Sheffield Children's NHS
NHS Foundation Trust

Quality Account 2023/24

About Sheffield Children’s NHS Foundation Trust

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

Our services encompass:

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

This Quality Account is the culmination of the past 12 months of our work on quality, safety and patient experience. We hope that you find it informative.

Part 1: Statement from the Chief Executive

This year, we launched our Quality Promise which describes our commitment to children, young people and families, supports the Trust's Caring Together strategy and our shared purpose of 'providing a healthier future for children and young people'.

We engaged with hundreds of children, young people, families, colleagues, and partner organisations in developing the Quality Promise. We listened carefully to personal stories and feedback to ensure it really captures what matters to children, young people, and families.

At the heart of the Quality Promise is our commitment to providing safe, kind and outstanding care. It sets out our journey of quality improvement over the next five years and builds on what we've done this year including:

- The implementation of the Patient Safety, Incident Response Framework (PSIRF), development of alternative methodologies and investment in our new learning response leads and care group governance arrangements.
- Introduction of several new quality related roles including Quality Matrons, Patient Engagement Leads, Sepsis Nurse, Infection Control Lead Nurse and Safeguarding Lead Nurse.
- The introduction of new Safety Wednesday governance arrangements and the Safety, Quality, Risk and Learning Committee.
- Continuing work on our new Helipad and securing the funding for a new National Centre for Child Health Technology which will help put children and young people at the centre of all that we do as a paediatric centre of excellence.
- Rapidly reducing our waiting lists, especially for those patients waiting longer than 78 weeks.
- Implementing a number of new quality-related IT projects including Electronic Prescribing and Medicines Administration.
- Increasing our work around Super Saturdays and Health Inequalities work including engagement undertaken with under-represented communities (including Somali, Roma, people living with autism, Special Education Needs engagement).

The next 12 months will prove to be an exciting quality journey for the Trust. We look forward to you joining us on it.

Ruth Brown
Chief Executive

XXXXX 2024

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

Priorities for Improvement 2024/25

At Sheffield Children's NHS Foundation Trust, we are absolutely committed to continually improving patient safety and the quality of our care across our acute, community and mental health services. We have therefore carefully considered our quality priorities for 2024/25 by:

- Reviewing the national improvements that all NHS organisations have to make (standards and targets).
- Actively listening to issues that have been highlighted by children, young people, families, and our colleagues.
- Reviewing patient and carer feedback around improvements that they would like to see.
- Reviewing the themes that have been identified through the year for quality and safety.
- Assessing our performance for quality and safety against best practice.
- Considering our strategic direction using our Quality Promise and Caring Together strategy to guide us through the next five years.

Our quality priorities for 2024/25 are therefore as follows:

1. **Develop our awareness and recognition of sepsis, by improving colleague awareness, the tools we use to spot sepsis, and our access to expert knowledge.**

Our reason for selecting this priority is because findings of our recent audits and investigations into our serious incidents have shown us that we have more to do as a Trust in terms of our awareness and recognition of sepsis. Nationally, reports from bodies such as the Parliamentary Health Services Ombudsman and the Health Service Journal show that recognition of sepsis has not improved as much as expected, and patients are not always being diagnosed or treated quickly enough.

We will:

Learn and improve our practice from listening to families, clinical audit, and case reviews

- Build on the findings of our 2023 Trust wide Sepsis Audit by improving our opportunities to learn from clinical audit. This includes sharing learning through a Sepsis Grand Round, and ward-based huddles to raise awareness and embed education.

- Adopt a regional and national approach with other sepsis leads to benchmark our practice (so we can see how well we are doing in comparison to other organisations).

- We will work directly with parents of children who have had sepsis to understand their experience and ensure that their voices are heard and understood.

- Conduct a review of all our significant cases of sepsis to identify any themes or trends that we can address that will help us to take earlier or preventative action in future.

Improve our systems and provide training to support early recognition and timely escalation and treatment of sepsis

- Include recognition and management of Sepsis in our resuscitation training for new and existing clinical staff.

- Link in with the Children and Young People's Alliance across South Yorkshire and Bassetlaw to share resources so we can improve the management of sepsis.

