



Sheffield Teaching Hospitals
NHS Foundation Trust

Quality Report 2024/25



PROUD TO MAKE A DIFFERENCE

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST



Contents

1. Introduction	4
1.1 Statement on Quality from the Chief Executive	5
2. Priorities for Improvement	10
2.1 Priorities for Improvement 2024/25	11
2.2 Priorities for Improvement 2025/26	15
3. Trust Overview	17
3.1 Services Provided	18
3.2 Care Quality Commission (CQC)	19
4. Performance on Quality 2024/25 (Safety)	20
5. Performance on Quality 2024/25 (Experience)	30
6. Performance on Quality 2024/25 (Effectiveness)	46
Appendices	64
Appendix 1 - Work Race Equality Standard (WRES)	65
Appendix 2 - Workforce Disability Equality Standard (WDES)	66
Appendix 3 - Audit and Confidential Enquiries	67
Annexes	72
Annex 1 - Statements from our Partners on the Quality Report	73
Annex 2 - Statement of Directors' Responsibilities for the Quality Report	78
Annex 3 - Glossary	80

Part 1 - Introduction



1.1 Chief Executive's Statement



2024/25 has been extremely challenging for the NHS as a whole and was dominated by complex operational pressures, continued industrial action, high demand for both emergency and planned healthcare and a challenging financial position.

All these things impacted on our organisation, but I am proud to say that our teams have gone above and beyond to ensure we continued to deliver improvements, all of which have impacted positively on the quality, convenience and timeliness of patient care.

We achieved the majority of our 2024/25 operational objectives, but we know we have more to do in terms of meeting all the required levels of performance and in particular eradicating the remainder of the longest waiting times for diagnosis or planned treatment which includes some areas of cancer care.

Throughout the year we continued to build on our work to make Sheffield Teaching Hospitals NHS Foundation Trust a “brilliant place to work” and expanded our partnership activities to benefit local communities, our sustainability and wider NHS system working.

Improvement and innovation continued to be our watch words in 2024/25, and we had an increased number of submissions for the second year of our Dragons' Den innovation fund which encourages staff at all levels of seniority and in all roles to bid for monies to support an innovation which benefits patients and/or staff or makes better use of resources.

Our PROUD Improvement programme launched in 2024 has now been accessed by thousands of colleagues from across the organisation to give them the tools to identify, test and embed change. We also launched our PROUD Leadership programme this year which supports leaders across the Trust with the learning and tools to navigate the challenges and opportunities they are facing.

Turning to our operational performance, like other trusts across the NHS, we experienced unprecedented levels of demand for emergency care, compounded by high levels of flu and other seasonal respiratory viruses which led to a high level of admissions. Admitting these patients in a timely manner was particularly difficult because at any one time we had as many as 250 patients on our wards with “no criteria to reside”. These patients were not in the place best able to meet their ongoing needs now that their clinical care was complete. In line with our Winter Plan, we opened additional bed capacity and expanded several of our admission avoidance services like virtual wards, remote monitoring and the Same Day Emergency Care Centre. Within the accident and emergency department we worked with Yorkshire Ambulance Service to introduce a new Ambulance Streaming Sister role, and a ‘Booster’ service improvement programme was put in place with a focus on improving timeliness of triage for walk-in patients in addition to those arriving by ambulance. An emphasis was also placed on more timely flow of patients out of the accident and emergency department and into admission areas, creating space for the ‘next ambulance patient’ to be brought into the accident and emergency department and handed over. All this work has started to have an impact on ambulance handover and patient wait times.

Unfortunately, patients who attend our accident and emergency department with mental health emergencies often wait longer than physical health

patients to transfer to an appropriate mental health service or unit. We have seen some improvement in the last 12 months following work with partners across the city, but this work must continue as a priority into 2025/26.

In terms of planned care, we have almost eliminated the longest waits for treatment we had as a legacy from the pandemic at the same time as reducing waiting times for new patients despite our waiting list growing. We still have more to do to return to our previous waiting times which were among the best in the NHS, but we are making good progress. Regrettably we have not been as quick to completely recover our cancer and diagnostic performance despite continued efforts across the different tumour sites. Significant progress has been made, and we are working with our partners across the South Yorkshire and Bassetlaw Cancer Alliance to further improve shared treatment pathways and transform care delivery models for the future.

Throughout the year we built further on the patient safety work initiated following our Care Quality Committee (CQC) inspection in 2022 and in particular the recognition and response to deteriorating patients and learning from incidents. A particular area of focus was the development of our Cause for Concern process which is based on Martha's law, and which will provide a clearly communicated process for relatives or carers to escalate any concerns they may have about a patient.

We also continued to build on safety improvements in our maternity service. One example is that we have seen a significant improvement in the quality of x-rays taken on the Neonatal Unit which has resulted in a higher standard of images at the first attempt and fewer babies being exposed to unnecessary doses of radiation. We have also seen sustained improvement reflected in the latest MBRRACE Perinatal Mortality Rate which showed our data is now in line with other large specialist maternity

units. We were also pleased that the results of the 2024 NHS Maternity Survey showed Jessop Wing to be the 11th most improved maternity service in the country. This was particularly pleasing because it was based on the opinions of our parents who have used our service and felt they had experienced a high standard of compassionate care. The Jessop Wing scored 'better than expected' in comparison to other Trusts in several areas, with no areas scoring 'worse' than other Trusts. 99% felt they were treated with respect and dignity during labour and birth and 97% felt they had confidence and trust in staff (during labour and birth).

Multi-disciplinary working between our vascular, diabetes, acute and community podiatry teams has resulted in us becoming one of the best performing centres in the country for preventing diabetes related foot ulcers which, if left untreated, can lead to foot amputation. 85.7% of patients with diabetic foot ulcers are seen within 13 days of presentation, compared to an average of 66.6% in England and Wales as whole. Seeing patients quickly is vitally important because ulcers can deteriorate rapidly and lead to amputation if not treated. Foot clinic sessions in hospital now focus on seeing the most serious cases, while less severe cases are seen in a patients' home following investment in additional community podiatry capacity. Patients are referred to the community podiatry team the same or next working day. An image sharing platform has also been set-up to enable the podiatrist to share images if consultant advice is required. Investment in another surgical robot will enable even more patients with prostate cancer to benefit from less invasive surgery and a shorter recovery time. Our surgical teams have successfully carried out the region's first robotic-assisted hysterectomies for severe endometriosis and we have introduced mechanical thrombectomy for lung clot removal. This procedure is carried out under local anaesthetic and takes less than an hour.

We were thrilled when Cathy Harrison, one of our advanced nurse practitioners was named UK Nurse of the Year. Cathy has brought transformational change to the care of patients with bleeding disorders not just in Sheffield but nationally and across the World.

As part of a national initiative, we introduced opt-out blood borne virus testing in our accident and emergency department which means that people aged 16 and over who receive routine blood tests when they attend the accident and emergency department will be tested for HIV, hepatitis B and hepatitis C, regardless of symptoms unless they choose to opt-out. The routine testing is supporting earlier detection and diagnosis of the blood borne viruses, saving lives and giving people access to the latest and most effective treatments (which can be curative in the case of hepatitis C). More than 56,000 blood tests are carried out in our accident and emergency department a year and in just a few months since the start of the testing, positive cases have been identified and treatment provided.

All the improvements our teams have made this year have our PROUD values at their heart – putting patients first, being respectful, taking ownership to solve problems or make things better, working in unity as a team and delivering. They also deliver on our main aims as a Trust which are set out in our corporate strategy: Making a difference – the next chapter 2022-2027:

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

The improvements range from work that is enabling more patients to receive treatment in the familiarity and comfort of their own home, to the innovative use of technology to speed up diagnosis and take big strides forward in both our sustainability and equality, diversity and inclusion work. I have mentioned a few examples, but the list is by no means exhaustive and further details can be found in our latest Change Makers report (www.sth.nhs.uk).

Much of last year was focussed on preparing for the implementation of our new Connect Electronic Patient Record (EPR) which is one of the biggest investments we have ever made. The system which will go live this summer will support how we deliver safe, timely patient care and provide the foundation for our ongoing digital transformation. A key consideration in the procurement of the new system was the potential for the integration of other systems and interoperability with other NHS partners in the future given the increasing emphasis on system working and collaboration.

Another opportunity we are exploring is artificial intelligence. Artificial intelligence is becoming more prominent in many areas of life, and healthcare is no different. This presents opportunities to enhance and complement the crucial work of our clinicians, and there are excellent examples of how artificial intelligence is being used to help within our Trust with the diagnosis of kidney and heart conditions and dementia. Our innovative artificial intelligence tool developed to speed up MRI heart scan comparisons in a matter of seconds is attracting interest from across the NHS and further afield. As well as providing a faster diagnosis for patients it frees up clinicians to spend time with patients rather than on administration. The development was profiled as an example of an innovation that could point to a better future for the NHS on BBC Panorama. We will make these changes carefully – as well as offering fantastic potential benefits, there are also risks and we will ensure that any artificial intelligence is introduced safely.

As well as our new electronic patient record, we have invested to ensure our facilities and equipment keep pace with healthcare developments. We have refurbished the theatres in the Chesterman Cardiac Centre, installed two more linear accelerators to support delivery of cancer care and refurbished the Rivelin Ward in the Jessop Wing. We also carried out required reinforced aerated autoclaved concrete (RAAC) eradication work and replaced the generators at the Hallamshire Hospital. This was in addition to purchasing replacement and new medical equipment for use in a number of services.

Many of the achievements and developments outlined in this report would not be possible if we did not have financial stability and therefore our financial performance is one of our core aims to support the delivery of safe, high quality patient care. I am pleased to report that we have ended the 2024/25 financial year with a small £0.03m over delivery against our £6.9m surplus financial plan. The financial climate across the NHS and wider public sectors remains extremely challenging, and achieving this financial outcome has taken a huge effort from staff across the Trust. Continuing to explore every opportunity to further improve our operational efficiency in response to a changing financial regime, will be critical. The delivery of an ambitious cost improvement programme to achieve a sustainable financial position will be a key priority in 2025/26 and will focus on driving out variation that is not necessary, refining our ways of working and through partnerships explore how we deliver the best value for the resources we are given. During the year we have not just looked at what is happening inside our organisation but also our impact on our wider communities and how we can positively contribute to reducing health inequalities and improving our sustainability. We are passionate about ensuring vulnerable communities have the same access to healthcare as others and our teams are always looking at how we can adapt what we do to meet specific needs.

We have a strong culture of research and innovation across our organisation and our researchers work across many specialities and disease areas to advance care and provide the evidence needed to introduce more effective interventions, new technologies and ways of working to shape future care.

Our longstanding partnerships with the City's universities play an important role in driving forward cutting-edge research and innovation, and we are supported in all our research activities by a multiplicity of partnerships at local, national and international level. I have shared just a few examples below of where we have made a real difference to people here in Sheffield and further afield.

We led breakthrough research which demonstrated that survival rates for patients with operable bladder cancer were significantly improved when patients were treated with an immunotherapy drug before and after surgery. Survival rates for advanced bladder cancer have remained stagnant for many years, so these findings offer hope to thousands of patients who face this devastating diagnosis.

Patients living with rare diseases face many challenges, so providing them with access to cutting-edge treatments before they are rolled out in the NHS can be transformative. In Sheffield we have been leading the way in this area with trials such as Fortitude which is a landmark study exploring whether the progression of a rare, incurable disease known as facioscapulohumeral muscular dystrophy can be disrupted by switching off the DUX4 gene. This gene is widely viewed as the gene that triggers muscle weakness and degeneration in patients with this degenerative condition.

The AWARE-IBD study funded by the Health Foundation's Common Ambition programme has improved outcomes for patients with debilitating lifelong conditions such as Crohn's and Colitis. As well as leading to fewer hospital admissions and investigations for the patients with IBD who took part in the study, a new national IBD toolkit, co-designed by the patients has been developed.

Working strategically with the health technology industry can be a force to help us improve the health of the population and respond to the challenges the NHS is facing. Our first-ever research partnership event with the Association of British Health Technology Industries and the Shelford Group, a collaboration between ten of the largest teaching NHS trusts was attended by representatives from over 30 health tech companies in addition to representatives from Sheffield's NHS and innovation organisations. Through a series of panel discussions, "Collaborate to Innovate" focused on ways to develop, evaluate and adopt novel health technologies to meet patients' needs effectively and build on the strength of Sheffield's existing local health tech innovation ecosystem.

Jessop Wing became a site to recruit newborn babies into the world leading Generation study testing babies for genetic conditions, the team have also become a study site for a new trial investigating whether routinely taking iron during pregnancy can prevent anaemia.

Over the last year our researchers have led innovative patient engagement work that has supported communities historically underrepresented in health research to lead healthcare research. Led by the NIHR HealthTechnology Research Centre Devices for Dignity in Long-Term Health Conditions, the team of researchers worked with the Sheffield Somali Community Centre to develop CognoSpeak TM, an artificial intelligence tool that uses speech and language analysis to detect memory problems at an early stage and thus predict dementia. By training the

technology on 50 Somali participants, the cutting-edge tool is now more inclusive and can recognise speech patterns in those who do not have English as a first language.

A groundbreaking research programme designed to improve health in Black communities was also launched by our NIHR Sheffield Biomedical Research Centre and the NIHR Sheffield BioResource Centre. The Improving Black Health Outcomes BioResource programme will match participants with relevant research studies to explore how Black communities develop and experience health conditions. These include sickle cell disease, diabetes, cardiovascular disease and kidney disease.

In conclusion we have had another challenging year but one which has ended with real improvements in our performance and an optimism which is being harnessed as part of the development of our new STHCare2035 clinical blueprint which will shape how we deliver care into the future. Our overriding priority will continue to be to deliver safe, high-quality care for all our patients and provide a brilliant place to work for our staff. We see the benefits of working collaboratively and at scale to overcome some of the common challenges facing health and social care currently and collaboration will be key as we navigate the national and local changes ahead. Our quality priorities will guide our work, and we will monitor progress in terms of benefits to patients and our staff.



Kirsten Major
Chief Executive

Part 2 – Priorities for Improvement



2.1 Priorities for Improvement 2024/25

Safety - Improve the assessment and management of pressure ulcer risk to ensure patient safety.

Background

Feedback from a number of sources (Pressure Ulcer Root Cause Analysis investigation incident themes / Pressure Ulcer Review Meeting, internal audit documentation audits and Care Quality Commission inspections) had indicated that pressure ulcer risk was not always correctly identified.

The National Wound Care Strategy Programme / Health Innovation Network published pressure ulcer recommendations and a clinical pathway (October 2023) to provide clear advice to health or care practitioners, service managers and commissioners about the fundamentals of evidence-informed care for people who were at risk of developing pressure ulcers. This document stated that everyone receiving care from a health or care professional should be screened for pressure ulcer risk using PURPOSE-T (or another validated risk assessment tool that, as a minimum, contains the same risk factors as PURPOSE-T).

Objective breakdown

The purpose of this objective was to improve the assessment and management of pressure ulcer risk to ensure patient safety through the implementation of PURPOSE-T across all in-patient areas.

Achievements against objective

- Agreed trajectory for PURPOSE-T implementation met and further implementation of PURPOSE-T across the wider organisation, including Community Services, Accident and Emergency Department and Maternity Services.
- PURPOSE-T built into the new Electronic Patient Record.
- Pressure ulcer rates and categories monitored through the Pressure Ulcer Strategic Group with oversight from the Nurse Executive Group.
- Embedding of PURPOSE-T as an objective of the Nursing and Midwifery PROUD Improvement plan.
- To improve compliance with PURPOSE-T the following improvement actions have been taken:
 - Newsletter to advise staff how to correctly complete forms with targeted support.
 - Mandating of sections of the form in MetaVision for Critical Care areas.

This was a one-year objective, and the objective aims are complete. PURPOSE-T has been implemented across all inpatient areas and the wider organisation, with no delays, to improve the recognition of risk of pressure ulcers. Ongoing oversight of further improvement work in relation to the assessment and management of pressure ulcer risk will be through the Pressure Ulcer Strategic Group.

Patient Experience - Improve the experience of people who are blind or visually impaired, with a focus on communications.

Background

Feedback via Healthwatch and The Sheffield Royal Society for the Blind from patients who are blind or visually impaired indicated that their experience could be improved through better communications and increased staff awareness of needs.

Discussions with Sheffield Royal Society for the Blind highlighted that communication needs and preferences of people who are blind or visually impaired had changed as new technology had become available and we needed to ensure that the ways in which we communicate reflected the individual preferences of patients.

Studies nationally have highlighted a failure to meet the communication needs of people who are blind or visually impaired as a key barrier to accessing health and care services.

Objective breakdown

The purpose of this objective was to improve the experience of people who are blind or visually impaired, with a focus on communications by adopting a co-production approach to:

- Implement tangible actions to increase staff awareness of resources available and best practice when caring for patients who are blind or visually impaired.
- Understand and increase the number of blind or visually impaired patients whose Accessible Information Standard (AIS) communication preferences are recorded and met.
- Engage with patients who are blind or visually impaired to understand their experience, with a focus on communications.

Achievements against objective

- Face to Face interactive training was delivered by Sheffield Royal Society for the Blind for staff and volunteers.
- Evaluation of training has been very positive.
- Increased communication to e-communications was positive.
- Improved recording of patients AIS requirements and will be further strengthened when the new Electronic Patient Record is launched.
- Positive links with Sheffield Royal Society for the Blind with plans for further work.
- Assistance dog policy was reviewed to provide clarity for staff.
- Priority areas and communication plan for toolkit roll out have been agreed.

This was a one-year objective, with most objective aims complete. Roll-out of the Visual Impairment Toolkit was not complete; however, funding had been agreed in principle and the process for procurement was being finalised, and due for completion by July 2025.

Ongoing oversight of further improvement work in relation to improving the experience of people who are blind or visually impaired will be through the Patient Experience and Engagement Group.

Effectiveness - Improve the management of pain for patients.

Background

Following an analysis of patient experience data with regards to Pain Management a deep dive was undertaken. This deep dive, completed in September 2023, included a patient experience survey and clinical audit. The results highlighted some positive areas but also identified that:

- Pain prescribing across the Trust was not in line with the pain score/World Health Organisation (WHO) pain ladder.
- Care plans did not always include any detail on pain management.
- Patients were not always getting the pain relief requested within the 30 minutes set by the Trust policy.
- Patients did not always understand expectations in terms of pain and the approach to pain management.

To further explore knowledge amongst resident medical staff a survey was undertaken which showed a lack of confidence with regard to management of pain in complex cases, particularly substance misuse and issues accessing pain guidance and resources.

Objective breakdown

The purpose of this objective was to improve the management of pain for patients by:

- raising awareness of pain assessment and appropriate management with nursing and support staff.
- ensuring there were discussions with patients about expectations of pain.
- ensuring analgesia was prescribed according to the WHO pain ladder.
- establishing a process for the recording of functional pain scores within an effective care plan.
- ensuring patients received pain relief within 30 minutes where appropriate and safe.

