists are following the Trust protocol for management of patients who are not brought for dental appointments in the paediatric dentistry clinic was supported by the following objectives:

- Assess if missed appointment history has been accurately recorded in case notes as per patient appointment system.
- Establish compliance of missed appointments being followed up within the paediatric department.
- Ensure legible documentation of all missed appointments with an action plan including:
  - whether the dentist has assessed risk of harm to the child
  - the decision whether or not to share information
  - and with whom (school nurse, safeguarding lead, paediatric liaison nurse, social worker, health visitor)
  - actions taken
  - any follow up required

Improvements have been seen from cycle one to cycle three. The risk score has reduced from 8 to 6 with further actions in place to reduce this. CCDH are part of the Outstanding Outpatients Group. The team are working toward the HIPPO model to improve standards in Out-Patient areas specifically in relation to booking processes and cancellations of appointments. A re-audit is planned in 2020.

c. Clinical research

The number of patients receiving NHS Services provided or subcontracted by Sheffield Teaching Hospitals in 2019/20 that were recruited to studies during that period to participate in the National Institute of Health Research (NIHR) portfolio research trials was 6601.

Patient and public involvement and engagement

During 2019/20, the Trust has been building on its already significant patient and public involvement and engagement activity. We have continued to promote, support and develop the activities of the existing public involvement groups and panels, to ensure that research at the Trust is relevant and of clear benefit to patients.

The Clinical Research and Innovation Office (CRIO) previously reported on their selection to be one of ten ‘test bed’ sites in the UK that trialled a set of national standards for public involvement in research. This project came to a conclusion in May 2019 and their experiences fed into the production of a final set of Standards that were launched in November 2019. Going forward, the launch of these Standards has, and will, enable us to continue to make meaningful changes and improvements across our public involvement activities. Locally, involvement in this project continues to lead to improved collaborations with other departments across the Trust including strong partnerships with the National Institute for Health Research funded infrastructures hosted at Sheffield Teaching Hospitals.

Nationally, the experiences and feedback from our involvement in the Test Bed project will be captured in case studies being developed by the National Institute for Health Research Standards Partnership to provide guidance and support for other organisations and groups seeking to improve the quality of their

public involvement activities. Additionally, our involvement in this project has led to opportunities to present and showcase our work at events both regionally and nationally, and we've recently had abstracts accepted for presentation at the national NHS R&D Forum Annual Conference.

As well as the invaluable role they play in contributing to developing research at the Trust, public involvement contributors have continued to make a substantial impact to research nationally by co-authoring journal publications, sitting on Trial Steering Committees for large National Institute for Health Research funded grants led by the Trust, being lay members on Research Ethics Committees, and championing research across the region. The involvement and experiences of these individuals are shared with other public contributors from the Trust via a bi-annual Patient and Public Involvement newsletter.

In order to increase diversity of representation of our public involvement groups, and ensure accessible opportunities for underserved groups or communities to get involved in research, increasing awareness of research is fundamental. To this end, the Collaborative Patient and Public Involvement and Engagement group have been engaging with different groups and networks at the Trust and across Sheffield to raise awareness of health research.

Events

In line with our commitment to engage and involve more diverse groups, our event activities over the last year were developed with this in mind.

For 2019, the annual National Institute for Health Research campaign for International Clinical Trials Day was celebrated alongside the worldwide science festival, Pint of Science. Over 3 days in May, there were researcher-led interactive activities taking place in pubs and cafes across Sheffield. This was a crucial development in our engagement activities as the audiences were broadly comprised of those in age groups not habitually served by our activities.

To further engage with the local community about research at the Trust, we attended a volunteer fair organised by Sheffield Volunteer Centre at Sheffield Hallam University where there were a broad spectrum of people who were already involved with, or looking to become involved with volunteer activities across Sheffield.

Training and support

The CRIO continues to offer public involvement volunteers the opportunity to attend training in research and public involvement. To ensure that public involvement contributors who are part of Trial Steering Groups on research projects hosted by the Trust are adequately supported, this year we have developed bespoke training sessions specific to the needs of those involved.

Communications

Developed in collaboration with Trust staff and our public involvement members, the pages of the CRIO website have been reviewed and updated. We have ensured that information is up-to-date and relevant, the pages are easy to navigate and people can easily direct themselves to the information that they want to find. We were responsive to the COVID-19 pandemic and swiftly updated our pages to inform the public about changes to public involvement and research at the Trust as a result of the pandemic, and to direct them to scientifically based sources of information.

To improve our communications with staff, we have identified opportunities to promote and share the successes of researchers at the Trust, and the benefits of funding such as from the Sheffield Hospitals Charity in benefitting patients both now and in the future.

We shared information about research and innovation at the Trust and opportunities to get involved via the Good Health magazine which is available to all Trust members.

Staff Engagement

Increasing staff engagement and raising awareness of research at the Trust is key in

ensuring that patients have the opportunity to get involved in and participate in research. This year saw the launch of the Research Champions and Cafes Strategy. The aim of the Research Champion role is to capture and engage staff within the directorates across the Trust, to spread the knowledge of current research activities and promote patient involvement. This role is a crucial link between both clinical and research teams and will encourage staff engagement and increase the profile of research in clinical areas. To date, there are 4 research champions who are supported by their managers in taking on this role, and over the coming months and years we aim to see increased awareness of research across the Trust, and more opportunities given to patients to get involved in research.

Research Cafes provide a focal point for staff, patients and the public to find out about clinical research in a friendly and approachable environment. The Jessop Wing have held several cafes for staff, where there has been information about research, trials that are currently running and opportunities to get involved.

To engage with staff, patients and the public to promote the benefits of research in improving healthcare, research and clinical staff joined together to promote Hypo Awareness week in September/October to raise awareness of the signs and symptoms of hypos for people living with diabetes, and how to treat them. Staff profiles from a variety of health professions, including a diabetes researcher, were shared by the Trust Communications team both internally and more widely via social media. Such an approach is vital to highlight the interconnectedness of research with clinical care in improving patient outcomes.

Engaging with all staff Trust-wide to increase awareness of research is a long term aim for us, and in May 2019 we shared information about research and details of where to find out more, in all staff payslips.

d. Commissioning for Quality and Innovation (CQUIN Framework)

A proportion of Sheffield Teaching Hospitals NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2019/20 are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

In 2019/20, £9,996,524 of our contractual income was conditional on achieving the Quality Improvement and Innovation goals agreed between Sheffield Teaching Hospitals and NHS Sheffield Clinical Commissioning Group (CCG) / NHS England. 1.25% of contract income was associated with the National (CCG commissioned) CQUIN schemes. 1.55% associated with the NHS England CQUIN schemes.

In total across all Commissioners there were 11 different CQUIN schemes which included a focus on preventing ill health by risky behaviours, i.e., use of alcohol and tobacco, and the management of the prescribing of drugs for the treatment of Hepatitis C.

During 2019/20 the Trust secured £9,069k on achieving the Quality Improvement and Innovation Goals. The Trust had to invest £448k to deliver the schemes.

e. Care Quality Commission (CQC)

Sheffield Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully compliant. Sheffield Teaching Hospitals NHS Foundation Trust had no conditions on registration.

The Care Quality Commission has not taken enforcement action against Sheffield Teaching

Hospitals NHS foundation Trust during 2019/20.

Sheffield Teaching Hospitals NHS Foundation Trust has not participated in any special review or investigations by the CQC during the reporting period.

The Trust's Healthcare Governance Committee has continued to oversee the implementation of the action plan following the 2018 CQC unannounced inspection.

f. Data quality

Sheffield Teaching Hospitals NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

99.9 per cent for admitted patient care

99.9 per cent for outpatient care

99.2 per cent for Accident and Emergency Care

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

100 per cent for admitted patient care

100 per cent for outpatient care

100 per cent for Accident and Emergency Care

Sheffield Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit process during 2019/20. Sheffield Teaching Hospitals NHS Foundation Trust continues with the following programmes to improve its data quality:

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

The Data Security & Protection Toolkit assessment, the replacement of the Information Governance Toolkit, was submitted in full in March 2020.

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.