- Implement electronic early warning systems so it is easier to identify. We are part of the SPOT trial which will develop a national standardised early warning score for children.
- Improve our training to improve the practice of communication and listening to patients and their families when they have concerns about deterioration.

2. Improve our bereavement services, so that our families have access to timely, kind, and efficient support that meets their needs, when they need us.

Our reason for selecting this priority is because recent bereavements, complex complaints, and recommendations from inquests at the Trust have demonstrated that our bereavement care is not always in line with our Quality Promise.

There has been significant quality improvement work internally which has systematically assessed the issues using a clinical microsystems methodology. The microsystem team have made several improvements and continue to meet to ensure families receive equitable and personalised support following the death of their child.

We will:

- Recruit two additional roles focussed solely on bereavement support including a bereavement administrative coordinator (0.4 WTE) and a bereavement support nurse (0.8 WTE).
- Form a bereavement support team that is properly built into the Trust structure to make the service more centralised with better oversight from the lead Joint Agency Response nurse and bereavement support nurse when appointed.
- Ensure keyworkers feel supported to carry out their roles. The bereavement support nurse will be responsible for overseeing and delivering education and training to other keyworkers in the Trust to ensure bereavement support remains consistent and of a high standard.
- Publish keyworker standard operating procedure (SOP) documentation on the intranet to outline the responsibilities and boundaries for keyworkers and ensure all families receive the Trust's minimum core offer.
- Make the bereavement admin coordinator responsible for ensuring each family contact in the SOPs have been completed and documented by the keyworker.
- Produce an electronic document so that keyworkers can easily demonstrate that actions outlined in the SOPs have been completed to ensure that governance and documentation is robust.
- Work closely with the patient safety, governance, and complaints teams to ensure processes are streamlined and families receive appropriate communication and support when a complaint or PSII is raised.
- Confirm a process for keyworkers to refer families for additional support to Bluebell Wood Children's Hospice including bereavement counselling.
- Commit to providing bereavement support that is culturally appropriate for each family and be guided by those with lived experience.

3. Continue to implement the Waiting Well project (with a specific focus on Neurodisability), to reduce the risk of young people and their families coming to harm and help them to feel fully informed while waiting.

Our reason for selecting this priority is due to increased waiting times/lists and the subsequent need to ensure patients and families feel supported and safe during this time. Waiting list recovery is also a key priority for the NHS in 2024/25.

Waiting Well aims to support young people and families to remain well whilst they are waiting for their appointment or procedure. This includes providing access to information and resources that will help to improve overall health (such as oral health, physical exercise, etc.)., as well as providing tailored resources for specific health conditions.

Waiting Well also oversees the implementation of the text validation process, which involves asking patients if their appointment/procedure is still required and provides a contact route if a child's condition has changed whilst waiting. This process also aims to support with waiting list recovery (by way of reducing Was Not Bought rates and unnecessary appointments) and subsequently reduce patient waiting times.

We will:

- Provide specialty-level referral receipts for families that will include speciality-specific information/resources and average waiting times.
- Work closely with patients and families to better understand what support they would find useful while they are waiting to be seen.
- Continue to operationally embed Text Validation within appropriate clinical specialties.
- Improve our communication with patients between the point of receiving their referral and offering an appointment.
- Team up with Care Group and clinical colleagues to explore new ideas and initiatives with that will help patients and families to wait well.
- Focus on providing greater support to patients waiting for an appointment in Neurodisability, including better communicating/clarifying the grading process with families.
- Provide patients and families with transparent waiting times for RTT and non-RTT specialties.

Our Progress against our 2023/24 priorities

Last year we set ourselves the following three quality priorities:

1. Implement the Patient Safety Incident Response Framework to improve systems, processes, and training for patient safety.
2. Reduce elective waiting times to achieve 65 weeks, whilst ensuring "well prepared" outpatients and surgical pathways.
3. A focus on ensuring outstanding experience at Sheffield Children's through a co-productive and vibrant involvement and engagement approach with children, young people, families, and communities.