Achievements against objective

- A patient leaflet on pain management was developed and published.
- Acute Pain SharePoint site was developed and accessible via the Trust intranet.
- Functional pain scores have been included within the new Electronic Patient Record.
- Education days were delivered to mark Pain Awareness month.
- A series of short "Pain Bite" training videos were launched and promoted trust wide during Pain Awareness month.
- A digital patient story was developed for use in training and awareness.
- Pain Management awareness for resident medical staff became part of the ongoing resident doctor programme, rather than induction.
- The pain management care plan was developed and made ready for when the new Electronic Patient Record goes live.
- New Trust-wide Integrated Pain Working Group established.
- Audit of documentation for 100 patients across 20 wards, showed:
 - All patients had a pain assessment.
 - 96% of those with pain were administered some form of analgesia.

- Patient survey of 175 patients across 20 wards showed an improvement in the numbers of:
 - patients who received pain relief within 30 minutes.
 - patients who reported that their pain was well managed
 - patients who felt their pain medication had been explained to them.
- The repeat survey of resident doctors showed improvements in awareness and confidence.

This was a one-year objective, with most objective aims complete, and results of the repeat patient experience survey, clinical audit and resident doctor surveys all showing an improvement in performance. It was not possible to launch the pain management care plan due to the delay with the new Electronic Patient Record, however this is included and ready for when the new system goes live in July 2025. Ongoing improvement work will be overseen by the new Integrated Pain Group, who report to the Quality and Safety Executive Committee.

2.2 Priorities for Improvement 2025/26

This section describes the Quality Improvement Priorities that have been adopted for 2025/26.

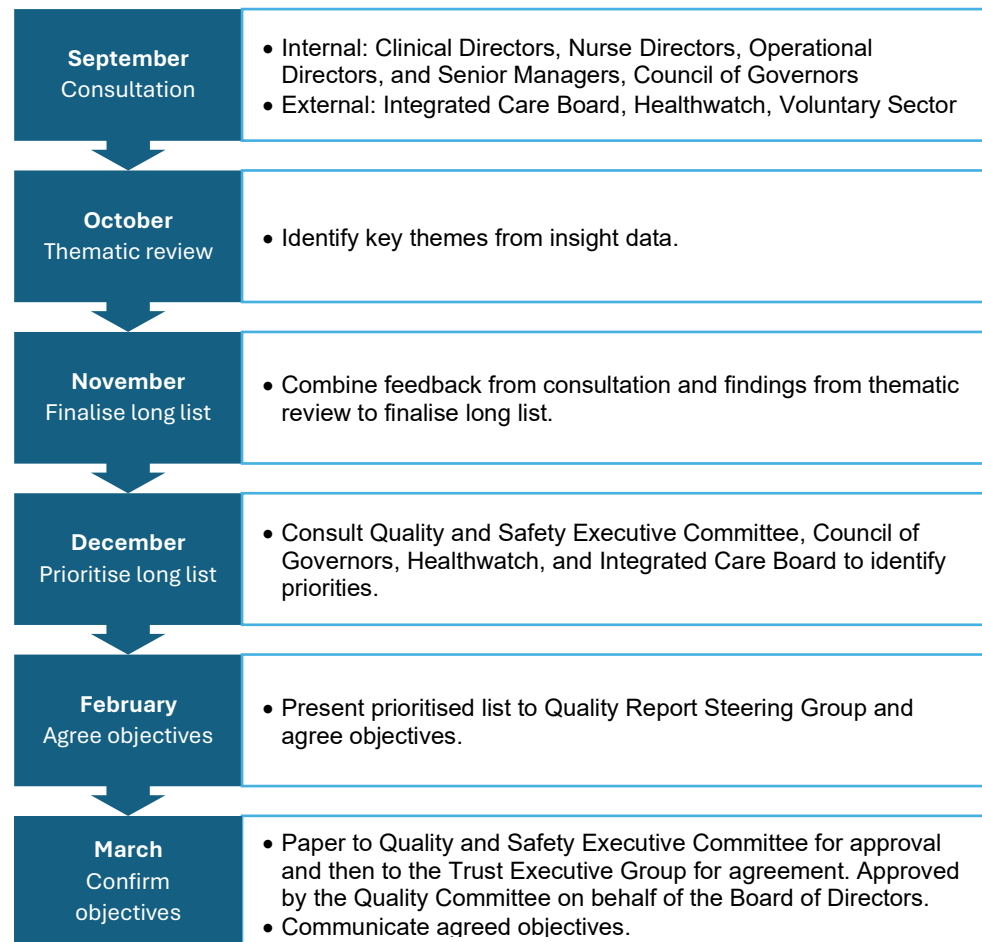
To ensure the Trust is constantly improving the quality of care and the patient experience, new Quality Objectives are selected each year.

Our 2025/26 Quality Objectives have been selected after a detailed consultation internally with Clinical Directors, Nurse Directors, Operational Directors, Senior Managers, and Council of Governors as well as external agencies including the Integrated Care Board (ICB) and Healthwatch. Suggested topics for objectives were triangulated with data from audit, incidents, and complaints, as well as consideration of areas likely to have a significant impact on the quality of care delivered to our patients.

Following discussion on 4 February 2025 at the Trust's Quality Objective Steering Group, chaired by the Chief Medical Officer (Operations) with membership including the Chief Nurse, Quality Director, Trust Governors, Senior Managers, Sheffield Healthwatch and voluntary sector representation (Sheffield Churches Council for Community Care), three Quality Objectives were agreed. These Quality Objectives were approved by the Quality Committee, on behalf of the Board of Directors, in April 2025.

The objectives for 2025/26 span the 'Patient Experience', 'Safety' and 'Effectiveness' domains within the Trust's Quality Strategy, and are presented on the following page.

Opposite is the process followed to select the 2025/26 Quality Objectives, the same process will be followed to select the 2026/27 Quality Objectives:



2025/26 Objectives

	Patient Experience	Safety	Effectiveness
	Improve the support given to older people with frailty admitted to hospital to prevent deconditioning.	Increase and improve system-based learning achieved following near miss and low harm incidents.	Improve services for young people including healthcare transition.
Rationale	<p>Many patients with frailty will spend most of their time in bed and only walk a few steps a day, which, when combined with acute illness, produces a rapid loss of mobility and muscle strength resulting in:</p> <ul style="list-style-type: none"> • Increased risk of mental and physical deconditioning • Poor patient experience • Harm to patients such as pressure damage, poor nutrition and hydration, falls • Increased length of stay in hospital, increasing their care needs and demand on services, and increase future rehabilitation requirements 	<ul style="list-style-type: none"> • To increase the number of learning responses (Swarm Huddles, After Action Reviews and MDT Learning workshops) undertaken for incidents coded as near miss or low harm. • To ensure that in line with Patient Safety Incident Response Framework (PSIRF), near miss and low harm incidents are reviewed using system-based methodologies and not root cause analysis. • To ensure the learning responses for near miss and low harm incidents are of high quality and are system-based. • To raise awareness and increase knowledge and skill for all staff reviewing incidents to strengthen learning and improve safety culture. • To increase the tools available to support a greater variety of learning styles. 	<ul style="list-style-type: none"> • Develop robust reporting and governance structures. • Develop leadership capability in healthcare transition within directorates. • Involve young people's voice into the clinical strategy and delivery programme. • Improve the offer of healthcare transition training for staff. • Improve mechanisms for receiving and acting on meaningful feedback from young people.
Output/ metrics	<p>Improved experience for older people with frailty admitted to hospital through the following metrics:</p> <ul style="list-style-type: none"> • Frailty score. • Barthel Score. • Gap analysis (Current practice v best practice). • Time to intervention (days). • Registered service evaluation. • Reduced length of stay for frailty patients. • Increase in patients who are out of bed for lunch. • Increase in patients in their own day clothes during their hospital stay. 	<ul style="list-style-type: none"> • Increase in number of learning responses (Swarm Huddles, After Action Reviews and MDT Learning workshops) undertaken following near miss and low harm incidents. • Increase in number of system-based learning outcomes and actions following review of near miss and low harm incidents. • Increase in methods utilised to share learning to meet a greater number of learning styles. • All clinical directorates will have shared system-based learning from a near miss or low harm incident at a relevant forum. 	<ul style="list-style-type: none"> • Robust transition governance arrangements established in two pilot Care Groups, with a view to rolling out Trust-wide in year two. • New oversight group for healthcare transition established, with agreed reporting arrangements to monitor performance against agreed key performance indicators. • Developmentally appropriate healthcare and healthcare transition training to increase by >20% for all staff involved in the direct care of young people up to the age of 25 years. • Newly developed healthcare transition standard operating procedure template adopted by pilot Care Groups and adapted and operationalised for local requirements.

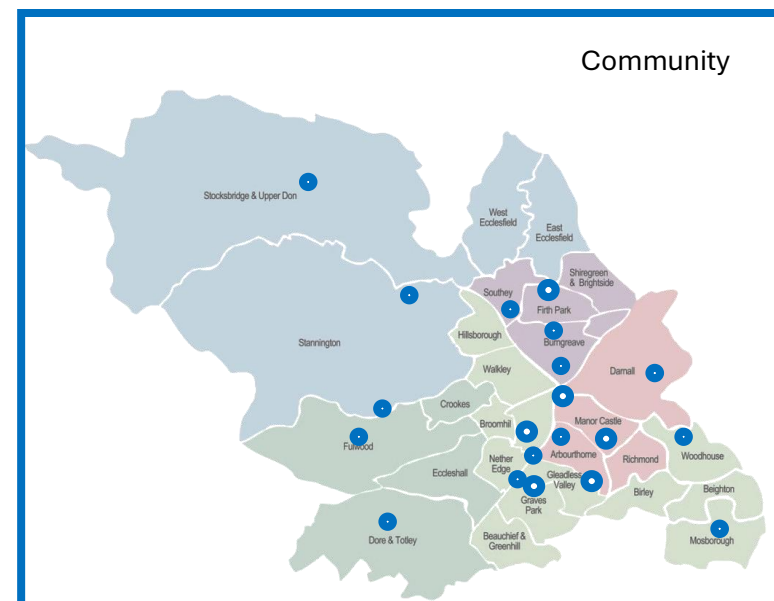
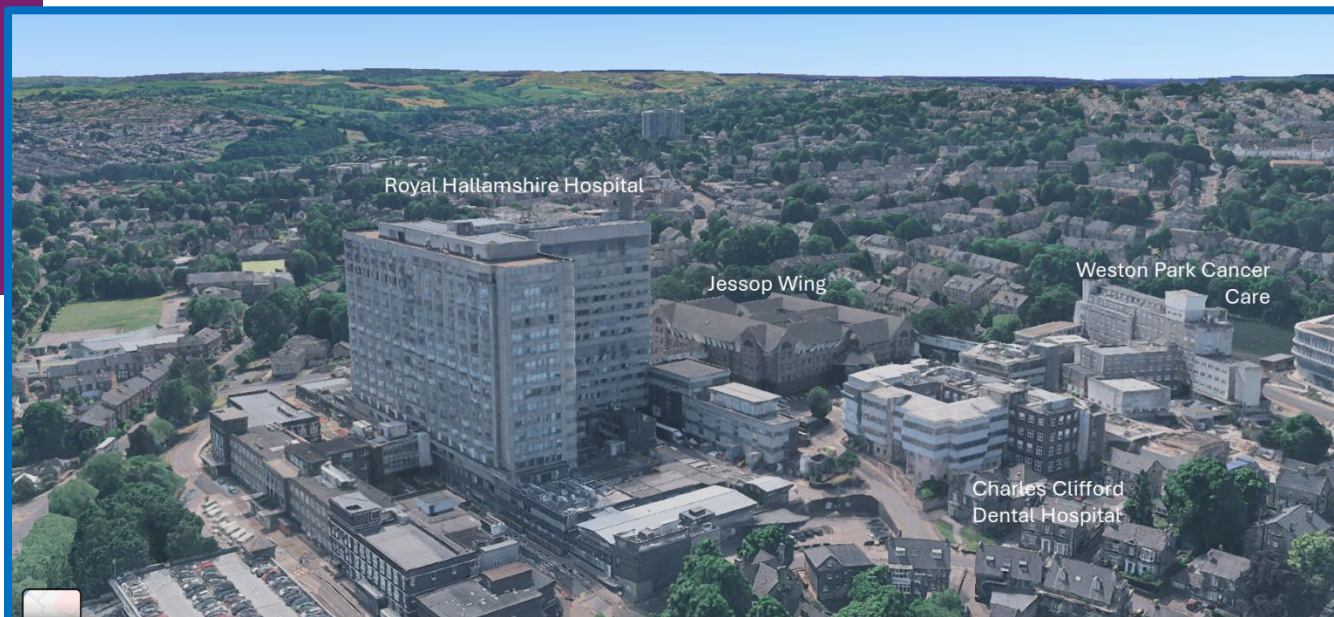
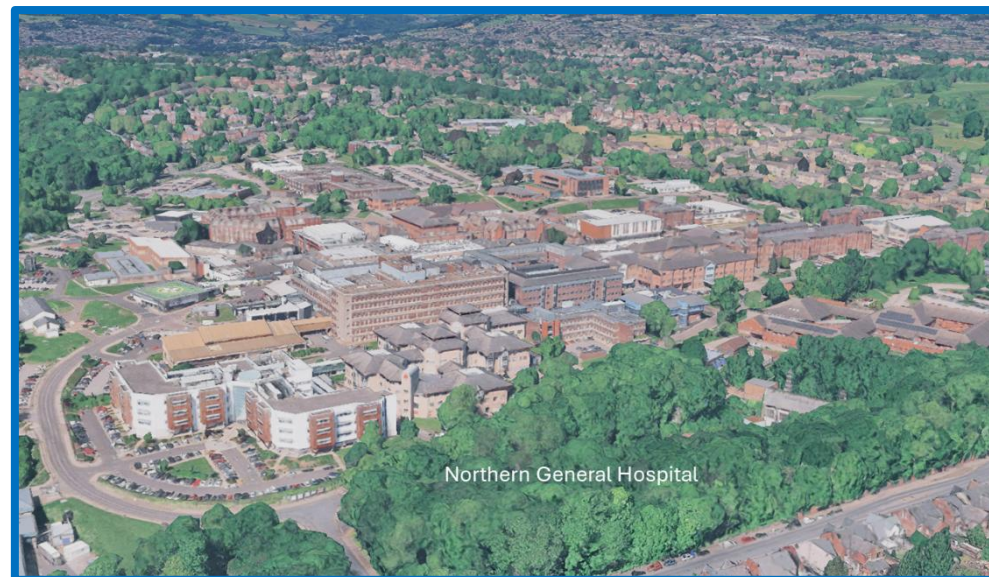
Part 3 – Trust Overview



3.1 Services Provided

During 2024/25 Sheffield Teaching Hospitals NHS Foundation Trust were commissioned to provide 87 NHS England (NHSE) specialised service specifications, a full range of routine elective services (medical and surgical), maternity services, emergency/non-elective services, community services, public health screening programmes and secondary care dental services.

During 2024/25 significant progress was made to recover elective capacity with a focus on treating long waiting patients who would have waited 52 weeks or more, including patients waiting longer than the 65 week wait standard, by the end of March 2025. This was delivered through core Trust capacity, and by insourcing and outsourcing additional capacity from independent sector providers in the most challenged specialties and diagnostic modalities including neurosurgery, gynaecology and MRI.



3.2 Care Quality Commission (CQC)

The Trust is required to register with the CQC, and its current registration status is fully registered. The Trust has no conditions on registration. The CQC has not taken enforcement action against the Trust during 2024/25.

Full Inspection

Following the full CQC inspection in September 2022, and the publication of the findings in December 2022, there have been no further full inspections, and therefore the Trust's overall CQC rating remains at 'Requires Improvement'. The breakdown of current CQC ratings for the Trust are presented below:

Current CQC Ratings (2022 Inspection)

	2022 Inspection
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement
Overall rating	Requires Improvement

The high-level action plan which was developed in response to the 2022 CQC Inspection Report continued to be progressed throughout 2024/25, with all workstreams now being closed and ongoing work for each workstream being overseen by the relevant committee.

Regular meetings take place between the Trust and NHS South Yorkshire ICB to provide assurance that the improvement work following the CQC inspection has been maintained.

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection

The CQC carried out an inspection in relation to IR(ME)R in Neuroradiology, Royal Hallamshire Hospital on 31 January 2024. An

improvement notice was issued by the CQC under the Health and Safety at Work Act 1974 and the Ionising Radiation (Medical Exposure) Regulations 2017 relating to written policies and employers' procedures. An action plan was developed to address the issues highlighted in the improvement noticed and submitted to the CQC on the 14 March 2024.

The final inspection report was received by the Trust on 8 March 2024. The report did not identify any regulatory action but had identified some breaches. To prevent failing to comply with legal requirements in future, and to improve the quality of services, the CQC recommended that the Trust should take a number of actions to comply. A detailed action plan was developed addressing the issues identified and submitted to the CQC on the 3 April 2024. The Trust was notified on 9 April 2024 that CQC were satisfied that the Trust action plans and associated documents, submitted in response to the Improvement Notice and report recommendations, had addressed their concerns and they closed the file on the inspection.

On 2 July 2024 the CQC carried out an inspection in relation to IR(ME)R in Radiotherapy department, Weston Park Hospital. The final inspection report was received by the Trust on 29 July 2024 and identified three areas where a breach had been found which did not justify regulatory action. To prevent failing to comply with legal requirements in future, and to improve the quality of services, the CQC recommended that the Trust should take a number of actions to comply. A detailed action plan was developed addressing the issues identified and submitted to the CQC on the 23 August 2024.

The Trust was notified on 3 September 2024 that CQC were satisfied that the Trust actions taken, or were intending to take, would address the recommendations made with a view to maintaining compliance with IR(ME)R in the future and they closed the file on the inspection.

Part 4 – Performance on Quality 2024/25 (Safety)

4.1 Patient safety	21
4.2 Infection Prevention and Control	25
4.3 Safeguarding	27
4.4 Staff who speak up	28
4.5 Rota gaps	29
4.6 Coroners' Regulation 28 (Prevention of future death) reports	29



4.1 Patient safety

Patient Safety Incident Response Framework

The Trust implemented the national Patient Safety Incident Response Framework (PSIRF) on 1 January 2024 and a Trust specific Patient Safety Incident Response Plan (PSIRP) was published in addition to a maternity PSIRP. The PSIRPs, alongside associated policies and guidelines, set out

Trust Priority

- **Medication related**
Time sensitive medications delay
- **Communication**
Sharing of critical information during handovers or patients cared for on shared pathways
- **Appointment issues**
Delay in Outpatient appointment due to process issue
- **Infection Control**
Control measures not followed
- **Medical Records**
Data entry or transcript error
- **Discharge**
Inadequate or missing information
- **Delay in treatment**
Delay in treatment caused by process error
- **Diagnostic result issue**
Delayed result or result not available
- **Issue with Specimen**
Specimen processed incorrectly, or mislabelled by ward
- **Admissions**
Patient crowding in Emergency Department
- **Falls**
Where the contributory factors are unknown
- **Pressure Ulcer and Skin Damage**
Where the contributory factors are unknown

how the Trust responds to all patient safety incidents for the purpose of system and organisational learning to improve the safety for patients.