Fig: Patient Safety Alert

Reference	Title	Issued	Deadline (action complete)	Closed
NHS/PSA/RE/2019/002	Assessment and management of babies who are accidentally dropped in hospital	02/05/2019	08/11/2019	Closed
NatPSA/2019/001/NHSPS	Depleted batteries in intraosseous injectors	05/11/2019	05/05/2020	Closed
NatPSA/2019/002/NHSPS	Risk of death and severe harm from ingesting superabsorbent polymer gel granules	29/11/2019	01/06/2020	Closed
NatPSA/2020/001/NHSPS	Ligature and ligature point risk assessment tools and policies	3/3/2020	03/06/2020	Closed
NatPSA/2019/003/NHSPS	Risk Of Harm To Babies And Children From Coin/Button Batteries In Hearing Aids And Other Hearing Devices	13/12/2019	11/09/2020	Open

h. NHS Staff Survey

The response rate to the 2019 survey from STH staff was 45 per cent which was just below the national average for our benchmarking group of Combined Acute and Community Trusts (46 per cent).

The benchmarked findings of the 2019 survey are now presented as eleven theme scores (scored out of ten) which can be seen in the table below.

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

2018/19		2019/20	
Trust	National Average	Trust	National Average
46%	41%	45%	46%

Fig: Staff survey results

	2019/20		2018/19		2017/18	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.2	9.2	9.3	9.2	9.3	9.2
Health and wellbeing	6.0	6.0	5.9	5.9	6.1	6.0
Immediate managers	6.9	6.9	6.8	6.8	6.8	6.8
Morale	6.3	6.2	6.3	6.2	Not available	Not available
Quality of appraisals	5.7	5.5	5.6	5.4	5.5	5.3
Quality of care	7.4	7.5	7.4	7.4	7.5	7.5
Safe environment – bullying and harassment	8.4	8.2	8.4	8.1	8.4	8.1
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.9	6.8	6.8	6.7	6.8	6.7
Staff engagement	7.1	7.1	7.0	7.0	7.1	7.0
Team working	6.5	6.7	6.5	6.6	6.6	6.6

This year an extra theme on “Team working” has been added, to ensure that the team working questions are given more attention, given the latest research by Michael West et al that good team working is the most effective predictor of positive staff experience and positive patient outcomes. Questions from this theme along with equality, diversity and inclusion and bullying and harassment questions are included in the NHSI oversight framework.

Of the eleven themes in the 2019 benchmarked report 4 scored above average. These are:

- Morale
- Quality of Appraisals
- Safe Environment Bullying & Harassment
- Safety Culture

A further five scores were average:

- Equality, Diversity & Inclusion
- Health and Wellbeing
- Immediate managers
- Safe Environment – violence
- Staff Engagement

Only two themes scored below average:

- Quality of Care
- Team Working

No theme showed any year on year deterioration which was pleasing given the workload pressures staff sometimes face.

The highest score overall was achieved in Safe Environment – Violence (9.5) and the lowest was in quality of appraisals (5.7) albeit this was still above the average of 5.5. STH is close to the best in the benchmarking group for both the Safe Environment – violence and

Safe Environment - Bullying and Harassment score.

It was particularly pleasing to note in the survey that the percentage of staff recommending the Trust as a place to work to work increased by 1.4% for the fifth year running to 69.3% (well above the average of 64%). The percentage of staff recommending the Trust as a place for treatment remains high at 81% well above the average.

The staff survey results will be used to update the directorate staff engagement action plans and at a trust level the implementation of the ten themes of the STH people strategy continues which will also improve staff experience. This year we have worked to improve both health and wellbeing support and benefits for staff for example though the introduction of fruit and vegetable stalls at the NGH and RHH sites and expanding our range of salary sacrifice options to include gym membership. We were pleased to be finalists in both the national employee benefits awards and the NHSI / Burdett award retention awards.

The Trust also has an Equalities, Diversity and Inclusion (EDI) Board which provides effective governance of the agenda. The Board oversees the development and implementation of the Trust's strategic approach to meeting its duties set out in the Equality Act 2010, the requirements of key standards (such as the Workforce Race Equality Standard, Workforce Disability Equality Standard and the NHS Equality Delivery System2) and activities to embed best practice across all areas of the organisation.

With a diverse and broad membership that includes senior leaders and representatives of the Trusts three Staff Network Groups, the Board reports to the Trust Executive Group and oversees any work carried out in respect of workforce, patients and service delivery.

We have developed a new Equality, Diversity and Inclusion (EDI) Strategy that identifies and communicates what our priorities for action are as a Trust. We have identified 6 areas (our Equality Objectives) for us to focus on, which are:

- Improving performance – developing a robust way to manage performance and ensuring that all areas embed EDI best practice.
- Leadership and accountability – ensuring there is visible leadership of EDI, that people are leading by example and that we achieve what we say we will within the deadlines agreed.
- Trust and confidence – building strong community connections and networks so that our activity is informed by conversations with local people and partners.
- Behavioural and cultural change – embedding a zero tolerance approach across all areas of the organisation to any form of discrimination, bullying, harassment, and victimisation a well as bringing people together to create a social movement for change.
- Employee development – building the EDI capability of every member of staff so that we are all confident to challenge when we witness language or behaviour that doesn't fit with the Trusts' PROUD values, using positive action to build a diverse workforce, ensuring access to opportunities for current staff, supporting our Staff Network Groups and ensuring that we support our Disabled colleagues with reasonable adjustments.
- Audit and scrutiny – embedding an effective way of measuring and evaluating what we are achieving and what impact we are having across the organisation.

We have continued to be proactive in our focus and efforts to be an inclusive employer and promote equality and diversity for our patients and staff. Throughout the year our EDI Board has directed, supported and celebrated our progress. As a Trust we are continually building our capabilities to make this a brilliant personal place to work and improve the care that we provide for the communities we serve. Our achievements over the past year have included:

- Strengthened our EDI Team, our EDI Board and formed a number of sub-groups focused on progressing the following initiatives –
  - Accessible Information Standard (AIS)
  - Equality Monitoring of patients
  - Workforce Data
  - EDI Training

- Piloted a Reverse Mentoring Scheme which will be rolled out across the whole of STH.
- Produced a calendar of key dates and events for the Trust to mark and celebrate and have engaged in PRIDE month by raising the rainbow flag and creating rainbow crossings at both the Northern General and Royal Hallamshire Hospital sites.
- Reviewed and refreshed our Equality Impact Analysis (EIA) process and developed guidance and a form to support this.
- Piloted EIA training which will be rolled out across STH (both face-to-face and e-learning).
- Procured a new EDI e-learning provider and beginning to roll this out across STH and delivered EDI awareness sessions using MSTeams.
- Created an EDI Performance Dashboard which is being used to effectively report the progress being made.
- EDI has been embedded into all leadership courses, including how to become an inclusive leader.
- Coaching and mentoring of individual staff in relation to EDI is made available to all across STH.
- Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Data analysed and published and links to regional & national teams strengthened.
- 3 Staff Network Groups established for our BAME, Disabled and LGBTQ+ staff.
- Begun to establish stronger links with Voluntary Sector, specifically in relation to EDI, and are starting to work more collaboratively with external partners.
- Drafted a plan for the implementation of the national NHS Equality Delivery System 2 (EDS2).
- Strengthened risk management through our Integrated Risk and Assurance Register.
- Launched the NHS Rainbow Pin Badges scheme within our Trust.

As a Trust, we are not complacent and are continually learning about what discrimination is and how it is felt by those experiencing it within the NHS. Our aim is to continue to seek, value and listen to feedback and take positive steps using this feedback to protect and improve our NHS.