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

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

Actions:	Progress:
• Shape the Patient Safety Partner Model which empowers and champions the patient/family voice in contributing and being involved in 'their own care'.	We are in the process of liaising with partner organisations to develop a role description for patient safety partners with a view to recruiting to these roles in the coming months.
• Teaming up with Care Group colleagues engaged in the PSIRF implementation stakeholder task & finish group regarding improved internal processes for involving patient/families in the mandated engagement process.	The PSIRF stakeholder group continues into the embedding phase. Monthly meetings allow colleagues to feedback on their experiences to date with PSIRF and how we as Trust can work together to improve our processes.
• Take significant learning from Serious Incidents (SIs) / Patient Safety Incident Investigations (PSIIs) which reveal families have felt unheard and demonstrate the safety improvements we are making to strengthen the ability for them to be heard and to feel listened to. We should also use this opportunity to add how Sheffield Children's intend to strengthen the patient/family voice by growing the Patient Story model and expanding that to ensure it pollinates care groups.	As we consolidate our move to PSIRF, we are learning and developing our approach to the involvement of parents and families in our investigations. We meet early with families and co-develop our investigation terms of reference with them. When our investigations are complete, we share our learning with them, and some families also share their experiences directly with our colleagues to maximise impact and learning.
• Support the key principles of a patient safety culture, focusing on understanding how incidents happen, rather than focusing solely on human factors which naturally facilitates the	The implementation of PSIRF uses the Systems Engineering Initiative for Patient Safety (SEIPS). A 'work system' that consists of six broad elements: external environment, organisation, internal environment, tools and technology, tasks, and person(s). All Learning Response

perception of the apportioning of blame. • Ensure the NHS can focus on understanding how incidents occur, rather than apportioning blame on individuals involved, allowing for more effective learning and improvement, and ultimately enabling NHS care to be safer for patients.	Leads, care group governance leads and the patient safety team have undertaken or are undertaking HSIB training which focuses on the SEIPS model.
• Develop a Patient Safety Incident Response Plan (PSIRP) and Policy which will identify our Trust's unique patient safety incident profile and will enable the Trust to review existing safety improvement work to identify the Patient Safety Incidents/Events that will benefit most from Learning Responses and maximise the opportunities for improvement by way of other methodologies and tools.	The Trust has approved its PSIRP and policy which identifies our unique patient safety incident profile. Our plan will be revisited yearly to check we are still investigating the right things and that these investigations are having the right impact.
• Ensure organisational wide learning resources are developed to more effectively share and cross pollinate care groups/specialties. These new resources will be adopted and adapted during the implementation and establishment phase (2023/24) to ensure shared learning is evidencable and sustainable.	The Trust intranet patient safety page has been updated to include PSIRF and templates are available online for various methodologies. Learning Response Lead and care group governance lead workshops have been delivered by the Patient Safety and Education, Learning and Development Teams.
• Support development of a Patient Safety Incident Response System that prioritises compassionate engagement and involvement of those affected by Patient Safety Incidents regardless of gender identity, race, socioeconomics, background, or belief.	Early compassionate engagement with colleagues and families has commenced as part of PSIRF. The Patient Safety team are working closely with the child death team in early contact and sharing of reports with families. A SOP has been developed by the child death team in conjunction with feedback from families with a focus on key worker working closely with the LRL.

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

Actions:	Progress:
• Ensure no patients requiring physical healthcare are waiting over 65 weeks for their first treatment. We will do this by creating more capacity, changing our clinical pathways, and engaging with other health and social care partners.	The Trust continues to see reducing numbers of patients requiring physical healthcare waiting over 65 weeks. Delivery has been challenged by ongoing industrial action and a theatres business continuity incident in September 2023. The number of patients on theatres waiting lists have reduced during 2023/24. As of March 2024, remaining patients waiting over 65 weeks are largely in the plastics services awaiting specialist hand surgery due to maternity leave and sickness within this team.
• Actively keep our Child and Adolescent Mental Health Services waiting lists under constant review via several forums and groups and ensure that high risk patients receive a review within two weeks of referral. A recovery plan has been prepared by the service team and is monitored via existing monthly Operational Planning and Performance Meetings (OPPM) which feed Executive Director Led Performance and Quality Reviews (PQR). The purpose of this oversight is to help to identify blocks or challenges to established recovery plans and to ensure support can be offered swiftly if required, it also allows the Trust to respond quickly if waiting lists grow unexpectedly. Should waiting lists grow an urgent review of current plans would take place at the OPPM and PQR meetings and a revised plan formulated. At a service level oversight of waiting lists is via Patient Tracker List meetings, and the Duty Team review patients waiting if further information is received since the initial referral.	Community CAMHS waiting lists and trajectories are actively monitored in OPPM, Performance Quality Review (PQR) and performance committee meetings. Delays in recruitment within CAMHS teams have meant the trajectories are behind plan and an increase in more urgent patients is currently being reviewed by OPPM. A more detailed review of progress against plan is currently being undertaken via this group.
• Look to enhance our Mental Health offer in terms of crisis care, provision in education settings and on attendance to hospitals across the city.	A recent procurement for 111 crisis line coupled with safe space commissioning was unsuccessful due to none of the bids submitted meeting criteria. Rethink has been extended as provider for the crisis line for a further six months and a new provider is currently being explored. Work on 136 suite provision is being led by the South Yorkshire Mental Health, Learning Disability and Autism (MHLDA) group and the Trust is a key partner. No firm dates have been set for completion of this work.