Alongside nationally indicated priorities, 12 local and 10 maternity specific priorities are outlined in the PSIRPs as described in the below:

Maternity Specific

- **Unplanned Admission to Neonatal Unit**
All unplanned Term admissions to Neonatal Unit
- **Failure to follow protocol/ escalate**
Failure to escalate fetal monitoring concerns and deteriorating patient
- **Category 1 caesarean section**
Delay greater than 30 minutes for Category 1 Caesarean section
- **Communication issue**
Communication failure within team
- **Stillbirth/Neonatal Death**
Stillbirth/neonatal death occurring in the Jessop Wing
- **Drug related incident**
Omitted drug, wrong dose or frequency
- **Massive Obstetric Haemorrhage**
Antenatal or postpartum haemorrhage over 1500mls
- **Birth Injury/ Complication**
Perineal trauma with Obstetric Anal Sphincter Injury
- **Delay in treatment**
Delay in acting on Cardiotocograph
- **Missed small for gestational age**
Baby born below the 3rd centile when growth issue not identified in pregnancy

System-based responses that can be undertaken in response to patient safety incidents include, Patient Safety Incident Investigations (PSIIs), After Action Reviews, Swarm Huddles and Multi-disciplinary learning workshops. The response type chosen will be guided by the opportunities for new learning and the needs of those affected. In 2024/25 20 PSIIs were declared, of which 17 met national criteria including four Never Events, and three related to local priorities (Delay in treatment, Stillbirth/Neonatal Death, and Birthing Injury/ Complication). 105 After Actions Reviews were undertaken, 496 Swarm Huddles and 175 Multi-disciplinary learning workshops.

Patient safety incidents

Examples of actions taken in response to findings and recommendations from patient safety incident learning responses include:

- revision and re-launch of the deteriorating patient screening tool to include guidance on escalation based on 'relative' or 'staff' concern in the absence of a raised early warning score,
- installation of wall racks in surgical procedural areas to enable segregation of histology samples when multiple samples are required for one patient,
- the trial of L-shaped draping for nerve root injections to cover the side not being injected and reduce the risk of wrong side injections.

	STH		
	2022/23	2023/24	2024/25
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.	31,359	31,119	30,453
Number of incidents reported Rate of ward-based patient incidents per 1000 bed days. Due to this no longer being published nationally through the National Reporting and Learning System the data presented are taken from local data.	29.9	29.3	27.6
The number and percentage of patient safety incidents that resulted in severe harm or death	189 (0.6%)	153 (0.5%)	152 (0.5%)
Never Events (Count)	8*	4	4

* 1 of the 8 Never Events for 2022/23 occurred at Spire Claremont Hospital

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 2024/25, four Never Events were declared, and all were in relation to 'wrong site surgery'.

Learning from patient safety incident responses including Never Events is shared through multiple fora within the Trust, including the Trust's Safety and Risk Forum, Management Board Briefing, relevant subject committees and via Trust-wide monthly safety messages from the Chief Medical Officer (Operations).

The Trust is continuously working to strengthen learning opportunities and ensure improvements made are sustainable and embedded. Examples of actions that have been taken in response to Never Events include optimising theatre environments to be more conducive to completing vital safety checks and standardising processes for the viewing of medical photography to enhance identification of the specific surgical site.

Duty of Candour

Duty of Candour in healthcare refers to the obligation for health and care providers to be open and honest with patients and their families when something goes wrong with their care, causing or potentially causing harm. This requires providers to apologise for the harm caused, even if there's no fault, and to explain what happened in a clear and understandable way.

The Trust Incident Management Policy reflects the expectation in relation to Duty of Candour and this is supported by the Duty of Candour Policy. Duty of Candour training is currently provided via an e-learning resource.

All incidents, including those which trigger the Duty of Candour, are reported on Datix, the Trust's electronic incident management system. For

the statutory Duty of Candour regulations to be considered, a patient safety incident has to be classed as an incident of moderate, major, or catastrophic severity. A trigger is then activated in Datix to prompt consideration whether Duty of Candour applies.

An audit completed in December 2023 demonstrated that evidence of Duty of Candour conversations and the associated written obligations were not consistently captured on Datix. In response, the Duty of Candour questions within Datix were reviewed and amended in January 2025 to ensure that the correct data pertaining to Duty of Candour were captured.

During 2024/25, the number of incidents that met this criterion was 1,451, this was a 18.5% decline from the previous financial year where the number was 1,702. Of the 1,451 incidents, Duty of Candour was confirmed on the Datix record as being applicable to 924 cases.

Further audits are being undertaken at monthly intervals to provide assurance that appropriate decisions regarding Duty of Candour are being taken in line with national guidance. Work is planned to develop additional training material and relaunch the training and education regarding Duty of Candour.

Patient Safety Alerts

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

The following are examples of actions taken and changes made as a result of Patient Safety Alerts closed in 2024/25:

- To reduce the risk of transfusion-associated circulatory overload (TACO) which can cause respiratory compromise following a blood transfusion, the Trust adopted a TACO risk assessment on all blood

transfusion charts and updated staff training to include actions to identify and respond to TACO.

- To decrease the risk of an oxytocin overdose during labour and childbirth, the practice of making up oxytocin prior to requirement on Labour Ward was discontinued in May 2024. Trolleys were introduced on the Labour Ward and Midwifery Led Unit with equipment to manage a Post-Partum-Haemorrhage and if it is required oxytocin is available but kept separately in the drug fridge.

Patient safety alerts 2024/25

Title	Issued	Deadline (action complete)	Open/ Closed
Discontinuation Of Promixin (Colistimethate) 1-Million Unit Powder For Nebuliser Solution Unit Dose Vials	17/03/2025	30/04/2025	Open
Risk Of Oxytocin Overdose During Labour And Childbirth	24/09/2024	31/03/2025	Closed
Shortage Of Erelzi (Etanercept) 50mg Solution For Injection In Pre-Filled Pen	03/05/2024	10/05/2024	Closed
Shortage Of Human Albumin 4.5% And 5% Dose Vials	30/07/2024	07/08/2024	Closed
Shortage Of Kay-Cee-L (Potassium Chloride 375mg/5ml) (Potassium Chloride 5mmol/5ml) Syrup	26/07/2024	12/08/2024	Closed
Shortage Of Molybdenum-99/Technetium99m Generators	25/10/2024	08/11/2024	Closed
Shortage Of Orenia Clickject (Abatacept) 125mg/1ml Solution For Injection Pre-Filled Pens	23/05/2024	06/06/2024	Closed
Shortage Of Pancreatic Enzyme Replacement Therapy (Pert)	24/05/2024	10/06/2024	Closed
Shortage Of Pancreatic Enzyme Replacement Therapy (Pert) - Additional Actions	18/12/2024	31/01/2025	Closed
Update on declaring compliance to NatPSA/2024/002/NHSPS from the NHS England Patient Safety Team	28/01/2025	14/02/2025	Closed
Update: Discontinuation Of Kay-Cee-L (Potassium Chloride 375mg/5ml) (Potassium Chloride 5mmol/5ml) Syrup	21/10/2024	31/10/2024	Closed

4.2 Infection Prevention and Control

Infection Prevention and Control continues to be a major focus of the Trust given its direct impact on patient outcomes and experience as well as the operational capacity of the Trust. In 2024/25, the Trust published an annual plan to outline its Infection Prevention and Control priority actions supplementing its ongoing activity detailed within the Infection Prevention and Control Framework, supported by individual policies and procedural documents.

Similar to other large trusts, during 2024/25, the Trust responded to significant, resource intensive outbreaks of influenza and norovirus and enhanced its preparedness for emerging or increasing threats posed by infections including mPox, measles, pertussis and high consequence infectious diseases. A further major and increasing threat is posed by

Clostridioides Difficile

Hospital Onset/Healthcare Associated cases

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.

Community Onset/Healthcare Associated cases

The rate per 100,000 bed days of Community Onset/Healthcare Associated cases community associated cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period.

	STH		
	2022/23	2023/24	2024/25
Hospital Onset/Healthcare Associated cases	26.35 (117 cases)	20.89 (93 cases)	25.68 (114 cases)
Community Onset/Healthcare Associated cases	10.70 (52 cases)	8.62 (42 cases)	11.12 (54 cases)

The rates are as stated in April 2025 on the UK Health Security Agency Healthcare Associated Infections database which uses KH03 occupied overnight beds per 100,000 as a denominator for this parameter.

Community onset cases presenting within 28 days of discharge, have been included in the objectives allocated to trusts since 2019/20. These rates are

resistant Gram negative bacteria, most concerningly carbapenemase producing Enterobacterales and numbers of detections of these organisms have increased in Sheffield as they have nationally. Mitigating the risk posed by these organisms requires a multi-pronged approach including staff education and practice development, facilities management and antimicrobial stewardship.

In May 2024, a new National Action Plan for Antimicrobial Resistance was issued and will guide the Trust activity in this sphere over the coming years. The Trust continues to perform well compared to peers with respect to antimicrobial prescribing data.

calculated from data as stated in April 2025 on the UK Health Security Agency Healthcare Associated Infections database also using KHO3 occupied overnight beds per 100,000 as denominator for this parameter.

Position against national objective

During 2024/25 there have been a) 114 C.difficile Hospital Onset/Healthcare Associated episodes detected and b) 54 C.difficile Community Onset/Healthcare associated episodes detected within the Trust; total of 168. The national objective threshold allocated to the Trust for 2024/25 was 129. This objective was therefore not achieved.

Nationally, a significant increase in rates of C.difficile infection was noted in 2024/25, mirroring the Trusts experience. The cause for this is unclear.

Typing of C difficile strains has not demonstrated expansion of any obvious more virulent or transmissible strain.

Existing measures to tackle C.difficile will continue including review of all cases for potential learning, promotion of antimicrobial stewardship and review of Infection Prevention and Control practice and cleanliness in areas with potentially linked cases and will be supplemented by further initiatives in the 2025/26 Infection Prevention and Control Annual Plan.

MRSA blood stream infections

	STH		
	2022/23	2023/24	2024/25
Trust Hospital Onset bacteraemia cases	2	6	0
Trust threshold for Hospital Onset episodes	0	0	0

Although the absence of any hospital onset MRSA bacteraemias in 2024/25 is clearly good news, the low expected numbers each year make it difficult to interpret as a single data point. A number of actions taken over the past 12 months to improve Trust performance with respect to Methicillin Sensitive *Staphylococcus aureus* bacteraemia should also help to prevent MRSA bloodstream infections.

4.3 Safeguarding

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

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

The Chief Nurse is the Trust Executive Lead for Safeguarding and represents the Trust on each of the Partnership Boards.

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

The Trust is required to provide assurances to the Safeguarding Partnership via an annual Section 11 Audit and assurance meeting, by the submission of data, and by contributing to Quality Assurance Action Plans.

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

The Trust holds a quarterly Safeguarding Assurance Group, presenting a Highlight Report after each meeting and providing an Annual Safeguarding Report to the Quality and Safety Executive Committee.

Mandatory quarterly reports are submitted to NHS England (NHSE)

- a) in respect of cases of Female Genital Mutilation identified by services in in the Trust, and
- b) for Prevent training compliance.

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

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

The Trust's Safeguarding Team supports staff and managers to identify and respond to adults and children, patients and staff, who are subject to domestic violence and abuse. The team works in close collaboration with the Emergency Department and the Maternity Safeguarding Team, and in liaison with external agencies.

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

4.4 Staff who speak up

The Trust is dedicated to creating an environment where employees feel protected and supported when raising concerns in the public interest. Employees of the Trust have multiple ways to raise concerns about patient or staff safety, wellbeing, unacceptable behaviour, or bullying and harassment. Staff are encouraged to initially address concerns with supervisors or line managers to facilitate prompt resolution.

The Trust's Lead Freedom to Speak Up (FTSU) Guardian, supported by voluntary Guardians and a network of Champions, provides comprehensive support for staff who feel unable to raise concerns through other channels. Contact details for Guardians and Champions are accessible via the FTSU intranet site, displayed on posters across the organisation, and available through a dedicated FTSU email address. An audit of the Trust's FTSU systems and processes has been completed, with all resulting actions successfully implemented, further solidifying the effectiveness of speaking-up mechanisms. To maintain the capacity required to address concerns, the Trust actively recruits voluntary Guardians, ensuring sufficient support for staff. Whistleblowing legislation, specifically the Public Interest Disclosure Act 1998 (PIDA), ensures workers are safeguarded from detriment or unfair treatment as a result of speaking up. All staff raising concerns receive feedback from either their Guardian or the investigating manager, reinforcing the Trust's commitment to transparency and accountability.

To raise awareness, the national FTSU eLearning packages (Speak Up, Listen Up, Follow Up) are utilised, highlighting the importance of speaking up and promoting a supportive environment. FTSU is also embedded into corporate induction programmes, as well as those for newly qualified midwives, Year 1 nursing students, and resident doctors, ensuring all new staff are familiar with speaking-up mechanisms. The presence of the FTSU team has been enhanced through active participation in meetings and

events. Staff engagement is further bolstered by promotional activities, providing opportunities for direct interaction with Guardians and Champions to discuss concerns and access support.

The FTSU Policy, updated in November 2024, includes new procedures for reporting sexual safety concerns and enhanced guidance on addressing detriment. Together with the Acceptable Behaviour at Work Policy, these policies outline inclusive and consistent arrangements for speaking up. Additionally, lessons learned from FTSU cases are shared regularly during meetings and forums, promoting shared learning and improvements across the organisation.

The Terms of Reference for the People Committee were updated and approved by the Board of Directors on 23 July 2024. Under Duties and Responsibilities 2.10, these updates ensure that the Trust has effective systems in place for raising concerns at work. This includes reviewing FTSU activity reports and monitoring progress against agreed priorities, further demonstrating the Trust's commitment to fostering a culture of openness and inclusion.

Collaboration between teams has been significantly strengthened to enhance the support provided to staff when speaking up. Connections with the Organisational Development team, to foster alignment and collaboration to build a culture that empowers staff to raise concerns confidently. By working closely with Organisational Development, Human Resources, Quality Governance, and staff partners, the Trust has established a unified approach to addressing concerns collaboratively. These collaborative efforts underpin the Trust's commitment to a culture of continuous improvement and shared learning, enabling staff to voice their concerns without fear of repercussions and promoting an inclusive, open working environment.

4.5 Rota gaps

There continue to be significant challenges in filling medical rotas. There are gaps on rotas due to lack of trainees allocated by NHS England's Workforce, Training and Education Directorate and the significant increase in less than full time training requests. The Trust has a very successful internal locum bank, with which around 90% of Trust doctors in training are registered, and this provides a cohort of doctors familiar with the Trust, its processes, procedures, and IT systems who can be asked to fill gaps. The Trust face additional challenges this year relating to the use of locums when considering the governments instruction to reduce the use of bank and agency spend. The Trust also continues to appoint non-training grade posts to support longer term gaps on rotas and continues to review the use of non-medical staff to support the clinical teams.

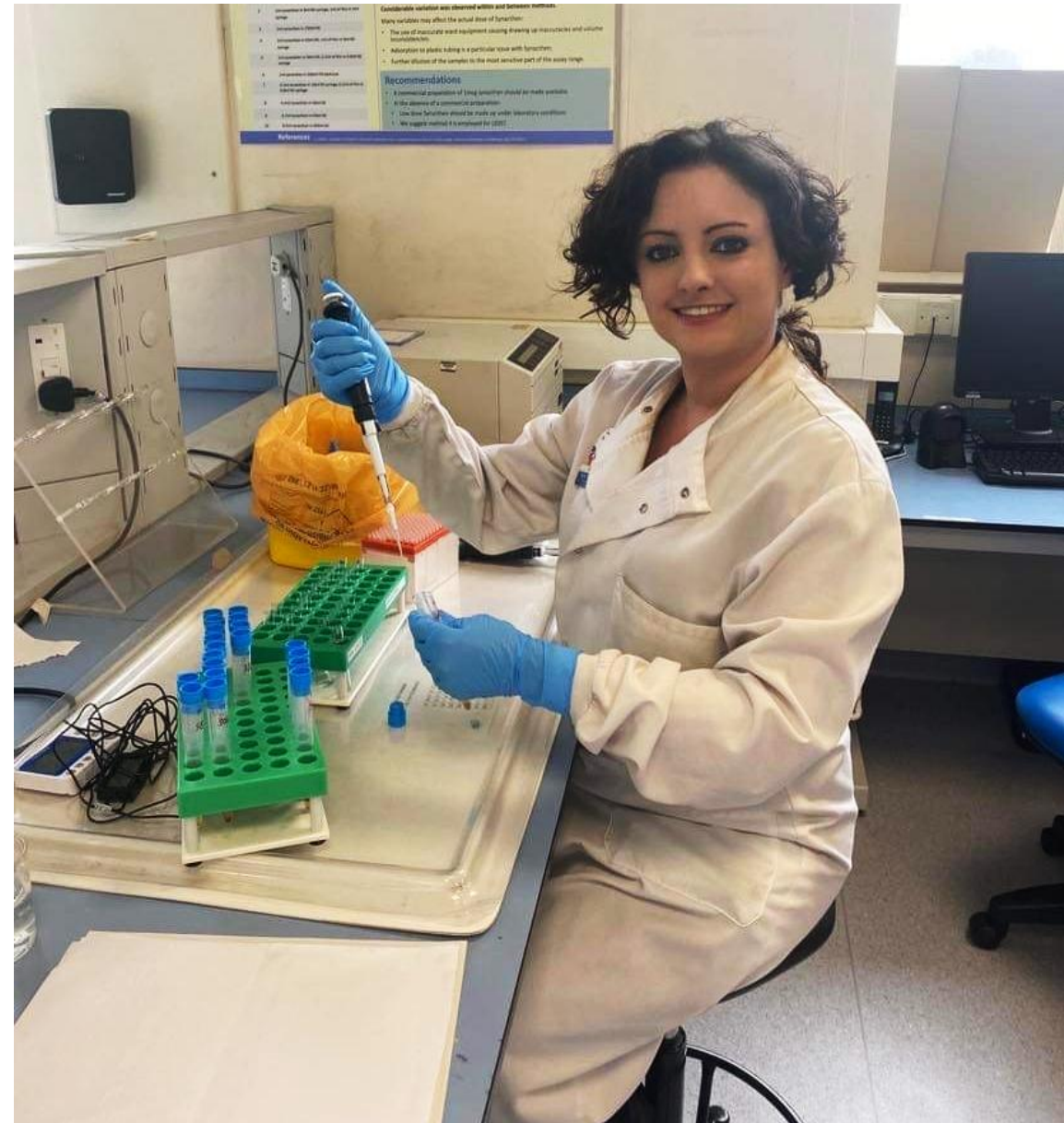
A well-established Hospital Out of Hours service is in place at both campuses and makes efficient use of the out of hours workforce, allocating tasks to the most appropriate staff member, some of whom are non-medical.

4.6 Coroners' Regulation 28 (Prevention of future death) reports

Following an inquest or investigation into a death, a coroner may issue a Regulation 28 Prevent Future Deaths report where the coroner believes that action to address some of the identified concerns should be taken to prevent future deaths. During 2024/25, no Regulation 28 reports were received by the Trust.