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

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

Fig: Work Race Equality Standard (WRES)

WRES Metric	Metric Description	Ethnic Group	2018	2019	Direction	Representative Target	North 2018	National 2018
Metric 1	Percentage of BME staff in Bands 8-9, VSM (including Executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce	BME Staff in Post	13.16	13.55	▲	19	10.50	19.01
		BME 8a + & VSM	4.30	4.35	▲	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	1.21	1.38	▲	1.00	1.39	1.45
Metric 3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process	BME	1.40	1.19	▼	1.00	1.36	1.24
Metric 4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff	White	1.06	1.02	▼	1.00	1.11	1.15
Metric 5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	21.03	22.1	▲	0	26.0	27.7
		BME	21.48	19.0	▼	0	25.8	28.7
Metric 6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	18.67	19.5	▲	0	21.8	23.3
		BME	24.28	21.2	▼	0	26.6	27.8
Metric 7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion	White	89.94	89.8	▼	100	86.9	86.6
		BME	74.79	71.2	▼	100	73.4	71.5
Metric 8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team	White	4.53	5.6	▲	0	6.0	6.6
		BME	12.67	11.3	▼	0	14.8	15.0
Metric 9	Percentage of BME Board membership	White	88	85	▼	81	90	-
		BME	0	0	▶	19	5	7

Fig: Workforce Disability Equality Standard (WDES)

WDES Metric	Metric Description	Disability Group	2019
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	3.65%
		Disabled 8a+ & VSM	1.97%
Metric 2	Relative likelihood of Disabled staff compared to non-disabled being appointed from shortlisting across all posts	Non-disabled	1.6
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by	Disabled	n/a 2019
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	27.3%
		Non-disabled	19.4%
	ii.Managers	Disabled	13.2%
		Non-disabled	7.3%
	iii. Other colleagues	Disabled	23.8%
		Non-disabled	12.2%
	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	48.4%
		Non-disabled	43.6%
Metric 5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Disabled	83.3%
		Non-disabled	89.0%
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	34.5%
		Non-disabled	22.6%
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	38.1%
		Non-disabled	52.3%
Metric 8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their	Disabled	75.7%
Metric 9	a. The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Organisation	7.0%
		Disabled	6.6%
		Non-disabled	7.1%
Metric 10	Percentage difference between the organisations Board voting membership and its overall workforce By voting membership of the Board	Disabled	0%
		Non-disabled	100%
	By Executive membership of the Board	Disabled	0%
		Non-disabled	100%

i. Annual patient surveys

Seeking and acting on patient feedback remains a high priority. The Trust continues to undertake a wide range of patient feedback initiatives regarding the services they provide. Survey work during 2019/2020 included participation in the National Survey Programme for inpatient, cancer and maternity services. National results, including comparative scores, will be available during 2020.

During 2019/2020, the Care Quality Commission published results from the Inpatient Survey (2018), National A&E Survey (2018), National Cancer Survey (2018) and the National Maternity Survey (2019).

National Inpatient Survey 2018

The National Inpatient Survey 2018 was carried out across 144 acute and specialised NHS Trusts. All adult patients (aged 16 and over) who had spent at least one night in hospital, and were not admitted to maternity or psychiatric units during July 2018 were eligible to be surveyed. A total of 1,194 eligible patients from this Trust were sent a survey, and 508 were returned, giving a response rate of 42 per cent. This is compared to the national response rate of 45 per cent.

Compared to other trusts participating in the National Inpatient Survey, this Trust scored 'about the same' as most other trusts on all questions.

In terms of the question relating to overall experience, the Trust score of 8.1 was ranked 'about the same' as the national average.

Following a significant improvement in 2017, for the 61 questions that were used in both the 2017 and 2018 surveys, performance has returned to the levels experienced in previous years. This resulted in the Trust not scoring significantly better in any questions in 2018, but scoring significantly worse in 13 questions. Results and comments from the National Inpatient Survey have been considered at the Patient Experience Committee (PEC) and an action plan has been put into place to address areas identified for improvement.

National Urgent and Emergency Care Survey 2018

The National Urgent and Emergency Care Survey runs every two years and the 2018 survey involved 132 NHS trusts with a Type 1 A&E department (major consultant led A&E department), of these 63 trusts also had a direct responsibility for running a Type 3 department (doctor or nurse led A&E/minor injury unit which treats minor injuries and illness without the need for an appointment).

Two separate questionnaires were used in the 2018 National Urgent and Emergency Care Survey, one for Type 1 services, and one for Type 3 services. These were sent to patients aged 16 years or older who attended Urgent and Emergency Services during September 2018. For this Trust, a total of 271 Type 1 patients returned the completed questionnaire giving an overall response rate of 30%, compared to a national response rate of 30%. A total of 139 Type 3 patients returned the completed questionnaire giving an overall response rate of 34%, compared to a national response rate of 29%

Compared to other trusts participating in the National Urgent and Emergency Care Survey, this Trust scored 'about the same' as all other trusts for Type 1, and 'better than' other trusts on three domains (8 individual questions) for Type 3.

In terms of the question relating to overall experience, the Trust score of 7.9 for Type 1 and 8.9 for Type 3 were ranked 'about the same' as the national average.

In 2018, the Trust did not score significantly better on any questions compared to 2016. The Trust scored significantly worse on one question (Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?) which scored 7.1/10 in 2018 compared with 8.2/10 in 2016.

The survey results have been presented to the Trust Patient Experience Committee and shared with the relevant staff where an action plan has been agreed.

National Cancer Patient Experience Survey 2018

The National Cancer Survey 2018 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 2018. A total of 2,534 eligible patients from the Trust were sent a survey, and 1,585 were returned, giving a response rate of 67 per cent. This is compared to the national response rate of 64 per cent.

The Trust scored within the expected range on 47 out of 52 questions, above the expected range on four questions and below the expected range on one question. Areas where the Trust scored above the expected range were:

- Groups of doctors or nurses not talking in front of the patient as if they were not there.
- Patients had confidence and trust in all doctors treating them.
- Patients' family or someone close definitely had opportunity to talk to a doctor.
- Staff told patient who to contact if worried post discharge.

The area where the Trust scored below the expected range was:

- Being given easy to understand written information about the type of cancer they had.

This question scored 69 per cent compared to a national average of 74 per cent. The Trust also scored below the expected range for this question in the 2016 and 2017 surveys at 69 per cent.

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

National Maternity Survey 2019

The 2019 survey of women's experiences of maternity services involved 126 NHS acute Trusts in England. Women were eligible for the survey if they had a live birth during February 2019 were aged 16 years or older, and gave birth in a hospital, birth centre, maternity unit, or at home. A total of 436 eligible patients from this Trust were invited to take part in the survey and 168 completed the survey giving a response rate of 39 per cent. This is an increase in the response rate for the 2018 survey of 35 per cent, and is also above the national response rate of 36.5 per cent (2019).

The Trust scored 'about the same' as other trusts in 47 out of 48 questions and 'significantly better' than other trusts in one question - 'In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?' (STH score 8.4, national average 7.6).

In 2019, the Trust did not score 'significantly worse' in any of the 39 questions asked in both the 2018 and 2019 surveys and scored 'significantly better' in three questions; outlined in the table below.

Fig: National maternity survey 2019 results – (questions scored significantly better than in 2018)

Question	2018	2019
Thinking about your care during labour and birth, were you treated with respect and dignity?	9.1	9.6
Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	6.3	8.1
Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	7.2	8.3

The Maternity Voices Partnership agreed an action plan to improve services for patients focusing on areas highlighted by the survey.

Friends and Family Test

The Trust continues to participate in the Friends and Family Test (FFT), which is carried out in inpatient, outpatient, A&E, maternity, and community services. The FFT asks a simple, standardised question (*Would you recommend this service to friends and family?*) with a six point scale, ranging from 'extremely likely' to 'extremely unlikely'.

During 2019/2020, the total percentage of patients who scored 'extremely likely' and 'likely' across all five elements of the FFT was 94 per cent which is the same as the 2018/19 score. This is above the National score of 93 per cent.

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

The Trust uses a number of different methods to carry out FFT depending on the patient group and care setting. Postcards remain a reliable method of collecting the views of patients, therefore this method continues to be used in most inpatient areas and within maternity services. Interactive Voice Messages and Text Messages are the main methods of carrying out FFT in A&E, outpatients and community settings.

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

Over the last 12 months, 130,586 FFT responses were received by STH across all areas. Inpatients (26 per cent) fell below the response rate target by 4 per cent, A&E (19 per cent) and maternity (19 per cent) fell below the response rate target by 1 per cent and community (12 per cent) fell below the response rate target by 0.5 per cent. Outpatients (8 per cent) achieved its response rate target for 2019/2020.

From April 2020, the requirements to gather FFT feedback in a fixed time period will be removed and therefore it will not be possible to report accurate response rates. The Trust will therefore monitor the number of responses received to ensure patients continue to be given the opportunity to feedback about their care and our FFT data is robust.

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

The Trust is also 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 per cent, A&E of 86 per cent, maternity services of 95 per cent, and community services of 90 per cent.

The Trust had not set a target for Outpatient services positive score previously but a target of 94 per cent was set in 2019. These targets are based on previous performance and on national average scores to ensure standards are maintained.

The scores and response rates across all areas of FFT comparing 2018/19 with 2019/20 are detailed below.