Part 5 –Performance on Quality 2024/25 (Experience)

5.1 Annual patient surveys	31
5.2 Patient Friends and Family Test	35
5.3 Complaints	37
5.4 NHS Staff Survey (including Staff Friends and Family Test)	40
5.5 Equality, Diversity and Inclusion	42
5.6 Delivering same-sex accommodation	45



5.1 Annual patient surveys

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

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

During 2024/25:

- The Trust participated in the National Survey programme for cancer care, maternity services, urgent and emergency care, and adult inpatients.
- The CQC published results for the 2023 National Adult Inpatient Survey, the 2023 National Cancer Patient Experience Survey, the 2024 Maternity Survey and the 2024 Urgent and Emergency Care Surveys.

The results for the 2024 National Adult Inpatient Survey and the 2024 National Cancer Patient Experience Survey will be published during 2025.

National Adult Inpatient Survey 2023

The National Inpatient Survey 2023 was carried out across 131 acute and specialist NHS trusts in England. All adult patients (aged 16 and over) who had spent at least one night in hospital during November 2023 and were not admitted to maternity or psychiatric units were eligible to be surveyed. For the 2023 survey, surveys were sent to 1,250 patients, from whom 465 responses were received, equating to a 40% response rate. This compares to a national response rate of 42%.

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

In terms of the question relating to overall experience, the Trust score of 8.4 was ranked 'about the same' as other trusts, with a score slightly above the national average of 8.1 and remains in line with the score from the 2022 survey.

In response to this survey, a Trust-wide action plan has been developed to improve patient experience during admission. The actions within this action plan focus on the following areas:

- Minimising disruption to sleep at night.
- Understanding patients' expectations related to hospital food and improving experiences of food provided.
- Improving communication with younger patients.
- Nurse staffing levels - understanding patients' perceptions of staffing levels and triangulating this against safe staffing data for the area.
- Improving patient experience in relation to pain management.

Responsiveness to personal needs of patients

This indicator measures hospitals' responsiveness to inpatients' personal needs based on a selection of questions from the National Inpatient Survey.

Benchmarking (based on the average scores across all NHS trusts who are contracted with Picker)			STH		
2022/23	2023/24	2024/25	2022/23	2023/24	2024/25
92%	93%	**	93%	93%	**

** The National Adult Inpatient 2024 Survey took place in January – April 2025 from a sample of patients who were inpatients during November 2024. Data from the Survey Contractor, Picker, is expected to be available in May 2025 with CQC results expected to follow in August 2025.

The Trust score is calculated from the most recent data from the national survey which was published in August 2024 for data from November 2023, using the following:

- Did you get enough help from staff to eat your meals? – 85%
- Do you think the hospital staff did everything they could to help control your pain? – 96%
- Were you treated with respect and dignity? – 98%

National Cancer Patient Experience Survey 2023

The National Cancer Patient Experience Survey 2023 was carried out across 132 acute and specialist NHS trusts in England. All adult patients (aged 16 and over) who had 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 2023 were eligible to be surveyed. For the 2023 survey, a total of 2,488 eligible patients from the Trust were sent a survey, from whom 1,283 responses were received, equating to a 52% response rate. This is in line with the national response rate of 52%.

The Trust scored 8.9 for the overall rating of care which is consistent with the Trust's 2022 score and aligns with the national average score of 8.9.

Compared to other trusts participating in the National Cancer Patient Experience Survey, the Trust scored 'about the same' as other trusts on most questions, and 'better' than other trusts on three questions. These were:

- If a member of your family or someone close to you wanted to talk to someone in the team looking after you during your stay in hospital, were they able to?
- Were you given information about where you could access other advice and support in dealing with the immediate side effects of your treatment.
- Have you had a review of your cancer care by a member of staff at your GP practice?

The Trust score 'worse' than other Trusts on three questions. These were:

- Overall, how did you feel about the length of time you had to wait for your test results to be shared with you?
- Was [your cancer diagnosis] explained to you in a way that you could understand?
- Were you told [about your cancer diagnosis] in a place that was appropriate for you?

The results of this survey have been reviewed and in response to this, the service has developed an action plan which includes actions focused around improving communication with patients across all stages of the pathway.

National Urgent and Emergency Care Survey 2024

The National Urgent and Emergency Care Survey 2024 was carried out across 120 NHS trusts with a Type 1 Accident and Emergency department and 70 with a Type 3 (urgent treatment centre/ minor injury unit) department. Patients were eligible for the survey if they were aged 16 years or older and had attended Urgent and Emergency Care Services (Type 1 or Type 3) during February 2024. This is a change in sample month compared to previous rounds of the National Urgent and Emergency survey, where the sample was previously drawn from attendances through the month of September. For the 2024 survey, trusts that run both Type 1 and Type 3 departments were required to sample 950 patients from Type 1 departments and 580 patients from Type 3 departments totalling 1,530 patients. For the Trust Type 1 survey, 285 responses were received, equating to a 31% response rate compared with the national response rate of 29%. For Type 3, the Trust received 141 responses, equating to a 25% response rate, compared with the national response rate of 26%.

Compared to other trusts participating in the National Urgent and Emergency Care Type 1 survey, the Trust scored 'about the same' as other trusts on most questions and 'somewhat better' than other trusts on one question; 'Were you told why you had to wait with the ambulance crew?'. Sheffield Teaching Hospitals did not score 'worse' than other trusts on any questions in the Type 1 survey.

Compared to other trusts participating in the National Urgent and Emergency Care Type 3 Survey, the Trust scored 'about the same' as other trusts on most questions, and 'somewhat worse' than other trusts on two questions; 'Were you given enough privacy when discussing your condition with the receptionist?' and 'Were you given enough privacy when being examined or treated?'.

In response to this survey the service has developed an action plan which includes actions to:

- Communication around waiting times to ensure that patients are kept up to date.
- Efforts to reduce incidents of violence and aggression as patients reported not feeling safe in the department.
- Plans to review the environment in the Minor Injuries Unit to improve privacy and dignity.
- Work with team to promote PROUD behaviours to improve interactions with patients and staff.

National Maternity Survey 2024

The 2024 survey of experiences of maternity services involved 120 NHS trusts in England. People were eligible for the survey if they had a live birth during February 2024, were aged 16 years or older, and gave birth in a hospital, birth centre, maternity unit, or at home. A total of 416 eligible patients from the Trust were invited to take part in the survey and 150 completed the survey giving a response rate of 36%, compared with the national response rate of 41%.

Compared to other trusts participating in the National Maternity Survey, the Trust scored 'about the same' as other trusts for most questions and scored 'better' than other trusts on two question and 'somewhat better' than other trusts on a further three questions. The Trust did not score 'worse' than other trusts on any questions. The questions where the Trust performed better than other trusts were:

- During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history? (Better than other trusts)
- At any point during your maternity care journey, did you consider making a complaint about the care you received? (Better than other trusts)

- Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together? (Somewhat better than other trusts)
- Thinking about your care during labour and birth, were you treated with respect and dignity? (Somewhat better than other trusts)
- In the four weeks after the birth of your baby did you receive help and advice from a midwife about feeding your baby? (Somewhat better than other trusts)

Compared to the 2023 results, the Trust saw a statistically significant increase in performance on two questions and scored about the same as the previous year on the remainder of the questions.

In response to this survey the service has developed an action plan which includes actions to:

- Improve information and support around maternal mental health.
- Improve arrangements for partners being able to visit and/or stay after birth.
- Run a campaign promoting staff leading conversations with prompts that will enable people to raise any concerns and ask any questions they may have, and ensure that they understand the information they have been given.
- Introduce Quality Improvement Lead Midwifery role within the department.

5.2 Patient Friends and Family Test

The Trust continues to utilise the Friends and Family Test (FFT), which is carried out across inpatient, outpatient, accident and emergency, maternity, and community services. The FFT asks a simple, standardised question; 'Overall, how was your experience of our service?' with a six-point scale, ranging from 'very good' to 'very poor'. The definition of positive and negative scores are in line with national guidance and therefore the positive score is based on responses of 'very good' and 'good'. The negative score is based on responses of 'poor' and 'very poor'. Neutral responses of 'don't know' or 'neither good nor poor' do not count towards a positive or negative score but are included in the denominator.

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

During 2024/25, the overall positive score across all services was 92%. This is consistent with the Trust-wide position of 92% seen in 2023/24 and is in line with the national score of 92%.

FFT responses are collected through postcards, text and interactive voice messaging, and an online survey which is available through a link on the Sheffield Teaching Hospitals website and QR codes on FFT posters displayed in ward and clinic areas. The survey is also available in 'easy read' and alternative language versions. FFT results are monitored through monthly reports distributed to relevant colleagues across the Trust. Wards and departments are able to access their FFT data including full patient comments relevant to their area, and top themes from comments, via an online patient experience system.

The Trust is committed to maintaining good positive scores for FFT to ensure a positive patient experience in all services. Therefore, in the 2024/25 year the Trust has been working to the following positive score targets:

- Inpatients – 94%
- Maternity services – 92%
- Community services – 94%
- Outpatient services – 94%
- Accident and Emergency – 79%

The scores across all areas of FFT comparing with 2022/23 and 2023/24 are detailed on the following page.

The Trust continues to take the following actions to improve the quality of services, and through this, improve positive FFT scores:

- A monthly report is circulated across the Trust informing staff of scores and the number of responses, as well as enabling them to review the comments that patients have made about their experience. These results are reviewed by individual wards and departments who take appropriate action.
- FFT is monitored on a monthly basis through the Patient Experience and Engagement Group, which escalates trends or concerns to the Patient Experience and Engagement Executive Committee and takes relevant actions to improve the Trust's FFT position.
- Deep dives are undertaken on a six-monthly basis to better understand the feedback data being collected and identify any additional actions which could be taken to improve experience for example, patient feedback prompted a quality objective on pain management during 2024/25.
- Reviewing current practice for FFT feedback collection to identify opportunities to improve the data quality and response rates across the organisation.

In the 2024/25 year, the messaging for the Community Services text and interactive voice messaging was updated so that patients receive a message asking about their experience of a specific named service. Prior to this change a significant number of neutral 'don't know' responses were being received for the Community FFT and it was felt that this may be because patients weren't clear which service they were being asked about. Since the implementation of the new Community FFT messages in October 2024, a step change in positive score has been seen and the 94% positive score target has been consistently achieved.

Patients who gave a positive score

The percentage of patients who attended the Trust during the reporting period who provided a response of either 'Good' or 'Very Good', when asked for their overall experience of the service.

	Benchmarking Combined Acute/ Acute and Community Trusts			STH		
	2022/23	2023/24	2024/25*	2022/23	2023/24	2024/25
All areas	90%	92%	92%	91%	92%	92%
Inpatient	93%	94%	95%	92%	93%	94%
Accident and Emergency	76%	80%	79%	81%	83%	79%
Maternity	92%	93%	92%	88%	91%	91%
Outpatient	93%	94%	94%	94%	94%	94%
Community	93%	95%	94%	93%	92%	93%

**The 2024/25 national data is published by NHS England and reports approximately 2 months behind the current position. The 2024/25 scores shown are currently calculated from the period February 2024 - January 2025 as the full 2024/25 year data is not expected to be available until June 2025.*

5.3 Complaints

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

All contacts received by the PALS are assessed to see if they can be dealt with quickly, for example by taking direct action, or by putting the enquirer in touch with an appropriate member of staff. This course of action is agreed with the patient and the contact is recorded as a concern (informal complaint). During 2024/25, we received 3,124 informal concerns to which we were able to respond quickly.

If the concern or issue cannot be dealt with informally or if the enquirer remains concerned, the issue is categorised as a formal complaint and processed accordingly. During 2024/25 1,117 formal complaints were received. The number of formal complaints received by the Trust decreased by 1.9% during 2024/25

A breakdown of formal complaints and concerns received during 2024/25 compared with previous years is provided below.

Total number of complaints received:

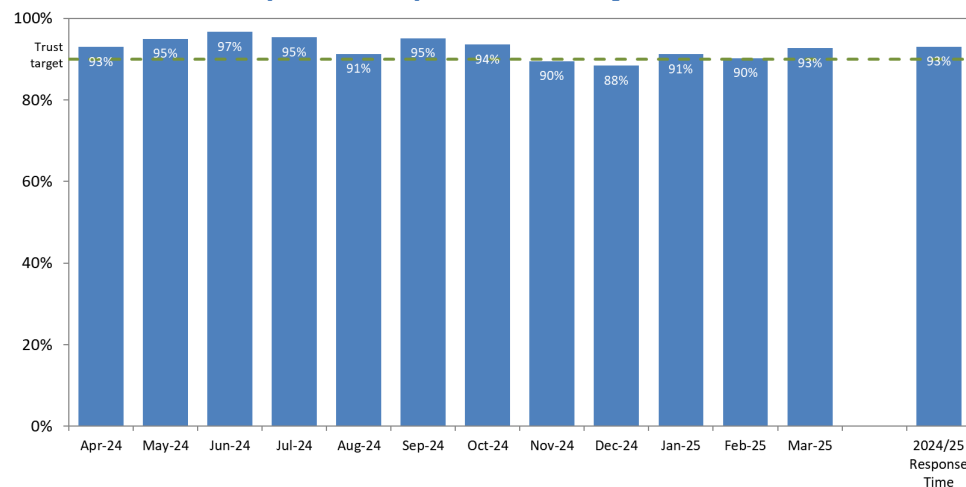
	2022/23	2023/24	2024/25
New informal concerns received	2,856	2,525	3,124
New formal complaints received	1,216	1,135	1,117
Total	4,072	3,660	4,241

Of the formal complaints closed (1108) during 2024/25, 602 (54%) were upheld or partially upheld by the Trust.

Where complainants remain unhappy with the Trust’s response, they can refer to the Parliamentary and Health Service Ombudsman (PHSO) to get an independent and objective body to review their complaint. The PHSO investigate complaints made regarding Government departments and other public sector organisations and the NHS in England. During 2024/25 the PHSO closed five cases regarding the Trust, none were fully upheld and four were partially upheld.

The complaint response time target is that at least 90% of complaints are closed within the agreed timescale. This target was achieved in 2024/25, with 93% being responded to in time, or with an agreed extension.

Breakdown of complaints response times by month



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

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

Datix is used to record all complaints and concerns that are received so that we can more accurately report on themes and trends. It is important to note that each case may have more than one subject recorded.

When presented as a percentage, complaints relating to 'Communication with patient' have decreased by 2.2% however those relating to 'Communication with Relative/Carer' have remained static (0.6% decrease). These have been reviewed, and they are across all Trust services and departments. Examples of cases may be patients not feeling information about care and treatment has been communicated effectively or patients chasing appointments/follow up as this has not been communicated as expected.

Complaints relating to 'Attitude' have decreased by 2.4%. These have been reviewed, and they are across all Trust services and departments. Where appropriate, the patient's experiences and perceptions are shared with staff members but also with wider teams for reflection.

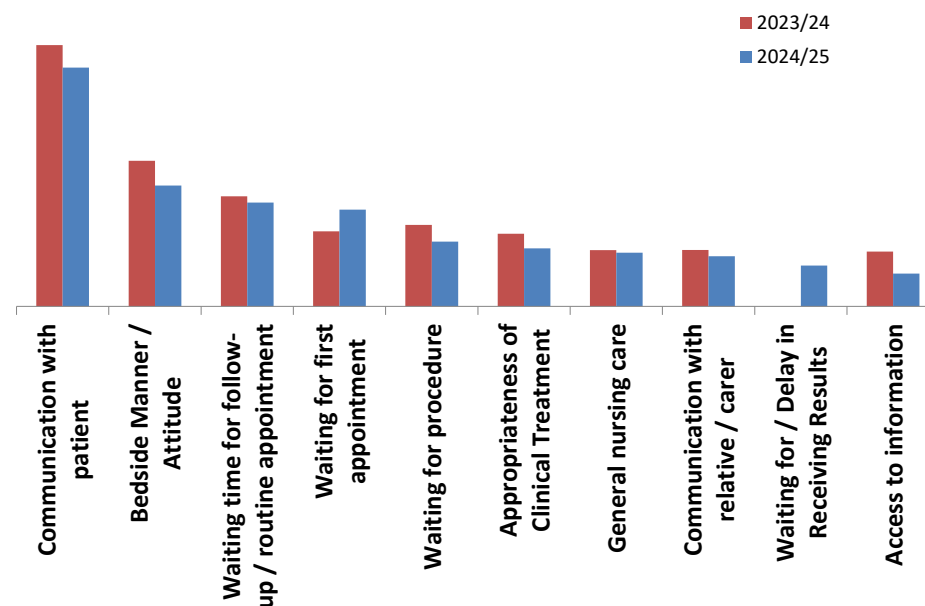
A deep dive regarding attitude of staff was undertaken and presented to the Patient Experience and Engagement Group. The review highlighted that whilst 'staff attitude' was rarely the sole topic of the complaint, a theme emerged relating to the importance of listening and this learning has been shared with staff. Just under a third of complaints were not upheld; where

complaints were upheld the Trust's PROUD behaviours were utilised in discussions with staff to reinforce appropriate behaviours.

Complaints about 'Waiting time for follow-up/routine appointment' and 'Waiting procedure' have seen a 0.6% and 1.6% decrease respectively. However, complaints about 'Waiting for first appointment' have increased by 2.1%.

The Complaints and PALS team added a new category of 'Waiting for / Delay in receiving results' in June 2024 as they had seen an increase in cases specifically about this issue.

Breakdown of themes (as a percentage) raised through complaints



The Trust remains committed to learning from, and taking action as a result of, complaint investigations. In order to share learning the Patient Experience and Engagement Group receives regular reports detailing

learning from complaints and also reporting on timescales for completion. In addition, there is a rolling programme of Care Group presentations at the Patient Experience and Engagement Group where learning from complaints and patient feedback, and the improvements made in response to this, are shared.

Examples of actions taken as a result of complaints include:

- **Concern:** (Cardiothoracic Services) A booking for a British Sign Language interpreter to accompany a patient during their procedure was made for the incorrect site (NGH rather than at RHH).
- **Action:** The standard operating procedure has been updated to include greater emphasis on staff checking the correct location of the appointment when booking additional support, such as interpreters.

- **Concern:** (Clinical Infection, Immunology and Dermatology) Patient with ADHD became overwhelmed due to staff not introducing themselves to the patient, and delays to and changes made during their clinic appointment.
- **Action:** Staff have undertaken training with regard to meeting the needs of neurodivergent patients.

- **Concern:** (Obstetrics) Patient had a negative experience when booking their induction of labour.
- **Action:** The directorate are reviewing the induction of labour process, to improve patients' experiences as part of a year long quality improvement project.

5.4 NHS Staff Survey

The response rate to the 2024 survey from Trust staff was 56% which is a significant improvement on that achieved the previous year and above the national average for our benchmarking group of Acute/Combined Acute and Community Trusts (49%).

Response rate to the NHS Staff Survey – Staff involvement

2022/23		2023/24		2024/25	
Trust	National Average	Trust	National Average	Trust	National Average
39%	44%	39%	45%	56%	49%

Staff survey results

	2022/23		2023/24		2024/25	
	Trust	Benchmark group	Trust	Benchmark group	Trust	Benchmark group
We are compassionate and inclusive	7.2	7.2	7.2	7.2	7.3	7.2
We are recognised and rewarded	5.7	5.7	5.8	5.9	5.9	5.9
We each have a voice that counts	6.6	6.6	6.7	6.7	6.7	6.7
We are safe and healthy	5.9	5.9	6.0	6.1	6.1	6.1
We are always learning	5.3	5.4	5.6	5.6	5.6	5.6
We work flexibly	5.8	6.0	5.9	6.2	6.0	6.2
We are a team	6.5	6.6	6.6	6.7	6.7	6.7
Staff engagement	6.7	6.8	6.8	6.9	6.8	6.8
Morale	5.7	5.7	5.9	5.9	6.0	5.9

As in 2023, the 2024 NHS Staff Survey was once again benchmarked in line with the NHS People promise. There is a theme for each of the seven elements of the NHS People Promise plus the Staff Engagement and Morale retained from previous years. As in previous years each theme is scored out of 10. Each of the themes is further broken down into sub-theme scores with the exception of 'We are recognised and rewarded'.

For the 2024 NHS Staff Survey when compared to the Trust's benchmarking group of acute and combined acute and community trusts, the Trust scored above average for three themes, average for two themes and below average for four themes as detailed below:

Above Average for three themes:

- We are compassionate and inclusive
- We are safe and healthy
- Morale

Average for two themes:

- We are recognised and rewarded
- We each have a voice that counts

Below average for four themes:

- We are always learning
- We work flexibly
- We are a team
- Staff Engagement

Compared with 2023, all nine themes showed an improvement with five noted as statistically significant improvements. There were no deteriorations. The Trust received a certificate from NHS England to acknowledge the significant improvements achieved.

The highest Trust theme score for 2024 is 'we are compassionate and inclusive' (7.30) and the lowest 'we are always learning' (5.61) which was the same in 2022 and 2023.

The percentage of staff recommending the Trust as a place to work has increased to 61.80%, up from 60.51% in 2023) and above average for our benchmarking group (60.90%). The percentage of staff who would recommend the Trust to friends and family as a place to be treated was slightly down at 69.52% from 70.05% in 2023, but above average for our benchmarking group (61.54%).

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.

Benchmarking Combined Acute/ Acute and Community Trusts			STH		
National average	Highest performing trust score	Lowest performing trust score	2022/23	2023/24	2024/25
61.54%	89.59%	39.72%	68.38%	70.06%	69.52%

The Staff Survey results will be used to update directorate action plans, the People Strategy workstreams and the People Promise retention work. We will also continue to use the National Quarterly Pulse survey to ensure we get more regular feedback from staff on their staff experience.

The Trust continues to recognise the great work that individuals and teams carry out by nominating staff for national awards and through our Thank You awards which were held at an event at Cutlers Hall in November 2024. Over 490 staff also received a long service award at a ceremony earlier on the same day.

The Trust's reward programme for colleagues has continued to develop, which includes salary sacrifice options, staff discounts in dining rooms and on public transport, loans via salary, salary advances via the Wagestream

app and opportunities to save via salary with both Wagestream and Sheffield Credit union. A meal planning platform, called Five Dinners, which aims at reducing stress and waste, was also added to the reward programme this year.

The reward package is one of the most comprehensive packages in the NHS with the Trust being shortlisted for its financial wellbeing strategy at the all industry Employee Benefit awards in 2024 and again for best range of public sector benefits in 2025.

The Trust continue to support staff Health and Wellbeing with access to our Employee Assistance Programme provider Vivup available 24 hours a day which is also offered to staff household members (16+) We increased the support for staff who are carers with the introduction of unpaid leave for planned care of adult dependents.

Through the 'we are safe and healthy' workstream of the people strategy the Trust continue to work towards developing a more positive culture of wellbeing through the introduction of wellbeing champions. Sheffield Hospital Charity have funded a post to lead on this work and there are now over 400 trained Wellbeing Champions across the Trust drawn from a variety of roles and grades. The champions provide wellbeing information to front line staff, support more regular wellbeing conversations and can signpost colleagues appropriately. The Trust also has a growing network of trained Professional Nurse/ Midwifery advocates who proactively support staff via restorative clinical supervision. Schwartz rounds also provide a safe space for staff to reflect on the emotional impact of healthcare which are offered trust wide, thanks to the support of Sheffield Hospital Charity. The Charity also fund a Vivup counsellor to work on site one day a week to help staff and small teams in high pressure areas develop strategies for coping with stress/ difficult situations.

The Trust has continued with its work to support Menopausal colleagues in the workplace and thanks to the support of the South Yorkshire ICB have trained a cohort of 83 menopause advocates and champions. Working

initially with the menopause advocates and now wellbeing champions we have developed a programme of wellbeing trolley visits to take information about all the menopause, emotional, financial and physical wellbeing support available out into busy clinical areas to raise awareness and reach staff with limited IT access.

The Trusts two Health and Wellbeing and Staff Engagement Sharepoint sites continue to develop, making it easier for colleagues to access information about wellbeing support and staff discounts from home or on their mobiles.

5.5 Equality, Diversity and Inclusion

The Trust has a strong governance framework in place for equality, diversity and inclusion (EDI), which includes a dedicated EDI Executive Committee that oversees the development and implementation of our strategic approach and the work to embed best EDI practice across all areas of the organisation, to benefit our patients and our workforce.

The EDI Executive Committee has a diverse and broad membership that includes senior leaders, service managers and representatives of the Trust's four Staff Network Groups. It reports to the Trust Executive Group and to both the People and Quality Committees. The Annual EDI Reports and the Trust's EDI Strategies are approved by the Board of Directors.

The Trust's EDI Executive Committee oversees the progress being made against the metrics within both the NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

A copy of the Trusts' data matched against both the WRES and the WDES metrics and associated Action Plans can be found on our website at [Sheffield Teaching Hospital Equality and Diversity \(sth.nhs.uk\)](https://sth.nhs.uk).

Our WRES (Appendix 1) and WDES (Appendix 2) data has highlighted the areas where we need to take further action to improve the experiences of our Black, Asian and ethnic minority and disabled colleagues.

The Trust's EDI Team works in collaboration across the organisation to embed EDI best practice. Our four Staff Network Groups offer peer support, advice and guidance and act as a voice for the organisation on issues that impact on women, Black, Asian and ethnic minority, disabled, and lesbian, gay, bisexual and trans (LGBTQ+) colleagues.

The Trust approved its second EDI Strategy, 2025-29, in March 2025 and work is ongoing to communicate its ambition and engage everyone in its implementation. We have identified seven priority objectives in our new strategy, which are:

- Creating an inclusive culture
- Ensuring our decision-making is fair, equitable and inclusive
- Improving patient access and experience
- Building relationships with diverse colleagues and communities
- Creating a diverse workforce and leadership team
- Establishing the Trust as a leader on EDI
- Making EDI everyone's business

The Trust continues to aspire to be a Trust that values its workforce and supports them to bring their whole selves to work, and to be an organisation where our patients can easily access high quality services that are personalised to meet their individual needs.

Our aspiration is to be an inclusive organisation, and we are achieving this by:

- Robustly and reliably managing our EDI performance and ensuring that all areas of the Trust embed best practice.

- Ensuring that our leaders are allies to EDI and that they role model inclusive management practices as well as operating in alignment with our PROUD values and behaviours.
- Building strong workforce and community connections and networks so that our activity is informed by conversations with staff, local people and our partners.
- Recognising and tackling discrimination, bullying, harassment and victimisation effectively and bringing people together to create a social movement for positive and long-lasting change.
- Building the EDI capability and competency of every member of staff so that we are all confident to challenge when we witness inappropriate or offensive language or behaviour.
- Using positive action to build our diverse workforce, ensuring fair and equitable access to opportunities for our current colleagues and those who want to work with us.
- Supporting our four Staff Network Groups and enabling them to provide constructive challenge to the Trust and our work on EDI.
- Evaluating what we are achieving and what impact we are having across the organisation by analysing our Staff Survey results by Protected Characteristics and benchmarking against other similar organisations.

The Trust has implemented the NHS Equality Delivery System 2022 (EDS2022), which requires the Trust to review a selection of services from an equality, diversity and inclusion perspective. Each review looks at issues such as patient access and outcomes, our workforce profile and their experiences and leadership diversity. Five reviews have been undertaken to date into maternity services, accident and emergency services (with a focus on mental health provision), diabetes services (with a focus on the transition from children's/young peoples to adult services), blood cancer services (including haematology, sickle cell and thalassemia) and sexual health services. Three areas for review during 2025/26 have been identified, namely community respiratory services for those

diagnosed with chronic obstructive pulmonary disease, cardiology and cardiothoracic services and orthopaedic services.

We have created, alongside the new strategy, a Year 1 Implementation Plan that is flexible and adaptable to ensure that it contains the appropriate actions to ensure that we tackle the Trust's real and immediate priorities for action. It also shows how the Trust will continue to meet its statutory obligations under the Equality Act 2010, the NHS Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Accessible Information Standard (AIS).

Our achievements over the past year include:

- Maintained a Top 100 Employees position for two consecutive years, achieved a Gold Award and ranked 20th overall in the Stonewall Workplace Equality Index.
- Awarded a 'Good' rating for our Workforce Race Equality Standard.
- Continued to run our in-house Reciprocal Mentoring Programme.
- Over 60+ e-learning courses and bespoke training programmes, including microaggressions and Non-Binary, Trans, and Gender Diversity, have been created and delivered across the Trust.
- Ran monthly EDI webinars across a range of topic areas.
- Our network of Workplace Dyslexia Assessors is continuing to support staff with, or those who may have, Dyslexia with over 200 referrals into the service being received.
- Our first Learning Disabilities Strategic Vision and Plan was launched, and we have introduced the Oliver McGowan autism awareness training.
- Delivered a Quality Objective focusing on improving access to services for patients with hearing and visual impairments.
- Analysis of HR Cases data shared with the EDI Executive Committee and wider Trust.
- Inducted and trained over 120 EDI Champions from across the Trust in a wide range of roles.
- Monitored the diversity of training course attendees to ensure equitable access to opportunities.
- Piloted a dedicated Institute of Leadership and Management Level 3 programme for our Black, Asian and ethnic minority colleagues.
- Launched our Workplace Reasonable Adjustments Policy and Passport.
- Completed five Equality Delivery System 2022 (EDS22) reviews into selected services.
- Created an annual Inclusion Calendar and marking key dates with communications and events.
- Continued to support our four Staff Network Groups: Race Equality and Inclusion, Disability and Wellbeing, LGBTQI+, and Women's. All continue to grow from strength to strength and bring significant value and unrivalled insight to the Trusts' work on EDI.
- Reviewed a large selection of HR policies to ensure they're accessible, inclusive and compassionate.
- Continued to use and develop our EDI Data Dashboard.
- Worked collaboratively and in partnership with EDI Leads across the Integrated Care Board (ICB), Sheffield City and Shelford Group of trusts.
- Supported the establishment of the Sheffield Race Equality Partnership to tackle systemic racism within our organisations and to support Sheffield's ambition to become an anti-racist city.
- Positively evaluated our Board of Directors EDI Development Programme consisting of three full-day modules focussing on engaging and equipping all Board members with the right level of awareness and understanding on the topic of EDI and ensuring they understand their role.
- Undertaken EDI analysis of Staff Survey data that drills down to understand colleagues with a Protected Characteristic experiences.

- Continued our mandatory requirement for all Band 8a+ and Consultant roles to follow an ethnically and gender diverse process from the start of the recruitment process and agreed to extend this to Band 5/6 in Nursing and Band 3's in the Facilities Department. This programme, along with other factors such as our international recruitment, have resulted in an increase in Black, Asian and ethnic minority individuals in Band 8a+ and VSM roles (from 5.4% in 2020 to 8.5% in 2024) and across the total workforce (from 14.1% in 2020 to 23.4% in 2023).
- Produced our third Annual EDI Report for 2024 that highlights some of the successes of the Trust over the past year and what the focus of the next 12 months will be. This can be found on the [Trust's website](#).
- Published our 2024 performance against the Workforce Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) metrics and created a combined action plan, our performance against which is being actively monitored.
- Produced and published our annual Gender Pay Gap data and report and produced our first Ethnicity Pay Gap report.
- Quality assured over 100 Rapid Equality Impact Assessments.
- Continued to embed our approach to Equality Impact Assessments (EIAs) by making it a key part of policy development and ensuring that all key decisions, changes to services or policies, and any new proposals are supported by a Rapid EIA.
- Engaged with our colleagues, patients, partners and key stakeholders on the development of our new EDI Strategy, 2025-29.

The Trust will continually seek to improve its engagement and involvement of colleagues, patients and the wider community in everything that we do. We want to enable people to share their experiences, both positive and negative, of receiving care and working for us so that we continue to be

self-aware and understand what we are getting right, what we are getting wrong and how we can improve.

5.6 Delivering same-sex accommodation

The Trust remains committed to ensuring that men and women do not share sleeping accommodation, except when it is in the patient's overall clinical best interest or reflects their personal choice. There have been no breaches of this standard during 2024/25.

The Trust is aware of the Supreme Court ruling on the definition of a woman on 16 April 2025 and is awaiting guidance from NHSE on the implications of this for the Trust and the wider NHS. The Trust is committed to continuing to safeguard the dignity of all our patients by treating everyone with fairness and respect by following the current legal requirements and current NHSE guidance. Our ambition is to be an inclusive organisation that values everyone for who they are.

Part 6 – Performance on Quality 2024/25 (Effectiveness)

6.1 Clinical Audit	47
6.2 Mortality (SHMI) and learning from deaths	54
6.3 Single Oversight Framework	56
6.4 Readmissions	57
6.5 Clinical research and innovation	58
6.6 Data quality	63



6.1 Clinical Audit

During 2024/25, 74 national clinical audits and confidential enquiries covered relevant health services that the Trust provides.

During that period the Trust participated in 68 of the national clinical audits and confidential enquiries in which it was eligible to participate. The national clinical audits in which the Trust was eligible to participate during 2024/25, and those in which it did participate, where data collection was completed during 2024/25, are presented under Appendix 3.

The Trust did not participate in the following national audits:

British Hernia Society Registry

At present the Registry is 'opt in', with patients providing written informed consent prior to their enrolment. No data has yet been submitted by the Trust as obtaining patient consent brings a significant workload on top of the consent process for surgery. The Trust is still exploring ways of obtaining patient consent for the Registry. The patient information leaflets for hernia will be modified to include the Hernia Society Registry information.

Gestational Diabetes Audit

Data that is routinely collected for maternity services nationally via the Maternity Services Data Set and linkage with other existing NHS datasets, is being utilised. At present MSDS does not capture Trust patients with a Gestational Diabetes Mellitus diagnosis. This will be resolved with the introduction of the Trust electronic patient record in July 2025.

National Ophthalmology Audit Database

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

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

Quality and Outcomes in Oral and Maxillofacial Surgery for b) Trauma; d) Non-melanoma skin cancers and e) Oral and Dentoalveolar Surgery

The Quality and Outcomes in Oral and Maxillofacial Surgery Programme aims to set up and develop a sustainable quality management and clinical effectiveness programme that delivers continuous improvement in the care of patients undergoing Oral and Maxillofacial Surgery, within all parts of the NHS. The programme has been split into five separate projects and the Trust is participating in two of the five (Oncology and reconstruction and Orthognathic surgery), but due to operational pressures has not been able to participate in the other three.

The Trust participated in-part in the following:

National Early Inflammatory Arthritis Audit

Most of the Consultant team have been unable to contribute to National Early Inflammatory Arthritis Audit due to significant clinical pressures.

National Vascular Registry

The lack of dedicated administrative support for the National Vascular Registry data submission and significant gaps in vascular radiology consultant staffing have continued to affect case ascertainment for the National Vascular Registry. To improve this, a business plan for dedicated National Vascular Registry audit clerk/coordinator support to submit data and follow up any missing data for cases has been prepared; achieving success with this remains a priority for the clinical team. Ongoing recruitment for substantive vascular radiologists remains a top priority for the Vascular Services Department.

National Emergency Laparotomy Audit

Many of the consultant team have been unable to contribute to National Emergency Laparotomy Audit due to significant clinical pressures.

Adult Asthma Secondary Care

The Trust participated only in part of the National Asthma Audit due to limited resources and significant clinical pressures.

National Clinical Audits

The reports of 44 national clinical audits were reviewed by the provider in 2024/25 and Trust intends to take actions to improve the quality of healthcare provided, examples of which are included below:

National Chronic Obstructive Pulmonary Disease Secondary Care Audit 2024

AIM: This continuous audit captures the process and clinical outcomes of treatment for patients admitted to hospital in England and Wales with Chronic Obstructive Pulmonary Disease exacerbations. The report presents the results of the cohort of patients discharged between April 2022 and March 2023.

The results for the Trust are better than the national average for five of the six Key Performance Indicators; Oxygen prescribed for the patient to a target saturation; Spirometry result available for the patient; Current smokers prescribed stop smoking drug and/or referred to behavioural change intervention; Respiratory review within 24 hours of admission to hospital and Key elements of discharge bundle provided as part of discharge. This audit report provided significant assurance about the quality of Trust services on review at the Clinical Audit Outcomes Review Group.

Improvements: The action plan seeks to further increase timely acute treatment with non-invasive ventilation to patients who meet the evidence-based criteria, this includes further provision of non-invasive ventilation beds. An action is in place to further increase the availability of the spirometry results from primary care.

The following key elements of the discharge bundle have been provided as part of discharge: -

- Follow up requests at home within 72 hours by person or by phone and
- Emergency drug pack provided or referred to community team for pack OR Emergency drug pack not provided as assessed as unsuitable.

National Respiratory Audit Programme - Organisational Audit: adult asthma / Chronic Obstructive Pulmonary Disease (COPD) 2024

AIM: The National Respiratory Audit Programme for England and Wales aims to improve the quality of care, services, and clinical outcomes for people with respiratory disease (including Asthma and COPD).

The audit collected cohort data from 1 April 2022 to 31 March 2023 for admissions information, and static data snapshots, for example number of beds, were taken from September 2023. Staffing information was a contemporaneous snapshot of the data from early 2024.

The Trust is fully compliant with the following key performance indicators:

1. Make 7-day respiratory specialist advice available to all patients admitted with an asthma/COPD exacerbation.
2. Have designated clinical leads in place for both asthma and COPD.
3. Ensure pulmonary rehabilitation services are available to COPD patients within 30 days of discharge.
4. Hold a weekly multidisciplinary team (MDT) meeting between hospital and community for COPD patients.
5. Have a transition service in place for children and young people moving to adult asthma services.
6. Provide access to a severe asthma service.

National recommendations include:

- Implementation of workforce ratios (appropriate workforce-to-patient ratios should be achieved, across England and Wales by 2026, in line with recommended ratios by the respiratory medicine Getting It Right Frist Time (GIRFT) report and British Thoracic Society workforce guidance).
- 7-day access to respiratory specialist advice and respiratory nurse specialists (access to respiratory consultant and respiratory nurse specialist to be made available seven days a week in hospitals in England and Wales by 2026).
- Supporting young people with asthma to transition into adult care (asthma transition services should be available to all young people transferring to adult services in England and Wales by 2026).
- Tobacco dependence treatment and support for children and young people (Treating tobacco dependence in children and young people with asthma).
- Widening access to Pulmonary Rehabilitation (Treating tobacco dependence in children and young people with asthma).