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

Fig: Response rates for FFT*

	2018/2019				2019/2020			
	STH		National		STH		National	
FFT Area	Response Rate	No. of Responses	Response Rate	No. of Responses	Response Rate	No. of Response	Response Rate	No. of Responses
Inpatient	29%	36,918	25%	2,783,223	26%	34,242	25%	2,572,766
Outpatient	9%	72,631	7%	3,971,072	8%	64,669	7%	3,963,404
Maternity	23%	4,033	n/a	n/a	19%	2,981	n/a	n/a
Community	13%	9,852	4%	1,365,878	12%	9246	4%	1,219,348
A&E	20%	21,958	12%	1,679,568	19%	19,448	12%	1,556,818

Fig: Scores for FFT*

	2018/2019				2019/2020			
	STH		National		STH		National	
FFT Area	Positive Score	Negative Score	Positive Score	Negative Score	Positive Score	Negative Score	Positive Score	Negative Score
Inpatient	96%	2%	96%	2%	96%	2%	96%	2%
Outpatient	95%	2%	94%	3%	95%	3%	94%	3%
Maternity	97%	1%	96%	2%	97%	1%	96%	1%
Community	90%	3%	95%	2%	90%	4%	95%	2%
A&E	87%	8%	87%	8%	85%	10%	85%	9%

*Due to the COVID-19 outbreak, there is no national data for March 2020. The above figures include data for April 19 – February 20.

j. Complaints

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

During 2019/20, we received 2,503 informal concerns which we were able to respond to within two working days. If telephone calls, emails or face to face enquiries are received by the Patient Access and Liaison Service (PALS) and if staff feel they can be dealt with quickly by taking direct action, or by putting the enquirer in touch with an appropriate member of staff, such as a Matron or Service Manager, contacts are made and the enquiry is recorded on the complaints database as an informal concern.

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

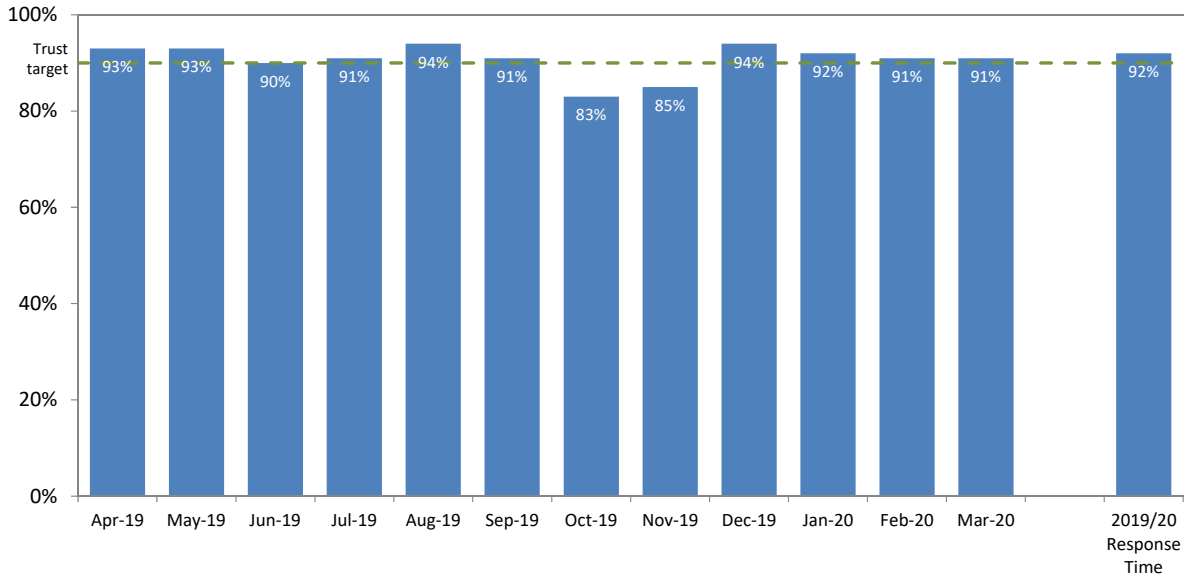
During 2019/20, 1,536 complaints requiring a more detailed and in-depth investigation were received. A monthly breakdown of formal complaints and informal concerns received during 2019/20 is provided below.

Fig: Complaints received during 2019/20 by month

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
New informal concerns received	202	196	199	232	215	244	253	197	202	234	200	129	2503
New formal complaints received	123	125	118	128	156	139	133	129	106	135	142	102	1539
All concerns combined	325	321	317	360	371	383	386	326	308	369	342	231	4039

Of the complaints closed during 2019/20, 586 (38 per cent) were upheld by the Trust. The Parliamentary and Health Service Ombudsman investigate complaints made regarding Government departments and other public sector organisations and the NHS in England. They are the final step of the complaints process, giving complainants an independent and objective body to review their complaint. During 2019/20 the Parliamentary and Health Service Ombudsman closed eight cases regarding the Trust, 63% (five) of which were partially upheld and no complaints were fully upheld.

Fig: Breakdown of complaints response times by month

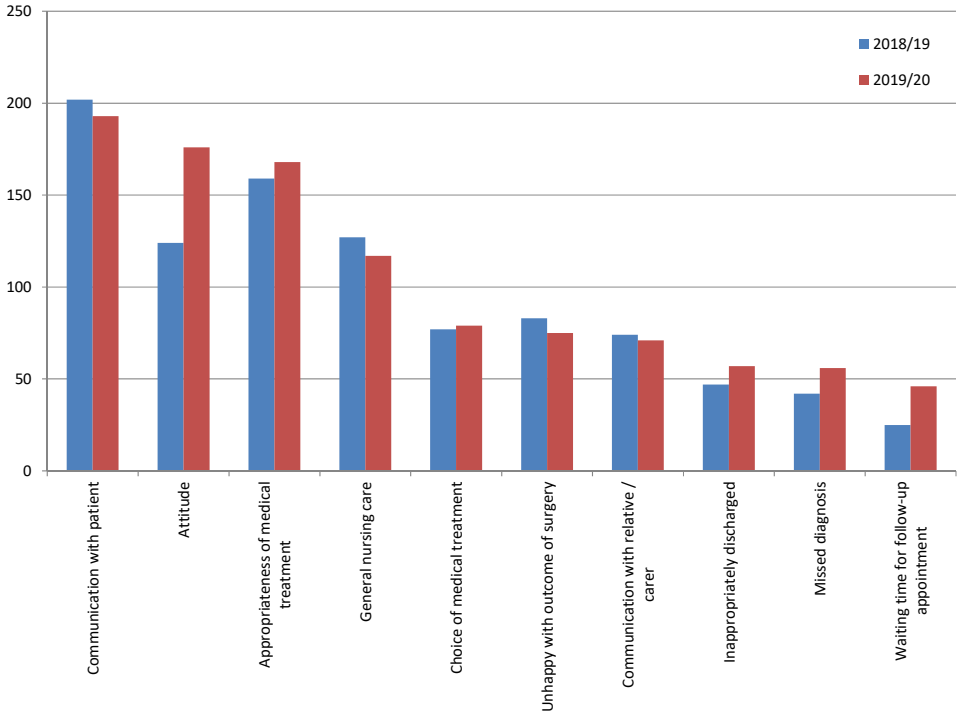


The complaint response time target is that at least 90 per cent of complaints are to be closed within the agreed timescale. This target was achieved in all but two months.

Monthly complaints reports are produced for the Patient Experience Committee showing the number of complaints received and target response times so that activity is monitored at directorate level.

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

Fig: Breakdown of complaints by theme



Findings from analysis of complaints show that the top five themes of complaints are the same as those identified last year. During 2019/20, 'General nursing care' has dropped out of the top three, and has been replaced by 'Attitude'.

When presented as a percentage, complaints relating to 'Attitude' are two per cent higher this year, complaints relating to 'Communication with patient' have decreased by one per cent and those relating to 'General nursing care' have decreased by (0.9%). Complaints relating to 'Waiting time for follow-up appointment' have increased by 1.3%. The remainder of the themes identified are comparable to last year, with a variation of less than one per cent.

National Review of Hospital Complaints

In January 2020 the Chair of Healthwatch England, Sir Robert Francis QC, wrote to NHS Trust Chief Executives to share a report of findings following a review of hospitals complaints. This report, Shifting the Mindset: A Closer Look At Hospital Complaints, highlights the need for trusts to take positive actions as a result of complaints and to prioritise these.

We remain committed to learning from, and taking action as a result of, complaint investigations.

At each meeting, the Patient Experience Committee receives a presentation, 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.

A selection of actions taken as a result of complaints is featured in the Trust's Annual Integrated Quality Report and these include the following:

Background: The patient attended the Emergency Eye Clinic complaining of sudden loss of vision, a diagnosis of Giant Cell Arteritis (GCA) was given and the patient was discharged home with a prescription of oral steroids. The following day the patient became unwell and had raised blood sugars. The patient continued to deteriorate over the day and suffered a cardiac arrest at home, and later died that evening. The patient's family raised concerns regarding the prescription of steroids to a patient with diabetes and the decision not to admit them to hospital.

Action: After investigation and discussions with the family it was identified there was a gap in providing information about the medication and the risk to blood sugar levels, and actions were taken, including;

- Discussing the case with the eye casualty team, pharmacy and rheumatology.
- A new leaflet about GCA was created which includes steroids use and the effects on diabetic patients.
- The case was discussed at M&M meeting with the outcome shared with the family.

Background: The Patient Advice and Liaison Service Manager provides quarterly reports to the Urology directorate to show the key themes raised in informal concerns.

Action: Following the data provided, an audit was undertaken by the urology team which discovered that over 45% of in hours calls to the Urology Assessment Unit (UAU) went unanswered and could have resulted in calls being diverted to an already busy line. The UAU phone was previously answered by a band 6 sister, the sister was tasked with running UAU along with taking the calls. This process was subsequently changed and a support worker now triages the calls and follows a flow chart. Having the support worker answer the phone means it is always answered and in a much shorter time, improving the service for patients and GPs.

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. The NHS improvement (NHSI) guidance was revised in September 2019 and the Sheffield Teaching Hospitals NHS Foundation Trust policy has been reviewed as a result. There have been no breaches of this standard during 2019/20.

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

Two Prevention of Future Death (Regulation 28) reports were received during 2019/20.

The first was addressed to a GP Practice, NHS Digital, Sheffield CCG and this Trust. This related to a patient not receiving appropriate antibiotics for a urinary tract infection. The concern primarily related to a technical issue in downloading a prescription between the GP and pharmacy. The Coroner also raised a Matter of Concern that there was potentially a delay in picking up a urine test result after the patient's discharge from hospital. Review of procedures at Sheffield Teaching Hospitals confirmed that the Standard Operating Policy (SOP) for review of non-urgent results was complied with and that the SOP remained appropriate given the resource available, the volume of test results and the fact that this would only very rarely yield any patient benefit.

The second Prevention of Future Death (Regulation 28) report related to a patient who had difficulties eating and drinking. The patient was assessed by Speech and Language Therapy who confirmed that they required a soft and bite sized diet that could be easily mashed or broken down with a fork. Upon admission to the Northern General Hospital, the patient's dietary requirements were not appropriately managed resulting in death due to upper airway obstruction. A number of actions were recommended by the Coroner, these include Trust wide training in respect of International Dysphagia Diet Standardisation Initiative descriptors for special diets and changes to the Standard Operating Procedure for Ward Meal Services. The Trust has undertaken these actions; training is in place and changes have been made to the Standard Operating Procedure.

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 2019/20, nine Never Events occurred at the Trust. Five were in relation to 'wrong site surgery', two 'incorrect implant/ prosthesis', one 'retained foreign object post procedure' and one 'overdose of insulin due to incorrect device'.

In response to the number of Never Events relating to wrong site surgery during 2019/2020 a proposal to develop a Trust wide action plan was approved by the Trust Executive Group. The action plan addresses issues relating to wrong site surgery/procedure/patient incidents . This action plan will be overseen by the Trust's Safer Procedures Committee and will report to the Safety and Risk Committee chaired by the Medical Director (Operations). Actions already taken include a Trust wide communications campaign called 'Pause before every Procedure.'

Learning from Serious Incidents and Never Events is shared through multiple forums within the Trust, including the Trust's Safety and Risk Committee and Forum, and Clinical Management Board to support wider learning.

n. Duty of Candour

An end to end review of the incident management process is underway and this will then inform review and update of the Trust's Incident Management Policy. As part of this work, the Duty of Candour Policy is being reviewed to align with the new Incident Management Policy. Duty of Candour refresher training will be provided for Trust staff during Q4 2020/21.

All incidents, including those which trigger the Duty of Candour, are reported on Datix, which is the Trust's electronic incident management system. In order for Duty of Candour to be considered, an incident has to be classed as a both a patient incident and an incident of moderate, major, or catastrophic severity. When this happens a trigger is instigated within Datix to consider whether Duty of Candour applies. During 2019/20, 314 incidents met this criterion and of these, 207 incidents were noted as requiring the statutory duty to be implemented.

Further analysis has been undertaken of the remaining 107 incidents where Duty of Candour was not deemed applicable during the incident review process, despite being a patient incident with a severity of harm of moderate or above. This identified 13 incidents that were linked to pressure ulcers which were present on the patient's admission, six incidents that were safeguarding incidents raised by staff regarding issues occurring externally to the Trust; and 44 incidents involved no harm, staff members or happened external to the Trust and should not have been recorded as moderate. In 63 of the 107 cases where Duty of Candour was not applied, this was appropriate as they did not meet the criteria and were in line with national guidance.

Of the remaining 44 incidents, 10 relate to potential hospital acquired Covid-19 and at the time of writing the report a central process has been agreed and will be rolled out to manage the duty of candour appropriately for all of these outstanding cases. A review of the remaining 34 incidents is underway and action is being taken to ensure that the Duty of Candour requirements have been met and the Datix record accurately reflects this.

o. Safeguarding adults

STH is one of a number of agencies who report to and attend meetings of the Sheffield Safeguarding Partnership for Children, Young People and Adults. The Partnership consists of Sheffield City Council, South Yorkshire Police, and NHS Sheffield Clinical Commissioning Group (CCG). The Partnership Executive Board leads and holds these individual agencies to account ensuring that agencies support and empower children and adults at risk, to protect them from abuse or neglect.

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

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

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 of 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

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

Standard 5

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

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

Standard 6

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

Standard 8

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

In November 2018 the national survey tool was replaced by a board assurance framework consisting of a standard measurement and reporting template, completed by trusts with self-assessments of their delivery of the Seven Day Service clinical standards. This self-assessment is now formally assured by the Trust Board of Directors and the completed template submitted to regional and national Seven Day Service leads to enable measurement against the national ambitions for Seven Day Service.

Key findings from the spring 2019 and autumn 2019 surveys demonstrate that the Trust has made continuing progress to meet these standards, as shown in the table below:

Fig: Results of the 2019 Seven Day Services Audit

Clinical Standard	Spring 2019 Results	Autumn 2019 Results
Clinical Standard 2 – Time to First Consultant Review:	70% of patients were seen and assessed within 14 hours of admission	81% of patients were seen and assessed within 14 hours of admission
	Variations exist across specialities with respect to time to first consultant review	Variations exist across specialities with respect to time to first consultant review
	Variations exist throughout the week for the majority of the specialities	There was little variation between weekday and weekend results (82% vs. 81%)
Clinical Standard 5: - Consultant Directed Diagnostics:	The Trust has reported that critical and urgent patients requiring the necessary diagnostics are receiving them in a timely manner	The Trust has reported that critical and urgent patients requiring the necessary diagnostics are receiving them in a timely manner
Clinical Standard 6 – Consultant Directed Interventions:	The Trust has reported that hospital inpatients have timely 24 hour access, 7 days a week, to consultant-directed interventions	The Trust has reported that hospital inpatients have timely 24 hour access, 7 days a week, to consultant-directed interventions
Clinical Standard 8 – On-going Review (Once Daily Review):	The majority of patients requiring a once daily review received one (95%)	The majority of patients requiring a once daily review received one (98%)
	Patients requiring a once daily review were less likely to receive one at the weekend compared to the weekday (91% vs. 97%)	Patients requiring a once daily review were slightly less likely to receive one at the weekend compared to the weekday (96% vs. 100%)
Clinical Standard 8 – On-going Review (Twice Daily Review):	The majority of patients requiring a twice daily review received one (99%)	All patients requiring a twice daily review received one (100%)
	Patients requiring a twice daily review were less likely to receive one at the weekend compared to the weekday (96% vs. 100%)	Patients requiring a twice daily review received one seven days per week

q. Learning from deaths

During 2019/20, 2,914[2] of Sheffield Teaching Hospitals NHS Foundation Trust's patients died, including 36 late foetal losses / stillbirths and 26 neonatal deaths. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 690 in the first quarter;
- 647 in the second quarter;
- 778 in the third quarter;
- 799 in the fourth quarter.