Improvements: Local actions were based on the national recommendations and included improving the patient experience of young people transitioning to adult services. Processes for transition are already in place at the Trust. Respiratory consultants at the Trust review patients at Sheffield Children's Hospital with the paediatric respiratory team, triaging appropriate patients to the severe asthma clinic. Reviews are organised at the Trust severe asthma clinic in the presence of a paediatric specialist nurse in specific circumstances. Paediatric respiratory physicians discuss more complex cases via the adult asthma multidisciplinary team before transition.

National Audit of Cardiac Rehabilitation 2023 (Report published in December 2024).

AIM: To support teams to achieve compliance with the seven National Audit of Cardiac Rehabilitation Accreditation Report Key Performance Indicators and, in doing so, support people with heart and circulatory disease to achieve the best possible outcomes.

- Data is submitted on an ongoing basis to the National Audit of Cardiac Rehabilitation.
- Certification is reassessed on a yearly basis with this report published in December 2024.

Improvements:

- Adjustments have been made to data collection methods so that there was an improvement in data capture to ensure that all National Audit of Cardiac Rehabilitation metrics were submitted.
- The team increased staff engagement with regards to increasing data collection by providing regular information updates at supervision and team meetings and recruited more data inputting staff.

This is the second year the Trust has achieved compliance with all seven Key Performance Indicators and obtained the Green Grade. The previous three years the Trust achieved Amber Grade. This audit report provided full assurance about the quality of Trust services on review at the Clinical Audit Outcomes Review Group.

Local Clinical Audits

The Trust reviewed 211 local clinical audit projects in 2024/25, of which 62 reports were also reviewed centrally by the Clinical Audit Outcomes Review Group. Examples of improvements to the quality of healthcare provided can be found below:

A Trust-wide Audit of Transition Services at the Trust (NICE NG43, QS140, NCEPOD)

An audit was carried out to assess Trust compliance with NICE guidance (NG43 and QS140) and National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations ('The Inbetweeners') regarding transition from children to adult services and was designed to give a baseline dataset of transition services within the Trust. The results demonstrated that there is variation in Trust compliance for many of the key standards. Only 21/46 (46%) of individuals recorded that young people have a single named practitioner for their transition process. 26/46 (57%) confirmed the use of written Transition plans within their service, and only 17/46 (37%) of individuals felt that young people are involved in their own transition planning. 28/46 (61%) of individuals recorded the use of transition clinics in their service.

In relation to local policies and training it was recorded that only 20/46 (43%) felt their area had a specific written procedure for transition, and only 25/46 (54%) of relevant staff had completed specific training for transition. The report provided limited assurance on the quality of services when reviewed by the Clinical Audit Outcomes Review Group and an improvement plan has been put in place.

Actions for Improvement:

- A standard operating procedure template to be created for services to adapt for use in their own clinical area.
- Standard operating procedure template should include named worker and transition plans as a requirement.
- To work with Learning and Development to develop a detailed training needs outline for developmentally appropriate healthcare and healthcare transition at the Trust aligned to the NHS England Transition Capability Framework and consider how this will be delivered utilising a variety of methods.

- Project team to feedback individual service-specific results to participants of the survey for local areas to develop local action plans and drive improvement.
- To identify the disparities between services the project team plan to feedback results to each sub-speciality service, meaning that improvement work can be customised. High performing specialities or directorates will be approached to share expertise and resources to ensure improvement work can be accelerated and compliance improved.

The team aim to complete a re-audit in 2026 once improvement work has been embedded.

A re-audit on the assessment and management of pain (targeted wards) 2024

This re-audit evaluated the assessment, analgesic administration for, and documentation of pain within the Trust. The aim of the re-audit was to measure compliance of these objectives with the Trust Acute Pain Guide, which includes the WHO pain ladder detailed below.



Key Findings:

Standards	2023	2024
100% of patients will be assessed for pain	100% (80/80)	100% ↔ (100/100)
100% of patients will have their pain score documented on the NEWS2 chart	100% (80/80)	100% ↔ (100/100)
Where appropriate, 100% of patients should be given analgesia according to their pain score/WHO pain ladder i.e. <ul style="list-style-type: none"> • Given analgesia according to pain score/WHO ladder • Given analgesia BUT does not match pain score and/or WHO pain ladder • Not given analgesia according to pain score 	18% (12/66)	30% (23/77) ↑
	71% (47/66)	66% (51/77) ↓
	11% (7/66)	4% (3/77) ↓
100% of patients will be reassessed following analgesia, where applicable*	96% (57/59)	95% (70/74) ↓

All patients had evidence of pain assessment in the form of a pain score, and 96% of those with pain were administered some form of analgesia. There was an improvement in compliance with patients being given the correct analgesia for their level of pain.

Further Actions for Improvement:

- Identify clinical areas from the re-audit and Patient Experience survey with lower compliance and provide training.
- Feedback results to individual areas and provide information regarding education resources available.
- Education for nursing staff and medical prescribers to continue via PALMS study days and training sessions by Acute Pain team.
- Improved documentation in care plans to include description of pain scores and treatment offered/administered. The new electronic system Connect EPR will include new patient care plans which contain a functional pain score.

The report provided significant assurance on the quality of services when reviewed by the Clinical Audit Outcomes Review Group. The team plan to re-audit following the launch of Connect EPR in Summer 2025.

Saving Babies Lives - audit requirements for neonatal aspects of Element 5

The aim of Element 5 of Saving Babies' Lives is reducing preterm birth and recommends three intervention areas to reduce adverse fetal and neonatal outcomes: improving the prediction and prevention of preterm birth and optimising perinatal care when preterm birth cannot be prevented. All providers are encouraged to draw upon the learning from the existing British Association of Perinatal Medicine toolkits.

Quarterly results demonstrated an improvement in compliance against the three standards measured. Between October and December 2023:

- 91% of women who deliver below 34 weeks gestation received antenatal counselling from the neonatal team (76% in previous quarter).
- 100% of babies born below 34 weeks' gestation, who needed invasive ventilation, used volume-targeted ventilation in combination with synchronised ventilation as the primary mode of respiratory support (89% in previous quarter).
- 100% of babies born below 30 weeks gestation started caffeine within 24 hours of age (95% in previous quarter).

The audit report was completed in April 2024 and provided full assurance on the quality of services when reviewed by the Clinical Audit Outcomes Review Group.

Actions for improvements: On-going preterm optimisation data monitoring through the Preterm Birth Optimisation group and quality improvement interventions as required.

Re-audit reviewing consent in conscious sedation in the Oral Surgery Department

The aim of this audit was to assess compliance against national guidelines for consent in patients undergoing conscious sedation for oral surgery procedures at the Charles Clifford Dental Hospital.

Results:

Standard	2018	2019	2022	2024
Written consent at a visit separate to day of treatment	8%	44%	68%	96%*
Consent obtained on day of treatment compliant with GDC standards	96%	100%	100%	100%
Risks of sedation discussed with patients	100%	100%	32%	100%
Benefits of sedation discussed with patient	100%	100%	32%	100%
Written information provided	100%	100%	32%	100%
Checks that patient understands information provided	100%	100%	100%	100%
Sedation options discussed with patients	58%	16%	48%	100%
Proposed technique discussed with patient	100%	100%	100%	100%
Information appropriate to patient's age and learning ability	100%	100%	100%	100%
Where written consent was obtained previously, verbal reconfirmation is sought on day of procedure	50%	100%	100%	100%
Written consent form completed at consultation	100%	100%	100%	100%
Responsible clinician's name documented	96%	100%	100%	100%
Responsible clinician's job title documented	96%	100%	100%	100%
Consent confirmed on day of treatment	92%	100%	100%	100%
Consent re-signed on day of treatment	50%	100%	100%	100%

*24/25 patients, one case had documented valid reasons for non-compliance - no risks associated.

This audit report provided full assurance on the quality of services on review by the Clinical Audit Outcomes Review Group.

Compliance of Neonatal hearing diagnostics to meet relevant requirements of the British Academy of Audiology Quality Standards in Paediatric Audiology

The aim of this audit was to determine whether local Trust implementation of newborn hearing diagnostic assessment at the Jessop Wing was in line with the national Newborn Hearing Screening Programme requirements, British Society of Audiology Auditory Brainstem Response guidance (2019), and the British Academy of Audiology Paediatric quality standards (2022).

Key Findings:

Standard	Compliance
1.1 - 97% of the proportion of babies requiring immediate referral for audiological assessment are offered a first appointment to Audiology that is within 4 weeks	95.8% (69/72)
1.2 - 100% of appointments are facilitated by appropriate qualified interpreters if required.	50% (1/2)
1.3 - 100% of differences between preliminary results and peer review Auditory Brainstem Response results are identified.	100% (17/17)
1.4 - 100% of reports are sent within two weeks of completion of testing	100% (17/17)
1.5 - 100% of equipment used should be within equipment calibration period.	100% (72/72)
1.6 - 100% of daily checks performed and documented.	100% (43/43)
1.7 - 100% of daily checks are documented	93% (40/43)

The results demonstrated good compliance with most standards, with an action plan in place to improve standards 1.2 and 1.7 and provided significant assurance on the quality of services when reviewed by the Clinical Audit Outcomes Review Group.

Actions for Improvement:

- Improve compliance to booking of appropriate interpreters and recording this in a standard way by implementing a new standard operational procedure on interpreter booking and recording
- All eligible Auditory Brainstem Response trace records having internal peer review / countersigning and sent for external peer review when

eligible. Refine the local procedure and add fail-safes to ensure countersigning and sending for peer review happens. Agree a process for this and update local policy.

6.2 Hospital-Level Mortality Indicator (SHMI) and learning from deaths

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 here.

	Benchmarking			STH		
	National average	Highest performing trust score	Lowest performing trust score	2022/23	2023/24	2024/25
The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust for the reporting period	1.0	0.70	1.28	0.99 Banding: as expected	0.97 Banding: as expected	0.96 Banding: as expected
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	44%	66%	17%	37%	37%	38%

(Source: figures extracted from NHS Digital SHMI data set, published 10 April 2025)

The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care because there is considerable variation between trusts in the way that palliative care codes are used. Adjustments based on palliative medicine treatment specialty would mean that those organisations coding significantly for palliative medicine treatment specialty would benefit the most in terms of reducing the SHMI value (the ratio of Observed/Expected deaths would decrease because the expected mortality would increase).

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

The Trust has taken action to optimise this coding rate, and so the quality of its services by embedding a business-as-usual process relating to palliative care coding. This process ensures all activity is captured by validating clinical coding against the Palliative Care Services own contact report and an Information Services User Report. The validation work is undertaken monthly. In 2024/25 the Trust rate of palliative care coding increased to 38% but remained lower than the national average of 44%. The Trust is committed to continuing the validation process in 2025/26 and the new Connect EPR will provide an opportunity for recoding of input from the service that is visible to the clinical coders.

Learning from Deaths

The Trust is committed to learning from all patient deaths. During 2024/25, 2,776 patients died (either as an inpatient or in the Emergency Department). The following number of deaths occurred in each quarter of the reporting period:

- 678 in quarter 1
- 640 in quarter 2
- 686 in quarter 3
- 772 in quarter 4

(Figures from the Bereavement Database and Information Services Report)

During 2024/25, 2,776 deaths were reviewed by a Medical Examiner. 144 cases have been referred for a Structured Judgement Review (SJR) case record review, most via the Medical Examiner system. 105 SJRs have been completed (73% of those referred) and five rejected. Three of the rejected cases had Patient Safety Incident Investigations underway and the remaining cases did not fit the SJR referral criteria.

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

- 31 in quarter 1
- 39 in quarter 2
- 33 in quarter 3
- 41 in quarter 4

(Data correct as of 14th April 2025)

There have been 32 neonatal deaths between 1 April 2024 and 31 March 2025. 25 have received a Perinatal Mortality Review Tool review, the equivalent of an SJR. Those that have not yet been reviewed are deaths that occurred in February and March 2025, and these will be evaluated in the April and May 2025 mortality meetings.

Deaths subject to a Patient Safety Incident Investigation are managed in line with Trust Incident Management processes. Between 1 April 2024 and 31 March 2025, one case was judged by the Safety Panel to have been more likely than not due to problems in the care provided to the patient.

Where an SJR is scored as 'poor' or 'very poor' by two independent reviewers, the directorate is requested to review the case and either follow the Patient Safety Incident Investigation (PSII) pathway, where it is considered that the death may have been more likely than not due to problems in care, or complete context around the care and an action plan for review at the Mortality Governance Group. Regardless of outcome, all SJR summaries are sent to relevant Directorates for discussion at speciality Mortality and Morbidity meetings where local actions can be agreed and progressed.

Regular feedback from specialty Mortality and Morbidity Meetings to the Mortality Governance Group has continued during 2024/25 and Trust best practice guidance has been updated. Analysis of SJR data has been done on a quarterly basis and findings disseminated within the Trust.

6.3 Single Oversight Framework

The Single Oversight Framework is the joint NHS England and NHS Improvement framework for assessing trusts' performance against key statutory performance indicators. Performance against these indicators is presented below:

	National Standard			STH		
	2022/23	2023/24	2024/25	2022/23	2023/24	2024/25
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	92%	92%	68.07%	63.84%	61.95%
Patients who require admission who waited less than 18 weeks from referral to hospital treatment	90%	90%	90%	64.29%	57.75%	63.21%
Accident and Emergency maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge	95%	76%	78%	74.13%	73.42%	72.78%
Cancer 62-day waits (including Urgent Suspected Cancer, Screening and Consultant Upgrades)	85%	85%	85%	48.2%	46.4%	51.3%*
C.difficile - Hospital Onset/Healthcare Associated cases	Comparative data is not available.			26.35 (117 cases)	20.89 (93 cases)	25.68 (114 cases)
C.difficile - Community Onset/Healthcare Associated cases	Comparative data is not available.			10.70 (52 cases)	8.62 (42 cases)	11.12 (54 cases)
Summary Hospital-level Mortality Indicator (SHMI)	See section 6.2					
Maximum six week wait for diagnostic procedures	99%	95%	85%	72.27%	81.69%	63.23%
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	95%	95%	95%	93.00%	92.38%**	89.65%

* During 2023/24, the cancer targets changed where the Trust is now measured against one overall 62-day target. As a result, performance for 2022/23 and 2023/24 is a merged total of the previous individual targets for comparative purposes.

** This figure represents Q1 only.

6.4 Readmissions

The percentage of patients readmitted to the Trust, within 28 days of being discharged from the Trust.

	STH		
	2022/23	2023/24	2024/25
Aged: 0 to 15	0%	0%	0%
Aged: 16 or over	13.45%	13.46%	13.59%

These data are a snapshot at the time the report is run and may change as live systems are updated. Due to these, figures reported for the previous year may change.

6.5 Clinical research and innovation

A new Research and Innovation Strategy was launched in 2024 which laid out the Trust's ambitions to ensure "Research and Innovation is Everyone's Business" and builds on key recent achievements. At the core of the strategy is how we will ensure our research directly benefits our patients and the people we serve, and how our innovations address unmet care needs as well as our delivery of efficient care. Underpinning this is the involvement of diverse voices in our research and innovation activities and increasing our partnership working.

Recruitment to trials

The number of patients receiving NHS Services provided or subcontracted by the Trust in 2024/25 that were recruited to studies during that period to participate in the National Institute of Health and Care Research (NIHR) portfolio research trials was 7,583.

Patient and Public Involvement 2024/25

Researchers across the Trust are committed to involving patients and the public in the design, delivery and dissemination of research in accordance with good practice and national standards. Involving people with lived experience of the conditions or services being researched is a priority and ensures research is underpinned by experiences and needs of those with the relevant health conditions. Over the previous year, many of our researchers have been invited to showcase their involvement activities at national and international conferences in recognition of the quality of their involvement activities and highlighting the impact involvement has on research. To ensure research is being designed and carried out inclusively and that it meets the needs of our communities, researchers are prioritising the relevant involvement of local communities and groups. In addition, we continue to forge and maintain excellent relationships with charities and patient organisations so that we can involve broad groups of patients in our

research and ensure the findings of our research are shared with those who stand to gain most from it.

Research teams are committed to involving people with lived experience on the review committees of our research databases, thus ensuring that those with relevant health conditions have a say in the decision-making processes. As well as involving the public and our communities in the design, delivery and dissemination of our research, we also involve them in other activities related to our research infrastructure and practices. Acting on the feedback we receive from participants in research, the Clinical Research Facility has worked with public contributors to develop videos to share with participants who will be taking part in research in the Clinical Research Facility to show them how to access the facility and what to expect on arrival. Extending their commitment to inclusive patient and public involvement and engagement and equipping staff with the necessary knowledge and skills for research activities, this year also saw the launch of their dedicated patient and public involvement and engagement training module for Clinical Research Facility staff which will now form part of all inductions for new Clinical Research Facility staff.

Events and Public Engagement

We continue to get actively involved with national campaigns including celebrating International Clinical Trials Day and #Red4Research and use these as a chance to showcase everyone involved in research including participants and public contributors, and also highlight the success and impact of our research. Given the success of previous years, we were invited to have an interactive research stand at Weston May Fayre in May 2024 to bring research to life with fun, hands-on activities.

Engaging with our local communities and underserved groups about research is a priority and over the last year research staff have undertaken

a wide variety of activities. These include presenting at annual flagship gatherings about clinical research to celebrate and empower African women entrepreneurs and professionals living in Europe, engaging with the public in underserved areas of Sheffield on the Weston Park Cancer Charity “Big Purple Bus” and attending health and wellbeing events held by local communities including at Madina Mosque. Via a variety of talks and workshops, we have continued to expand our outreach work in local schools and universities to raise awareness and understanding of clinical trials as well as the opportunities for having a career in research. University students have had the opportunity to shadow our Clinical Trials Assistant team showing the diverse nature of this role and the integral role they play in carrying out low risk non interventional research at the Trust.

The impact of our research is well recognised beyond Sheffield, researchers from across the Trust have showcased our research and its influence on policy and practice across the media including BBC News and Panaroma.

At a Trust level, funding has been secured by our Respiratory Directorate to include TV screens in patient areas to share research information and we hope that by sharing such information in a transparent way it will ultimately improve participation in research and also ensure the outcomes of research are shared and celebrated with staff and patients.

Equality, Diversity and Inclusion

Our commitment to ensuring we reduce health inequalities by involving under-represented groups in research, and further developing our links with community groups, was outlined in our recent Research and Innovation Strategy. Our NIHR infrastructures are leading the way in ensuring we increase research participation across under-represented groups and that our local communities are aware of and have the opportunities to take part in research.

The state-of-the-art PET-MRI facility at Sheffield Teaching Hospitals is Yorkshire’s only such facility and will speed up diagnosis of and lead to new treatments for many diseases including cardiovascular disease, chronic neurological diseases, cancer and more. To ensure our diverse communities of patients and research participants understand what will be involved if they undergo PET-MRI, our NIHR Sheffield Biomedical Research Centre are working with Language Associates at the Ethnic Minority Research Inclusion Group to translate our information video into languages commonly spoken by our patients; these include Urdu, Arabic and Polish.

We are using information from recently launched diversity surveys and activities to understand barriers to participation, identify target areas for engagement activities and improve diverse participation in research and representation in our workforce. In addition, where research studies have a focus on increasing participation of underserved groups, our Clinical Research Facility have adapted their processes to capture relevant information at study set-up to prioritise this. To support Clinical Research Facility staff, the role of Clinical Research Facility Equality Champion was established and we now have an Equality Champion as each Clinical Research Facility site to support education and knowledge around EDI.

Using novel approaches, research staff are exploring ways to mitigate the impact of language and literacy barriers in the involvement and participation of people in research. Some of this has been made possible by Trust opportunities such as the Chief Nurse Fellowship. Our first Chief Nurse Fellow utilised Art Based Research to explore the barriers South Asian women encounter in engaging with research related to menopause. An outcome of this work has been the development of a resource that equips researchers with tools to engage underserved groups and ensure their inclusion in future studies.

Training and Support

We have two staff members within the Clinical Research and Innovation Office who are now officially recognised as Associate Principal Investigator Champions. They act as a local source of information and support for Trust healthcare professionals who are interested in becoming Principal Investigators in research in the future. There are currently 34 active associate principal investigators at the Trust working on NIHR research studies within the Trust.

The Trust continues its role as a key partner on the Equity in Doctoral Education through Partnership and Innovation programme with Sheffield Hallam University. The programme is funded by Research England – part of UK Research and Innovation – and the Office for Students; it is a partnership that not only involves Sheffield Hallam University but operates across NHS Trusts and Universities in Nottingham and Liverpool and Sheffield Children’s Hospital. Therefore, our involvement in the programme not only improves access to doctoral education for NHS staff from racially minoritised groups, but also involves collaboration with other Trusts and Universities, providing regular opportunity to learn from each other on how we can develop employees from racially minoritised groups. A Masters degree and/or previous research experience are not a part of the eligibility, therefore the Trust are encouraging applications from Trust staff from racially minoritised groups with ideas of how they could improve patient care.

Currently there are five Trust staff members enrolled on the programme, and a further five potential candidates currently engaged with the workshops and application process for the recruitment of the final cohort in 2025.

The innovative Nurse, Midwifery and Allied Health Professional Research Internship Programme was launched in 2021, with four interns graduating from the scheme in June 2022. The initial scheme was a partnership

between the NIHR Sheffield Biomedical Research Centre, the Trust and the Sheffield Clinical Academic Training Programme.

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

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

Importantly, it offers the post-holders a one day per week secondment, with clinical academic mentorship, to pursue a small research project pertinent to both their professional background and to their clinical area of work. The award buys one day of the post-holder’s time to enable research capacity by providing funds to their clinical area for backfill. To date, 25 Trust staff members have completed the internship.

In 2024/25, the programme expanded to include additional support for a broader scope of healthcare professionals, and ongoing partnership was secured from the NIHR Sheffield Clinical Research Facility, NIHR Sheffield Biomedical Research Centre, the Clinical Research and Innovation Office and Clinical directorates. This has resulted in 15 interns enrolled in the current cohort, including nurses, midwives, allied health professionals, clinical scientists and medical photography. The success of the internship has resulted in an abstract being accepted at the ‘Making Research Matter in the North East and Yorkshire’ showcasing event in 2025, and the

development of a Clinical Academic Training Manager role which is now embedded in the Clinical Research and Innovation at the Trust.

Innovation

2023/24 saw the Innovation Team from the Clinical Research and Innovation Office successfully launch the Getting Back On Track Innovation Funding Programme on behalf of the Trust. A Dragons Den format was used, and 21 successful applicants were awarded funding between £2,000 and £25,000 to undertake innovation projects. In 2024/25, the Innovation team secured funding from the Trust to run the Dragons Den Innovation Programme again, and this time, matched funding was secured from Sheffield Hospitals Charity. The collaborative funding opportunity awarded 13 project teams funds of between £2,000 and £50,000 each to execute a diverse range of projects designed to improve patient care and unlock efficiencies for the Trust. Some examples of funded projects from this year include: i) "SNORE SAFE" which is a Preoperative Assessment initiative that looks to exclude the presence of Obstructive Sleep Apnoea in at-risk patients prior to surgery, with the introduction of at home overnight oximetry testing, and which is expected to generate return on investment after only six negative results from tested patients, ii) The Artificial Intelligence Hub – a pilot scheme to provide dedicated resource to support the Trust to safely assess and implement artificial intelligence solutions, and which hopes to generate evidence to support a business case for recurrent funding of the Hub as a long-term service.

The Innovation Team are currently working with several companies looking to pilot or co-develop new and emerging technologies within the Trust. They are working closely with Medipex to support Trust staff with innovative ideas and proposals to protect and exploit their intellectual property, identify and build relationships with appropriate industry partners, and find funding opportunities to support the development and commercialisation of their products.

Communications

Using well-established links, we continue to promote and share the many successes of researchers at the Trust via Trust Communications. Opportunities for staff to submit research and innovation success stories for regional and national awards are disseminated widely to ensure colleagues are recognised for their endeavours. We encourage our staff to get involved in national campaigns that showcase how researchers improve healthcare and the diverse career paths that people working in research have. We use our internal networks and close working relationships with research teams across the Trust to maximise the impact and reach of our communications.

Over this past year we have shared more exceptional examples of our impactful and collaborative research. This includes "game changer" trials of a drug that may reduce bladder cancer recurrence thus giving hope for thousands of patients, and how the integration of exercise, nutritional advice and psychological support into cancer care can improve survival rates.

Staff Engagement

The Trust remains committed to raising awareness of research across the Trust and increasing staff engagement with research particularly in those disciplines less well represented in research. Quarterly Nursing and Midwifery Research and Innovation newsletters are now well-established having commenced in 2023. They give nurses and midwives an overview of achievements, informative highlights, and signposting to the wide variety of opportunities for nurses and midwives to get involved in research and innovation. This complements the communications for nurses, midwives, allied health professionals, pharmacists and healthcare scientists from the Clinical Research and Innovation Office about opportunities and support available to staff to become research active. In addition, Directorates across the Trust regularly share research newsletters and run research awareness sessions for staff and hold study days to bring staff together to

share innovative research and ideas. The last year has also seen different Directorates hold “away days” with talks about research taking place and recent findings, careers in research, how to access research infrastructure and the importance and value of stakeholder research. We are delighted that such events have been successful and show the enthusiasm for research across the different professional groups at the Trust.

In December 2024, the Medical Research Council Impact Acceleration Account (MRC IAA) Showcase event took place to demonstrate the positive impact on patients that have arose from MRC IAA funded projects, and to raise awareness of new opportunities from the MRC IAA scheme. The scheme is a consortium in Sheffield between University of Sheffield, Sheffield Teaching Hospitals, Sheffield Hallam University and Sheffield Children’s Hospital. The event was well attended by Clinicians and Academics across Sheffield, with several opportunities for future collaboration in Research and Innovation already identified since the event. At the showcase, one trust led project was presented and two other projects that involved trust staff and patients were presented, with clear evidence of research that has benefitted patients in Vascular Services, Pulmonary Hypertension and Urogynaecology.

Awards

Over the last year we have seen more examples of our researchers being recognised for their expertise, previous and planned research, and commitment to research training through securing competitive fellowship awards from national funders. Such awards have spanned the breadth of experience levels from early career researchers up to Professor level. Three of our most experienced researchers were recently awarded Senior Investigator status from the NIHR. This was in recognition for the quality and volume of their research and its relevance and impact for patients and the public.

Many other researchers have received recognition from national societies for their expertise and commitment to research across a wide variety of Directorates.

Annual Surveys

The Participant in Research Experience Survey (PRES) asks participants of NIHR portfolio research about their experience of taking part in research. We use this data to continue to improve how our studies are designed and carried out. The data collection period for 2024/25 has just finished and will be analysed in due course, so here we report on feedback from 2023/24. Across the Trust we received responses for PRES from 29 different studies across 12 Directorates which was an increase from the previous year. This means half of our Directorates are now giving participants in research the opportunity to share feedback about their experience. The introduction of dedicated research support staff in some teams, together with more engagement with Directorates, has meant we have PRES feedback from Directorates previously not represented.

Via closer collaborative working between the Clinical Research and Innovation Office PRES team and the Clinical Trials Assistant team, systems and processes for including PRES delivery in study feasibility have been implemented in Clinical Trials Assistant led studies. Half of our PRES responses now come from studies delivered by the Clinical Trials Assistant team meaning we are now giving participants of low risk non interventional studies as well as experimental medicine studies the opportunity to share feedback.

Participants continue to report a positive experience of research. Positive aspects of participant’s research experience are related to the professionalism and friendliness of the research team, their feeling valued by research staff and their contribution to future healthcare.

6.6 Data quality

The Trust submitted records during 2024/25 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 (April 2024 to January 2025 data):

- 99.9% for admitted patient care.
- 100% for outpatient care.

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

- 100% for admitted patient care.
- 100% for outpatient care.

The Trust continues with the following programmes to improve its data quality:

- A programme of Data Quality work is well established to support the implementation of the Connect EPR and the data migration from Lorenzo into the new system. This work is supported by weekly 'Housekeeping' meetings with Care Groups to drive progress and monitor readiness.
- The Data Quality Team continue providing support to the organisation and consistently driving forward a coordinated Data Quality agenda across the organisation.
- The reporting dashboards to support improvement to Data Quality, including the Administrative Patient Safety Dashboard, Breaks in Process report and Administrative Safety Huddles are well established within the organisation. Administrative safety feedback from Care Groups is a regular agenda item at the Performance and Caseload Overview Group.

- The Data Quality Steering Group, chaired by the Assistant Chief Executive, continues to maintain oversight of data quality, and continues to support data quality improvement across the organisation. Regular review of the workplan is in place to target the areas of greatest risk.
- The Trust continues to undertake a range of discreet projects where data quality has been identified as requiring improvement such as clinical coding, new national datasets and review of existing data submissions.

Appendices

Appendix 1 - Work Race Equality Standard (WRES)

Appendix 2 - Workforce Disability Equality Standard (WDES)

Appendix 3 - Audit and confidential enquiries



Appendix 1 - Work Race Equality Standard (WRES)

WRES Metric	Metric Description	Ethnic Group	2022	2023	2024	Improvement	Representative Target	National 2023
Metric 1	Percentage of Black and Minority Ethnic (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	17.56%	20.69%	23.40%	●	21%	26.4%
		BME 8a + and VSM	6.88%	7.96%	8.53%	●	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	1.35	1.30	1.41	●	1.00	1.59
Metric 3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process	BME	1.16	0.84	1.25	●	1.00	1.03
Metric 4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff	White	0.81	0.78	0.88	●	1.00	1.12
Metric 5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	23.9%	24.5%	22.3%	●	0%	26.9%
		BME	26.7%	24.9%	24.5%	●	0%	30.5%
Metric 6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	20.4%	19.9%	19.1%	●	0%	21.7%
		BME	28.6%	25.2%	23.8%	●	0%	27.5%
Metric 7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion	White	59.0%	58.8%	57.7%	●	100%	59.4%
		BME	41.4%	42.8%	46.8%	●	100%	46.7%
Metric 8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team	White	5.9%	6.4%	6.5%	●	0%	6.6%
		BME	18.3%	18.0%	16.9%	●	0%	16.4%
Metric 9	Percentage of BME Board membership	White	81%	80%	94%	●	81%	-
		Unknown	13%	13%	0%	●	0%	-
		BME	6%	7%	6%	●	19%	15.6%

● change in a positive direction ● change in a negative direction ● no change

Appendix 2 - Workforce Disability Equality Standard (WDES)

WDES Metric	Metric Description	Disability Group	2022	2023	2024	Improvement	National 2023
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	4.53%	4.99%	5.86%	●	4.9%
		Disabled 8a+ and VSM	3.25%	4.51%	5.61%	●	-
Metric 2	Relative likelihood of Disabled staff compared to non-disabled being appointed from shortlisting across all posts	Non-disabled	1.09	1.09	1.03	●	0.99
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Disabled	0.00	0.00	4.56	●	2.17
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	29.5%	30.5%	27.6%	●	33.2%
		Non-disabled	22.4%	22.3%	20.7%	●	26.0%
	ii. Managers	Disabled	14.3%	13.2%	11.8%	●	16.1%
		Non-disabled	7.7%	7.4%	6.1%	●	9.2%
	iii. Other colleagues	Disabled	24.5%	22.3%	22.4%	●	24.8%
		Non-disabled	14.9%	14.7%	13.8%	●	16.5%
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	45.5%	46.6%	48.5%	●	51.3%	
	Non-disabled	43.5%	44.5%	48.1%	●	49.5%	
Metric 5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Disabled	51.7%	52.7%	51.8%	●	52.1%
		Non-disabled	58.2%	57.3%	57.2%	●	57.7%
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	32.0%	29.1%	30.8%	●	27.7%
		Non-disabled	21.9%	20.5%	17.7%	●	19.9%
Metric 7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled	36.0%	33.2%	34.7%	●	35.2%
		Non-disabled	43.8%	42.4%	44.1%	●	45.0%
Metric 8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	Disabled	74.7%	74.5%	75.8%	●	73.4%
Metric 9	a. The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Organisation	6.7	6.7	6.7	●	-
		Disabled	6.4	6.3	6.4	●	6.4
		Non-disabled	6.9	6.8	6.9	●	6.9
Metric 10	Percentage difference between the organisations Board voting membership and its overall workforce By voting membership of the Board	Disabled	12%	13%	12%	●	5.7%
		Non-disabled	69%	67%	88%	●	74.7%
		Unknown	19%	20%	0%	●	19.5%
	By voting membership of the Board	Disabled	12%	13%	12%	●	5.6%
		Non-disabled	69%	67%	88%	●	74.5%
		Unknown	19%	20%	0%	●	19.9%
	By Executive membership of the Board	Disabled	0%	0%	0%	●	5.4%
		Non-disabled	100%	100%	100%	●	79.1%
		Unknown	0%	0%	0%	●	15.5%

● change in a positive direction ● change in a negative direction ● no change

Appendix 3 - Audit and confidential enquiries

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
Acute care		
Breast and Cosmetic Implant Registry	Yes	100%
British Hernia Society Registry	No	Did not participate, please see supporting statement in section 6.1
Case Mix Programme	Yes	100%
Paediatric Intensive Care Audit Network	N/A	
National Major Trauma Registry. Previously The Trauma Audit and Research Network	Yes	75%*
National Emergency Laparotomy Audit	Yes	43.5%*
National Joint Registry	Yes	104.7%†
Sentinel Stroke National Audit programme	Yes	90%+
National Vascular Registry		
National Carotid Interventions	Yes	31%*
Abdominal Aortic Aneurysm	Yes	64%*
Peripheral Vascular Surgery - Lower limb angioplasty/stenting	Yes	34%*
Peripheral Vascular Surgery - Lower limb bypass	Yes	10%*
Peripheral Vascular Surgery - Lower limb amputation	Yes	16%*
UK Renal Registry		
Chronic Kidney Disease Audit	Yes	100%
National Acute Kidney Injury Audit	Yes	100%
RCEM Emergency Medicine:		
Care of Older People	Yes	100%*
Mental Health (Self-Harm)	Yes	100%*
Time Critical Medications	Yes	100%*
Blood and transplant - National Comparative Audit of Blood Transfusion programme:		
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	100%
National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusion against NICE Quality Standard 138	Yes	100%
National Comparative Audit of Blood Transfusion: 2023 Bedside Transfusion Audit	Yes	100%

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
Cancer		
National Oesophago-Gastric Cancer Audit	Yes	100%
National Bowel Cancer Audit	Yes	100%
National Lung Cancer Audit	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Audit of Metastatic Breast Cancer	Yes	100%
National Audit of Primary Breast Cancer	Yes	100%
National Pancreatic Cancer Audit	Yes	100%
National Kidney Cancer Audit	Yes	100%
National Ovarian Cancer Audit	Yes	100%
National Non-Hodgkin Lymphoma Audit	Yes	100%
Heart		
National Cardiac Arrest Audit	Yes	100%
National Cardiac Audit Programme:		
National Adult Cardiac Surgery Audit	Yes	100%
National Congenital Heart Disease Audit	N/A	
Myocardial Ischaemia National Audit Project	Yes	100%*
National Heart Failure Audit	Yes	100%*
National Audit of Cardiac Rhythm Management	Yes	100%
National Audit of Percutaneous Coronary Intervention	Yes	100%
National Audit of Mitral Valve Leaflet Repairs	N/A	
The UK Transcatheter Aortic Valve Implantation Registry	Yes	100%
Left Atrial Appendage Occlusion Registry	N/A	
Patent Foramen Ovale Closure Registry	N/A	
Transcatheter Mitral and Tricuspid Valve Registry	N/A	
Out-of-Hospital Cardiac Arrest Outcomes	N/A	
National Audit of Cardiovascular Disease Prevention in Primary Care	N/A	
National Audit of Cardiac Rehabilitation	Yes	100%

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
National Audit of Pulmonary Hypertension	Yes	100%
Long term conditions		
National Asthma and COPD Audit Programme:		
Adult Asthma Secondary Care	Yes	33%* please see supporting statement in section 6.1
Children and Young People Asthma Secondary Care	N/A	
Pulmonary Rehabilitation	Yes	84.7%
COPD Secondary Care	Yes	100%*
UK Cystic Fibrosis Registry	Yes	100%
National Adult Diabetes Audits:		
National Diabetes Core Audit	Yes	98%*
National Pregnancy in Diabetes Audit	Yes	100%*
National Diabetes Footcare Audit	Yes	Participated**
National Diabetes Inpatient Safety Audit	Yes	100%
Diabetes Prevention Programme Audit	N/A	
Gestational Diabetes Audit	No	Did not participate, please see supporting statement in section 6.1
Transition (Adolescents and Young Adults) and Young Type 2 Audit	N/A	
Mental health		
Learning from Lives and Deaths of People with a Learning Disability and Autistic People	Yes	100%
Mental Health Clinical Outcome Review	N/A	
National Clinical Audit of Psychosis	N/A	
Prescribing Observatory for Mental Health		
a) Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	N/A	
b) The use of melatonin	N/A	
c) The use of opioids in mental health services	N/A	
National Clinical Audit of Psychosis	N/A	

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
Older people		
Falls and Fragility Fractures Audit programme:		
National Audit of Inpatient Falls	Yes	100%
National Hip Fracture Database	Yes	107.7%†
Fracture Liaison Service Database	N/A	
Other		
National Bariatric Surgery Registry	Yes	100%*
National Obesity Audit	Yes	100%
National Ophthalmology Audit Database: Cataract Audit	No	Did not participate nationally / carried out local audit, please see supporting statement in section 6.1.
National Ophthalmology Database: Age-related Macular Degeneration Audit (year 5)	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery: a) Oncology and Reconstruction	Yes	83%*
Quality and Outcomes in Oral and Maxillofacial Surgery: b) Trauma	No	Did not participate, please see supporting statement in section 6.1
Quality and Outcomes in Oral and Maxillofacial Surgery: c) Orthognathic Surgery	Yes	Collation in progress
Quality and Outcomes in Oral and Maxillofacial Surgery: d) Non-melanoma skin cancers	No	Did not participate, please see supporting statement in section 6.1
Quality and Outcomes in Oral and Maxillofacial Surgery: e) Oral and Dentoalveolar Surgery	No	Did not participate, please see supporting statement in section 6.1
British Association of Urological Surgeons Urology Audits:		
British Association of Urological Surgeons Penile Fracture Audit	Yes	100%
British Association of Urological Surgeons Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices	Yes	100%
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit	Yes	64%
National Audit of Care at the End of Life	Yes	100%
National Early Inflammatory Arthritis Audit	Yes	16%
Society for Acute Medicine Benchmarking Audit	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Cleft Registry and Audit Network Database	N/A	
Women's and children's health		
Child Health Clinical Outcome Review Programme	N/A	

Audits and confidential enquires	Participation N/A = Not applicable	% cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme:		
Perinatal Mortality Surveillance and Confidential Enquiry	Yes	100%
Maternal Mortality Surveillance and Confidential Enquiry	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Paediatric Diabetes Audit	N/A	
Paediatric Intensive Care Network	N/A	
National Child Mortality Database	Yes	Links to MBRRACE
National Audit of Seizures and Epilepsies in Children and Young People	N/A	
Outcomes		
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death:		
End of Life Care	Yes	82%
Intensive Care Unit Rehabilitation	Yes	72%
Blood Sodium	Yes	100%
Acute Limb Ischaemia	Yes	100%
Emergency (non-elective) procedures in children and young people	Yes	79%

Please note the following

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

** National Diabetes Footcare Audit: the systems in the Trust do not allow us to identify number of eligible cases.

† Percentage of cases submitted to the National Joint Registry / National Hip Fracture Database compared to Hospital Episode Statistics. Compliance may be greater than 100% due to the timing of submission of data.