By 31 December 2019, 466[3] Medical Examiner (ME) reviews, 463[4] Structured Judgement Review (SJR) case record reviews and 11[5] Serious Incident (SI) investigations have been carried out in relation to the number of deaths included in data contained within the above paragraph.

In one case a death was subjected to both a case record review and an investigation.

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

- 106 in the first quarter (15 per cent of all deaths);
- 77 in the second quarter (12 per cent of all deaths);
- 63 in the third quarter (8 per cent of all deaths);
- 50 in the fourth quarter (6 per cent of all deaths).

One case, representing 0.3 per cent (0.3%) of the patient deaths during the reporting period, is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- 1 representing 0.3% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter

One case has been identified for further investigation and is being managed in line with Trust Incident Management processes. 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 (MGC).

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 (where these are within the scope of Directorates to do so). There are on-going discussions with Directorate Governance Leads and the MGC to standardise feedback mechanism for learning so that common themes can be identified by the SJR Facilitator.

Analysis of the data collected on the SJR Datix platform regarding overall care has identified areas of potential intervention. Some of these areas of work reflect national issues, such as the quality of notes documentation, and the move to an electronic patient record will help to mitigate this.

Thematic review of the End of Life Care section of SJRs has identified the most common positive comments to be related to:

- DNACPR
- Discussions with relatives
- Recognition of end of life

It has also signalled that the most common themes for improvement are:

- Documentation
- Review Process
- DNACPR
- Unnecessary interventions

This themed data contributes to the End of Life governance meeting with information pooled from various sources to target improvement work. This data is also reported to the Trust

[2] Source: Medical Examiner Office (16 July 2020)
[3] Source: Medical Examiner Office (16 July 2020)
[4] Source: Local SJR Database (16 July 2020)
[5] Source: Information Services Report 'IP/ED Deaths with Possible DI Datix Link' (23 July 2020)

Board of Directors quarterly. This analysis was reported to Board and TEG in April 2020.

111 case record reviews and 14[6] investigations have been completed after 31st March 2019 which related to deaths which took place before the start of this reporting period (1st April 2019). None are awaiting a first review. Six scored 1 or 2 and have been referred back to the relevant Directorates for completion of a Paper A or MGC review and one is awaiting a second review.

r. Staff who speak up

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

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

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

There are regular communications to Trust employees about the Freedom to Speak Up process and all staff raising concerns through this route receive feedback via the Guardian / Advocate who they raised their concern with and/or the investigating manager.

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

s. Rota gaps

Due to vacancies, COVID-19 related or unanticipated sickness some specialties have elements of their staff rota that need to be filled.

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

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

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

- Novel recruitment strategies

The Trust has devised innovative ways of attracting and maintaining medical staff who wish to take time out of training by creating posts catering for the needs of both the service and individuals. This has been done through the creation of Trust Clinical Fellows/Career Development posts, who are offered a combination of clinical work and development opportunities outside a traditional numbered training post, this approach has met with some success.

The Trust has also worked in conjunction with the Royal Colleges to consider suitably trained doctors from overseas in specialties such as Anaesthetics, Ophthalmology and Oncology. This has helped support service provision whilst providing development opportunities to the wider medical workforce from overseas that a large teaching hospital can offer.

[6] Source: Information Services Report 'IP/ED Deaths with Possible DI Datix Link' (23 July 2020)

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

3. Quality performance information 2019/20

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

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

Fig: Quality Performance Information

Prescribed Information	2017/18	2018/19	2019/20
The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust for the reporting period. National Average: 1.00 Highest performing Trust score: 0.69 Lowest performing Trust score: 1 .20 *(Figures for April 2019 – March 2020)*	0.96 Banding: as expected	0.97* Banding: as expected	1.00 Banding: as expected
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National average:37% Highest trust score: 58% Lowest trust score: 9% *(Figures for April 2019 – March 2020)*	27.4%	34%*	34%

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

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

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

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

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

*The SHMI reported in last year's Quality Report was qualified by the annotation that this was derived from the most recent rolling 12 month period i.e. October 2017 - September 2018. SHMI results are published in arrears because of the need to validate the data nationally. The value for April 2018 - March 2019 was reported as 0.97. This can be validated via the NHS Digital Clinical Indicators website.

Prescribed Information	2017/18 Finalised	2018/19 Finalised	2019/20 Provisional
Patient Report Outcome Measures (PROMs) The Trust's EQ5D patient reported outcome measures scores for:			
(i) Groin hernia surgery			
Trust score:	0.077	No longer part of the National PROMs programme	No longer part of the National PROMs programme
National average:	0.089		
Highest score:	0.122		
Lowest score:	0.000		
(ii) Varicose vein surgery			
Trust score:	*	No longer part of the National PROMs programme	No longer part of the National PROMs programme
National average:	0.096		
Highest score:	0.134		
Lowest score:	0.000		
(iii) Hip replacement surgery primary			
Trust score:	0.449	0.431	0.447
National average:	0.468	0.465	0.475
Highest score:	0.566	0.525	*
Lowest score:	0.376	0.348	*
(iv) Hip replacement surgery revision			
Trust score:	*	*	*
National average:	0.289	0.287	0.295
Highest score:	0.322	0.396	*
Lowest score:	0.227	0.206	*
(v) Knee replacement surgery primary			
Trust score:	0.376	0.335	0.405
National average:	0.338	0.338	*
Highest score:	0.417	0.405	*
Lowest score:	0.234	0.266	*
(vi) Knee replacement surgery revision			
Trust score:	*	*	*
National average:	0.292	0.288	*
Highest score:	0.328	*	*
Lowest score:	0.196	*	*

** Denotes that there are fewer than 30 responses as figures are only reported once 30 responses have been received. 2019/20 data are low due to being part through year and elective procedures having been stopped due to COVID-19. The most recent data available was published February 2020.*

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

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

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

- *Implementing decolonisation pre operatively*
- *Facilitated ward move to be nearer theatres for all arthroplasty patients*
- *Theatres started piloting a spot type probe attached to the patient from the Theatre Admissions Unit through to recovery. It monitors the patient's temperature throughout this journey. This supports NICE guidance that recommends maintaining the patient's temperature greater than 36 degrees to assist in wound healing and a reduction in SSI.*

Measures of Quality Performance	2017/18	2018/19	2019/20
Readmissions The percentage of patients aged: 0 to 15; and 16 or over, readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period. *Comparative data is not available* 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, continuing to enhance assessment areas such as the Frailty Unit on the NGH site and the Urology Assessment Unit on the RHH site that both serve to reduce readmissions and improve pathways for patients. Expanding our ambulatory care offering is also a priority in the coming months. An Action Plan has been developed to address any areas within the Trust where readmissions may be higher than comparative Trusts. This work will be overseen by the Central Readmissions Group.	 0% 14.88%	 0% 16.49%	 0% 15.23%
Responsiveness to personal needs of patients The Trust's responsiveness to the personal needs of its patients during the reporting period. National average: 91% (this is based on the average scores across all NHS trusts who are contracted with Picker Europe, the CQC's national surveys contractor) The Trust score is made up of the following: Did you get enough help from staff to eat your meals? – 86% Do you think the hospital staff did everything they could to help control your pain? – 93% Treated with respect and dignity – 98% Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by National CQC Survey Contractor. Sheffield Teaching Hospitals NHS Foundation Trust continues to take action to improve this rate, and so the quality of its services, by implementing local surveys during 2020/2021 to enhance our understanding of patient needs. The final programme for the additional local surveys is currently being agreed.	80.4%	93%	92%

Measures of Quality Performance	2017/18	2018/19	2019/20
Patients risk assessed for venous thromboembolism (VTE)s			
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. *Comparative data is not available* 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 having established processes in place that check if a patient has had a VTE risk assessment. Where this has not been completed this is followed up and completed.	95.29%	95.04%	95.35%
Rate of Clostridium Difficile			
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. *Please note the rate for 2019/20 is not comparable with previous years as the definition of a Trust Attributable case (now known as Hospital Onset/Healthcare associated cases) has changed to include more cases than previously. The denominator used is the 2018/19 figure as the 2019/20 figure is not currently available. The denominator figures are unlikely to change significantly year on year.	15.4	16.2	115/ 519481 = rate of 22.1 per 100,000 bed days
The rate per 100,000 bed days of hospital 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. Community Onset cases presenting within 28 days of discharge, are now included in the objectives allocated to trusts. How these will be taken into account nationally as regards published rates is, as yet, unknown. It is anticipated that rate and denominator data will be released in July 2020. For this report the Trust 2018/19 100,000 bed day data has been used as the denominator. The data will be updated once the methodology for calculating this parameter has been published. During 2019/20 there have been a) 115 C.difficile Hospital Onset/Healthcare associated episodes detected and b) 39 C.difficile Community Onset/Healthcare associated episodes detected within the Trust; total of 154. The national threshold allocated to the Trust for the combined total of a) and b) episodes for 2019/20 was 166 Hospital Onset/Healthcare Associated and Community Onset/Healthcare associated episodes have a root cause analysis to identify if there has been any possible lapse in care. For Apr to	Not recorded	Not recorded	39/ 519481 = rate of 7.5 per 100,000 bed days

Measures of Quality Performance	2017/18	2018/19	2019/20
Dec 2019 08 of the 101 cases during this time period have been highlighted as possibly having a lapse in care. This is a lower percentage than in previous years. Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described as the data is provided by Public Health England. 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	78.82%	74.70%*	73.22%
National Standard	85%	85%	85%
NHS Cancer Screening Service referral			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	91.84%	87.04%*	87.40%
National Standard	90%	90%	90%
*This figure is different from last year as it represents the whole year (April 2018 – March 2019) *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.	21,313	23,490*	11,686**
Number of incidents reported The incident reporting rate is calculated from the number of reported incidents per thousand bed days and the comparative data used is from the first 6 months of 2019/20.	39.2	45.8*	46.8
Cluster average: 49.8 / Highest performing Trust score: 103.8 / Lowest performing Trust score: 26.3			
The number and percentage of patient safety incidents that resulted in severe harm or death	50* (0.2%)	61* (0.3%)*	17 (0.1%)
Cluster reporting data: 19 (0 .3%) / Highest reporting Trust: 95 (0.5%) / Lowest reporting Trust: 0 (0%) * The figures for 2018/19 are different to those documented in last year's Quality Report as they have now been validated. **Full information for the financial year 2019/20 is not available from the National Reporting and Learning System (NRLS) until September 2020. Data reported covers April to September 2019.			

Measures of Quality Performance	2017/18	2018/19	2019/20
Sheffield Teaching Hospitals NHS Foundation Trust encourages reporting of all incidents and as a result has seen the numbers of reported incidents increase, reflecting a continually improving safety culture. The numbers of incidents reported are monitored by the Patient and Occupational Safety and Risk Committee's and at local Directorate governance meetings. *To note: As this indicator is expressed as a ratio, the denominator (all incidents reported) implies an assurance over the reporting of all incidents, whatever the level of severity. There is also clinical judgement required in grading incidents as 'severe harm' which is moderated at both a Trust and national level. This clinical judgement means that there is an inherent uncertainty in the presentation of the indicator which cannot at this stage be audited*			
Maximum six week wait for diagnostic procedures			
Sheffield Teaching Hospitals NHS Foundation Trust achievement.	92 .95%	98.75%	99.38%
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	88.64%	87.30%	83.99%
National Standard	95%	95%	95%
MRSA blood stream infections			
Hospital Onset bacteraemia cases in Sheffield Teaching Hospitals NHS Foundation Trust	3	2	3
Trust assigned cases in Sheffield Teaching Hospital NHS Foundation Trust (No longer applicable)	3	n/a	n/a
Sheffield Teaching Hospitals NHS Foundation Trust threshold for Hospital Onset episodes.	0	0	0
The Trust assigned category was introduced for the 2013/14 and ceased as 2017/18			
Patients who do not need to be admitted to hospital who wait less than 18 weeks for GP referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	94.4%	91.6%	90.9%
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	95.7%	93.4%	92.4%
National Standard	92%	92%	92%
Patients who require admission who waited less than 18 weeks from referral to hospital treatment			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	88.2%	85.2%	81.6%
National Standard	90%	90%	90%
Never Events (Count)			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	3	4	9

Measures of Quality Performance	2017/18	2018/19	2019/20
Certification against compliance with requirements regarding access to healthcare for people with a learning disability			
Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	Yes	Yes	Yes
Does the NHS Foundation Trust provide readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments?	Yes	Yes	Yes
Does the NHS Foundation Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Yes	Yes	Yes
Does the NHS Foundation Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Yes	Yes	Yes
Does the NHS Foundation Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Yes	Yes	Yes
Does the NHS Foundation Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Yes	Yes	Yes
Data Completeness for Community Services			
Referral to treatment information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	62%	60%	59%
National Standard	50%	50%	50%
Referral information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	100%	100%
National Standard	50%	50%	50%
Treatment activity information:			
Sheffield Teaching Hospitals NHS Foundation Trust achievement	100%	100%	100%
National Standard	50%	50%	50%

Measures of Quality Performance	2017/18	2018/19	2019/20
Friends and Family Test - Staff who would recommend the Trust (from Staff Survey) The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. National average: Combined Acute and Community Trusts – 71.0%. All Trusts – 71.4% Highest performing Trust score:(Combined Acute and Community Trusts): 90.5% Lowest performing trust score: (Combined Acute and Community Trusts): 48.8% Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is provided by the national CQC survey contractor. Sheffield Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve this percentage, and through this the quality of its services, by seeking staff views and involving them in improving the quality of patient services via Microsystems Academy approach and our on-going staff engagement work.	81%	81%	81%
Friends and Family Test - Patients who would recommend the Trust* The percentage of patients who attended the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. The Friends and Family Test (FFT) scores are now recorded taking the percentage of respondents who 'would recommend' our service which is taken from ratings One (Extremely Likely) and Two (Likely). Sheffield Teaching Hospitals NHS Foundation Trust considers that this data is as described, as the data is collected by the Healthcare Communications, verified by UNIFY and reported by NHS England. Sheffield Teaching Hospital NHS Foundation Trust continues to take the following actions to improve this rate, and through this the quality of its services: • A monthly report is circulated across the Trust informing staff of scores and response rates, as well as enabling them to review the comments that patients have left about their experience • Monthly FFT scores are compared with the 12 month Trust score as well as the 12 month national score to monitor performance • The Patient Experience Committee monitors FFT monthly for all elements of the FFT to identify any trends or concerns and takes the necessary action	All areas 94% Inpatient 96% A&E 88% Maternity 95% Outpatient 94% Community 89%	All areas 94% Inpatient 96% A&E 87% Maternity 97% Outpatient 95% Community 90%	All areas 94% Inpatient 96% A&E 85% Maternity 97% Outpatient 95% Community 90%

Measures of Quality Performance	2017/18	2018/19	2019/20
should the positive score fall in any particular area of the Trust. The FFT question will be changing from April 2020. The Patient Experience Committee will continue to monitor the positive score for all areas on a monthly basis. NHS England have advised that trusts should place less emphasis on response rates and as such the Patient Experience Committee will not review response rates monthly, however the number of responses received will be monitored and reported by exception, if there are any concerns regarding decreasing or low numbers of responses being received. * It's important to note that due to COVID-19 the use of FFT feedback cards was paused from 23rd March, this was predominantly in Inpatient and Maternity. FFT activity was stopped in all Community areas.			

4. Statements from our Partners on the Quality Report

Governor involvement in the Quality Board

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

Following agreement last year, three Quality Objectives for 2020/21 were agreed by the Quality Board in conjunction with patients, clinicians, Healthwatch Sheffield and governors. These were approved in November 2019.

Throughout 2019/20 the Quality Board met quarterly to observe and respond to best practice and uses this as a benchmark for other objectives.

We are welcomed and encouraged to be actively involved in influencing good patient care. Governors will participate in a stakeholder engagement event to monitor progress against the 2020-2021 quality objectives and to provide our views to consider the choice of quality objectives for 2021-2022.