Annexes

Annex 1 - Statements from our Partners

- NHS South Yorkshire Integrated Care Board
- Sheffield City Council Health Scrutiny Sub Committee
- Healthwatch Sheffield
- Trust Governors

Annex 2 - Statement of Directors' Responsibilities

Annex 3 - Glossary



Annex 1 - Statement on Behalf of NHS South Yorkshire Integrated Care Board



NHS South Yorkshire Integrated Care Board (ICB) commissions Sheffield Teaching Hospital Foundation Trust provide a very wide range of general and specialised services which we seek to continually innovate and improve the quality of and the experience of those individuals who access them. We do this by reviewing and assessing the Trust's performance against a series of key performance and quality indicators and evaluating contractual performance via the appropriate governance forums i.e. Contract Management Group, Quality Review Group and Contract Management Board meetings. We work closely with the Care Quality Commission who are regulators of health services in England and NHSE who leads on the National Health Service.

The ICB has had the opportunity to review and comment on the information contained within this Quality Account prior to its publication and is confident that to the best of its knowledge the information supplied within this report is an accurate and a true record, reflecting the Trust's performance over the period April 2024 – March 2025.

The ICB and Trust continue to work together to address issues related to clinical quality so that standards of care are upheld. The ICB recognises the hard work which the trust has undertaken following the CQC inspection and feedback.

In 2024/2025, the Trust identified three quality objectives to be achieved over a one-year period.

- **Quality objective one:** Improve the assessment and management of pressure ulcer risk to ensure patient safety.
- **Quality objective two:** Improve the experience of people who are blind or visually impaired, with a focus on communications
- **Quality objective three:** Improve the management of pain for patients.

To support long term improvements for service users, their carers and families the trust has committed to three new quality objectives over a one-year period from 2025 to 2026. The ICB will continue to support these programmes of work and looks forward to the objectives being met in full. The new objectives are outlined below:

- **Quality objective one:** Improve the support given to older people with frailty admitted to hospital to prevent deconditioning.
- **Quality objective two.** Increase and improve system-based learning achieved following near miss and low harm incidents
- **Quality objective three:** Improve services for young people including healthcare transition

The ICB will continue to collaborate with the Trust supporting quality improvement so that standards of care are upheld and also to evolve services and ensure the changing needs of our local population are met and inequalities reduced.

Alun Windle, Chief Nurse
9 June 2025

Annex 1 - Statement from the Chair of Sheffield City Council's Health Scrutiny Sub Committee

The first draft report was provided to Sheffield City Council Health Scrutiny Sub Committee on 5th June 2025. The following response was agreed at that meeting:

The Sub Committee welcomed the opportunity to discuss the Trust's Quality Accounts and they found the discussions informative and helpful. In particular the discussion focussed on a number of issues which the Sub Committee members sought clarification and reassurance on:

1. The increase in the number of informal concerns being raised, compared to static position on formal complaints. By far the most common concern expressed by patients was around waiting times. Members noted that the Trust intends to focus on this.
2. Inequalities: the Sub Committee would like to follow up with the Trust in more depth on this subject.
3. Transitions: noting that joint working with other trusts to develop a pilot is to be rolled out, in line with national and regional frameworks. The Sub Committee would like to link this up with its current scrutiny of the Sheffield All Age Autism Strategy, and would like the Trust to share learning around this work with partners.
4. Co-production work with blind and visually impaired patients: the Sub Committee considered this to be an exemplar, the Chair having received complimentary feedback on the process from the Sheffield Royal Society for the Blind. SRSB are particularly pleased that integrated work will continue with STH even after most of the outcomes have been achieved; they feel confident that STH is committed long-term to enhancing the experience of visually impaired patients.
5. Disabled parking: availability across the STH estate was raised as an issue for the Trust to improve on with urgency; the Sub Committee was aware that lack of blue badge parking is a problem frequently raised with Disability Sheffield.
6. 'Never events': the Sub Committee considered recent local press coverage of the four reported 'never events' to be misleading and were not concerned that this was a high number, when benchmarked nationally or considered against STH data from the last five years. The Chair urged local reporters to consider the impact of publishing statistics without context, commenting that the nature of this type of media report could cause unnecessary alarm for the general public and is unhelpful to NHS partners. The Sub Committee also noted that the number of Patient Safety Incidents reported is on a positive, downward trend, as is the number of PSIs resulting in serious harm or death.

7. Infection control: notably improving techniques around this, e.g. deep clean programme over the Summer, in preparation for Winter. The Sub Committee would like the Trust to share learning and do more in terms of collaborating with other partners to develop a holistic approach to infection control. Members would welcome the opportunity to be part of discussions around this in the context of Winter Planning in particular.
8. Closure of NHS England: members asked about the potential impacts of the abolition of NHSE, and were reassured to hear that STH feels it has robust, strength-led teams in place to see through programmes of improvement, and does not expect the top-level structural change to have a negative effect.

Sub Committee members were reassured by measures being put in place by the Trust to address these issues and received verbal updates very positively.

They wished to congratulate the Trust on their progress made since last year and particularly welcomed the development of its co-production work.

The Sub Committee looks forward to receiving further updates in the future.

Cllr Ruth Milsom
Chair, Health Scrutiny Sub Committee
9 June 2024

Annex 1 - Statement on Behalf of Healthwatch Sheffield

Thank you for sharing this year's Quality Account with us. Our response draws on experiences of hospital services that the public have shared with us this year, as well as patient and public perspectives from our volunteers.

Overall this report presents a picture of a Trust that is active in seeking out opportunities to learn and improve; CQC inspections and other feedback have raised some cause for concern, but examples of steady improvement on these action plans are promising.

Progress on last year's priorities shows lots of good work – we know that partnership working with the Sheffield Royal Society for the Blind has been a particularly positive experience for the Trust and hope to see initiatives like this continue, prioritising involvement of people with lived experience.

The priority objectives for the year ahead are clearly presented, with rationale and the key outcomes expected. It might be helpful to see more on 'how' these will be achieved, especially the objective around frailty. The objective around transitions is a joint objective with Sheffield Children's Trust – we are pleased to see co-working on this, as transition to adult services has been a key working area for children's services for a number of years.

Being involved in the Trust's quality objective steering group has been helpful for us, allowing us to hear regular updates on work to improve patient safety and experience, giving us greater insight on these priority work areas and the opportunity to share the experiences we are hearing.

The Trust has also demonstrated a listening attitude elsewhere in the report – for instance with examples of learning from complaints – and in our work with them over the last year. They have been responsive to feedback we've shared from patients and families, and have identified some changes to make in response (for example around wheelchair availability in hospital entrances). Sexual health services have engaged particularly positively when we have worked with them, and have been quick to implement initiatives to improve access for vulnerable groups.

However there are still some areas for concern, particularly around cancer care. Data shared in the report shows a concerningly low achievement against the 62-day wait target (from urgent referral to diagnosis and first treatment). We also know that nationally, South Yorkshire is a concerning outlier in terms of cancer outcomes. Over the year we have been hearing feedback from patients waiting for cancer diagnosis and for cancer treatment; these waiting times are a source of huge stress for them and their families, and many have felt that communication has been poor while they wait.

Timely hospital discharge continues to be a concern for the Trust and for patients too - throughout the year, hospital staff have engaged with our public and patient involvement forum on the work that is being done to address this, and we are aware that it is an area of high priority for the Trust and other system partners. Despite a number of successes with this work, we understand that increased hospital admissions and resource challenges make this position difficult to improve; we are also aware that work to understand discharge from a patient perspective has been limited, and we hope to see more focus on this as the improvement work continues over the next 12 months.

We will be interested to see how the launch of the new electronic patient record system goes later this year. We hope it will address some of the communication issues with patients, and lead to a more streamlined process for them which avoids the confusion that arises from separate systems in different departments.

Overall the story presented in this report is one of positive growth – with CQC inspections and other intelligence highlighting some watch points for the next year.

9 June 2025

Annex 1 - Statement from Trust Governor Involvement in the Quality Objective Steering Group

Two governors sit on the Quality Objective Steering Group, participating in the three meetings which were held during 2024/25. Our role is to assist the Group in choosing the appropriate priorities regarding improving the quality of care for patients and to share our views on progress being made against these priorities, which are always given due consideration.

Governors were present at all meetings that took place this year where presentations from the relevant lead for each Quality Objective attended and provided a detailed update on progress and reported any delays or barriers. Governors are pleased to note the good progress against the 2024/25 Quality Objectives where two are complete, and considerable improvements have been made on the third, with ongoing focus to ensure the progress made is maintained with clear oversight arrangements in place.

The Council of Governors were given the opportunity to contribute to the consultation for selecting the 2025/26 Quality Objectives. At the 4 February 2025 Quality Objective Steering Group meeting, three Quality Objectives were selected for 2025/26, as outlined in this report, which align to the 'Patient Experience', 'Safety' and 'Effectiveness' domains within the Trust's Quality Strategy.

The governors are pleased to be welcomed and encouraged to be involved in the selection of the Trust's quality priorities and the work of the Quality Objective Steering Group, which ultimately influence good patient care. We recognise the work undertaken by the staff in continually delivering improvements to patient care.

Joe Saverimoutou, Public Governor
Shirley Sherwood, Patient Governor
4 June 2025

Annex 2 - Statement of Directors' Responsibilities for the Quality Report

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25.
- 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 2024 to March 2025
 - Papers relating to quality reported to the Board over the period April 2024 to March 2025
 - Feedback from NHS South Yorkshire Integrated Care Board dated 9 June 2025
 - Feedback from Governors dated 4 June 2025
 - Feedback from local Healthwatch organisations dated 9 June 2025
 - Feedback from Sheffield City Council's Health Scrutiny Sub Committee dated 9 June 2025
 - The latest national patient surveys, dated November 2024 (Urgent and Emergency Care), July 2024 (Cancer), August 2024 (Adult Inpatient Survey), November 2024 (Maternity)
 - The latest national staff survey published March 2025

- 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



Annette Laban

Chair

24 June 2025



Kirsten Major

Chief Executive

24 June 2025

Annex 3 - Glossary

The table below provides a glossary of abbreviations and acronyms

ADHD	<p>Attention-Deficit/Hyperactivity Disorder A neurodevelopmental condition characterised by inattention, hyperactivity, and impulsivity.</p>
AIS	<p>Accessible Information Standard The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.</p>
BME	<p>Black and Minority Ethnic Black, Asian and minority ethnic (used to refer to members of non-white communities in the UK).</p>
COPD	<p>Chronic obstructive pulmonary disease The name for a group of lung conditions that cause breathing difficulties. It includes:</p> <ul style="list-style-type: none"> • emphysema – damage to the air sacs in the lungs • chronic bronchitis – long-term inflammation of the airways
CQC	<p>Care Quality Commission The independent regulator of all health and social care services in England. The Care Quality Commission monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety.</p>
EDI	<p>Equality, Diversity and Inclusion Interconnected concepts that aim to create fair and equitable environments where everyone feels valued and respected, regardless of their individual characteristics.</p>
EDS2022	<p>NHS Equality Delivery System 2022 A system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.</p>
EIAs	<p>Equality Impact Assessments A process used by organizations to evaluate how their policies, practices, and decisions might affect individuals with protected characteristics.</p>

EPR	<p>Electronic Patient Record A digital version of a patient's medical history and care information.</p>
FFT	<p>Friends and Family Test A national NHS tool allowing patients to provide feedback on the care and treatment they receive and to improve services. It asks patients whether they would recommend hospital wards and accident and emergency departments to their friends and family if they needed similar care or treatment.</p>
FTSU	<p>Freedom to Speak Up A policy and culture that encourages individuals, particularly within organizations like the NHS, to openly raise concerns and share their voices without fear of retribution</p>
GP	<p>General Practitioner Also known as a family doctor or primary care physician, is a doctor who provides comprehensive medical care to patients in their local community.</p>
HCAI	<p>Healthcare Associated Infections Infections acquired during the process of receiving healthcare in a facility, such as a hospital or long-term care setting, that were not present or incubating upon admission. They can result from medical or surgical treatments or contact with a healthcare environment.</p>
HES	<p>Hospital Episode Statistics A data warehouse containing details of all admissions, outpatient appointments and accident and emergency attendances at NHS hospitals in England.</p>
ICB	<p>Integrated Care Board They are responsible for planning and managing NHS services within their local Integrated Care System (ICS) area. ICBs work with local providers like hospitals and GP practices to develop a joint five-year plan that outlines how the NHS will contribute to the ICS's integrated care strategy.</p>
IR(ME)R	<p>Ionising Radiation (Medical Exposure) Regulations Guidance on the Ionising Radiation (Medical Exposure) Regulations 2017 for employers and health professionals who carry out medical radiological procedures.</p>
LGBTQ+	<p>Lesbian, Gay, Bisexual, Transgender, Queer Lesbian, gay, bisexual, transgender, and queer/questioning, with the "+" indicating the inclusion of other sexual orientations and gender identities.</p>

MBRRACE	<p>MBRRACE: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK The MBRRACE collaboration is responsible for running the national Maternal, Newborn and Infant clinical Outcome Review Programme, funded by the Healthcare Quality Improvement Partnership (HQIP). The main purpose of MBRRACE is to conduct robust national surveillance and investigate the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK.</p>
MDT	<p>Multi-disciplinary team A group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. Multidisciplinary Teams may specialise in certain conditions, such as Cancer.</p>
MRI	<p>Magnetic Resonance Imaging A medical imaging technique that uses strong magnetic fields and radio waves to create detailed images of the inside of the body.</p>
NCEPOD	<p>National Confidential Enquiry into Patient Outcome and Death The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice and identifies potentially remediable factors in practice. NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.</p>
NEWS2	<p>National Early Warning Score A scoring system used in hospitals to identify patients at risk of clinical deterioration.</p>
NHSE	<p>NHS England NHS England are responsible for overseeing the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012. NHS Improvement became part of NHSE and is responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.</p>
NICE	<p>National Institute for Health and Care Excellence An executive non-departmental public body of the Department of Health in the United Kingdom, which publishes guidelines in four areas:</p> <ul style="list-style-type: none"> • the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures) • clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions) • guidance for public sector workers on health promotion and ill-health avoidance guidance for social care services and users
NIHR	<p>National Institute for Health and Care Research An organisation which aims to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.</p>

PALMS	Personal Achievement and Learning Management System Trust electronic system that records all training and gives access to a wide range of online and face-to-face Mandatory Training and Job Specific Essential Training, as well as other courses
PALS	Patient Access and Liaison Service Offers support, advice and information on NHS services to patients, their carers, the general public and hospital staff.
PHSO	Parliamentary and Health Service Ombudsman Independently investigate complaints about UK government departments, other public organisations and the NHS in England.
PRES	Participant in Research Experience Survey An annual nationally standardised survey used to collect adults and children's views and experiences of participating in National Institute for Health and Care Research supported research.
PROMs	Patient Report Outcome Measures These are nationally mandated and provide a patient perspective of the effectiveness of the care they received - in simple terms, the improvement gain or loss following the procedure.
PROUD	PROUD The Trusts values: Patients First: Ensure people we serve are at the heart of all that we do Respectful: Be kind, respectful, fair and value diversity Ownership: Celebrate our successes, learn continuously and ensure we improve Unity: Work in partnership with other Deliver: Be efficient, effective and accountable for our actions
PSIRF	Patient Safety Incident Response Framework Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
PSIRP	Patient Safety Incident Response Plan Outlines how the Trust organisation responds to patient safety incidents, focusing on learning and improvement rather than blame.
PSIIs	Patient Safety Incident Investigations Undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation.

PURPOSE-T	<p>Pressure Ulcer Risk Primary or Secondary Evaluation Tool A tool to assess the risk of pressure ulcers in adults. It helps identify individuals at risk of developing pressure ulcers, those with existing ulcers, and those who have had ulcers in the past, supporting nurses in making informed decisions about prevention and treatment.</p>
SHMI	<p>Summary Hospital-Level Mortality Indicator An indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital.</p>
SJR	<p>Structured Judgement Review A method for reviewing patient care, particularly in the context of mortality, that involves making explicit judgements about the quality of care at different stages and scoring the care for each phase. It aims to identify strengths, weaknesses, and potential improvements in the healthcare process.</p>
STH	<p>Sheffield Teaching Hospitals NHS Foundation Trust</p>
TACO	<p>Transfusion-associated circulatory overload A serious complication of blood transfusions characterized by acute respiratory distress and pulmonary edema due to fluid overload. It occurs when the body's ability to handle the volume of fluid being transfused is overwhelmed, leading to fluid leakage into the lungs.</p>
VSM	<p>Very Senior Manager Individuals holding executive positions on boards or directly reporting to the chief executive. They are typically non-clinical, non-medical roles and are considered highly senior, often above band 9 on the Agenda for Change.</p>
WDES	<p>Workforce Disability Equality Standard A set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS organisations use the metrics data to develop and publish an action plan, building on high impact actions shared in the first ever EDI improvement plan.</p>
WHO	<p>World Health Organisation A specialised agency of the United Nations which coordinates responses to international public health issues and emergencies.</p>
WRES	<p>Workforce Race Equality Standard A requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME Board members across the organisation.</p>

For more information please contact:

Quality Governance Department

Sheffield Teaching Hospitals NHS Foundation Trust

21 Claremont Crescent

Sheffield

S10 2TA

www.sth.nhs.uk