Kath Parker, Patient Governor
24th September 2020

Statement from NHS Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has reviewed the information provided by Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) in this report. In so far as we have been able to check the factual details, the CCG view is that the report is materially accurate and gives a fair representation of the Trust's performance.

STHFT provides a very wide range of general and specialised services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve. The report fairly articulates where this has been achieved and also where this has been more challenging.

During 2019/20 the Trust has achieved a number of key Constitutional standards and key quality performance measures which includes achievement in the incomplete 18ww target and diagnostics in most months. However, the Trust has continued to experience challenges in the delivery of the 95% A&E target and a number of the cancer wait targets.

The CCG's overarching view is that STHFT continues to provide, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. This quality report evidences that the Trust has achieved positive results in a number of its key objectives for 2019/20. Where issues relating to clinical quality have been identified in year, the Trust has been open and transparent and the CCG has worked closely with the Trust to provide support where appropriate to allow improvements to be made.

The CCG were working jointly to agree priority areas for improvement in 2020/21, however this work was put on hold whilst the system focussed efforts on Covid-19 recovery. That said our aim is still to pro-actively address issues relating to clinical quality so that standards of care are upheld whilst services recover from the impact of Covid-19 and then continue to evolve to ensure they meet the changing needs of our local population and in particular look to reduce inequalities. The CCG will continue to work with the Trust to recover from the pandemic, considering appropriate targets whilst at the same time incentivise the delivery of high quality, innovative services.

Submitted by Beverly Ryton on behalf of:

Alun Windle, Chief Nurse, and Sophie Ludlam, Deputy Director of Contracting

5th October 2020

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

Thank you for sending me a copy of the Trust's Quality Report. Please find below the comments of the Healthier Communities and Adult Social Care Scrutiny Committee. I appreciate that the work of the Trust has been greatly affected by the need to respond to Covid and that some of the information contained in the report will now be outdated.

First and foremost, please pass on the thanks of the Committee to all front-line staff for all their efforts and sacrifices during the on-going Covid pandemic.

General Comments

- We are pleased to see the positive feedback from Patient Surveys and the Family and Friends Test.
- We note that the Trust met or exceeded the national standard for cancer referrals being seen within two weeks but underachieved on some of the standards for treatment.
- Multiagency working is crucial so we are pleased to note the preventative work being undertaken with the local Violence Reduction Unit. We appreciate that this may well have been affected by Covid but look forward to hearing more about the impact of this in the future.
- We commend the focus on diversity and equality as part of the Trust's People Strategy. We look forward to seeing the impact of this on the composition of the Trust's workforce and responses to the staff survey.
- While welcoming the range of surveys and audit work undertaken by the Trust, we were struck by the absence of evidence about the quality of key community based services. While this may be due to the absence of national indicators, it would be good to have assurance about these important services as well as the more clinically focused based provision of the Trust.

Priorities for Improvement

- We note the work being undertaken to scrutinise and improve the Trust's Hospital Standardised Mortality Ratio figures. We fully understand the issues about ensuring the use of comparable data. In future years we hope to see improvement in both the mortality indicators and data quality, in order to reassure the people of Sheffield.
- This report draws predominantly on the pre-Covid period and we recognise that the Priorities for Improvement were drawn up 10 months ago. This Committee is concerned about the impact of Covid on delays to the treatment of other conditions, including cancer. Clearly this is a national issue, however we will be looking for some reassurance on how the Trust has responded to this challenge locally.

Never Events

- Although this is a tiny proportion of the Trust's activity, we are concerned about the 'Never Events' and will be looking closely to see significant improvement is this area.

5th October 2020

Statement from Healthwatch Sheffield

Thank you for sharing this report with us. During this challenging time for the Trust, we would like to take this opportunity to extend our thanks to those working hard during the covid-19 pandemic.

Our response to the report includes feedback from volunteers, who were able to bring a patient and public perspective to the findings. The Trust has improved the accessibility of this report by explaining acronyms throughout. However, a lack of context and a strong focus on quantitative data makes it difficult for people to see how their experience compares to the bigger picture. Revisiting comments from previous years' Quality Reports would be helpful when writing this next year.

It is good to see that once again the Trust is performing well on a clinical level, with relatively consistent performance against

national targets, though we note that some targets for waiting times were not achieved. This broadly reflects the feedback that we hear – many people are keen to share positive stories of caring staff and effective treatment, but also tell us that they wait a long time for referrals. We also note that the Trust reports 9 'never events' this year– a small proportion of patients, but an increase on recent years. We would be interested to know whether the additional measures put in place in the action plan are proving effective in reducing these numbers.

We are happy to see progress on targets from last year, and hope that the Trust maintains momentum with any partially achieved objectives in the coming year. The suitability of patient letters is something we still hear about – especially for people whose first language isn't English (including deaf BSL users), or people with a learning disability or dyslexia. We hope that patients and the public will be involved in the further monitoring of this work as well as the initial consultation, and are adequately supported to join the Accessible Information Standards Group and other committees where they can have meaningful impact on the Trust's work. The work on patient letters links to wider issues about communication with patients (highlighted as the most common theme in patient complaints) and issues we've raised previously about Accessible Information, including the specific needs of the Deaf community. We are led to believe that the experience of deaf people accessing healthcare has not significantly improved since we wrote a report on this subject in 2018, indicating there is still significant work to be done. It is also important that communication is carefully considered during the pandemic, particularly for people who are digitally excluded.

We welcome the targets for the year ahead, especially around reviewing the complaints process. We know that the complaints process has been disrupted by covid-19, but we would urge the Trust to consider how they can move forward with this work in a flexible way, considering the additional impact of complaints which have been delayed. This objective would benefit from some clarity around the 'improved feedback' that it will be measured against, and how the Trust will work proactively to gather this feedback. As a local Healthwatch, we regularly advise members of the public about the complaints process, and would be keen to stay informed about progress on this objective. Relatedly, we would like to see some more detail about complaints from this year, including people's experiences of raising their concerns through informal means, and to what extent the Trust is supporting people to access independent advocacy.

The Quality Report details where the Trust has gathered patient feedback through complaints, the Friends and Family Test, national surveys, and other means, which we are pleased to see. It would be helpful for the public to see that the Trust learns from this patient feedback. Summaries of key learning or key actions from engagement would help to show that patient voice is being used proactively to improve future experiences.

Ensuring that patient feedback and experience can still be gathered and learnt from in the coming year will be important. Fewer face to face services will challenge the use of Friends and Family Test postcards – this may be an opportunity to explore whether satisfaction levels and comments differ for text respondents, who have the opportunity to reflect on their experiences when at home, and whether this offers a wider viewpoint. More broadly, there is a need to consider how to proactively hear from patients, when services and experiences may be very different this year.

We support the efforts towards equality and diversity in staffing, and hope to see meaningful engagement with local communities and voluntary sector groups to support this work. Some of the metrics measuring this are quite difficult to put into context, and open conversation with the public about this work would be a very positive step.

We all know that the coming year is going to bring increased challenges, and this may impact the Trust's workplan. We encourage the Trust to be open with the public about

these challenges, and return to any paused objectives when they are able to. We would urge the Trust to begin thinking early about how they're ensuring ongoing patient involvement, and how they're listening to and learning from patient feedback during this time.

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

2nd October 2020

Statement of Directors' Responsibilities for the Quality Report

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

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

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

The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed Requirements for Quality Reports 2019/20.

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 2019 to April 2020
- papers relating to quality reported to the Board over the period April 2019 to April 2020
- feedback from Commissioners dated 6 October 2020
- feedback from Governors dated 24 September 2020
- feedback from local Healthwatch organisations dated 2 October 2020
- feedback from Overview and Scrutiny Committee dated 5 October 2020
- the latest national patient surveys, dated June 2019 (Inpatients), October 2019 (Urgent and Emergency Care), January 2020 (Maternity) and September 2019 (Cancer)
- the latest national staff survey published February 2020
- the Head of Internal Audit's annual opinion of the Trust's control environment discussed at the Audit committee of 13 October 2020

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

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

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

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

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

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

By order of the Board of Directors

Tony Pedder OBE
Chairman
27 October 2020

Kirsten Major
Chief Executive
27 October 2020

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

The Communications Department
Sheffield Teaching Hospitals NHS Foundation Trust
8 Beech Hill Road
Sheffield
S10 2JF
Tel: 0114 266 8989

www.sth.nhs.uk