• Seek to reduce our non-Consultant waiting times (these include Physiotherapy, Occupational Therapy, Speech and Language Therapy (SLT), Psychology and Neurodiverse pathways) and support patients whilst they wait for care.	Work has progressed with SLT and the team recently presented to Performance Committee. This is led via the joint SCFT/ICB SLT group reporting to the Children's Delivery Group. `Work has not progressed on plans for OT/PT waits but these will be prioritised in the new work programmes within the new care group structure. Within the new Plan OT/PT will be alongside other Allied Health Professional (AHP) specialties including Dietetics and SLT. Management structure for this new arrangement is just being determined.
• Ensure that risk of harm is considered when prioritising patients on waiting lists. This will be done through the harm review panel, chaired by the Medical Director.	Continuing to monitor the harm rating of patients awaiting treatment on our elective theatre lists via Surgical and Corporate Harm Panel, ensuring additional capacity is provided or prioritised where required.
• Ensure effective use of our existing capacity through ensuring families and clinicians are well prepared for their outpatient appointments and procedures.	Well Prepared Outpatients and Well Prepared Surgery Programmes continue to develop mechanisms to ensure families and clinicians are well prepared for their outpatient appointments and procedures.
• Communicate with patients whilst they wait and engage them in preparing for their treatment.	Continuing to contact patients on elective waiting lists providing waiting well advice and confirmation that treatment is still required. Text contact process development for new and follow-up outpatients currently being rolled out in Dermatology.
• Ensure that patients do not come to harm whilst waiting through ongoing reviews by the Trust's Waiting Well Group. When a referral is received, patients are made aware how long the current wait is, and where they can get support from, there is also a resource library page on the Trust's website available.	During the past year the Waiting Well programme has updated the Referral Receipt process following engagement with communities, making it more accessible to patients and families. We have also extended the Referral Receipt campaign to Speech and Language Therapy, to work towards achieving equity across Systmone and Careflow services. The digital solutions to support with text contact for patients on the RTT, follow-up and elective waiting lists have been built in eDMS and Patient Hub. RTT and follow-up text validation continues to be trialed with the Dermatology service. This should shortly allow us to extend this across services booked via Careflow to remain in contact with families whilst they are waiting and confirm whether an appointment is still required. The Community CAMHS and S< waiting times are now displayed on the external Trust website as the wait for specific services (i.e., instead of showing the wait for Community CAMHS as a collective). The waits for these services now display as the 90th centile wait

	(as opposed to an average), in order to provide patients and families with a more transparent and likely wait to their first appointment. Work is on-going to update the waiting times for remaining non-RTT specialties.
• Invest around £517k to address waits in service centres to cover mental health practitioners, nurse specialists and additional capacity provided by a private contractor, Healios. This is detailed in the recovery plan submitted by the Service.	Investment provided to community CAMHS service and impact monitored via Waiting List Programme Board. Healios capacity has supported reduction in total waiting list however recruitment to key posts remains challenging to support longest waiting complex patients.
• Ensure that as a Trust we are seeking to communicate and engage patients in ways that allow us to address inequalities and that involves patient and families in their care. This will include coproduction of information and clinical advice.	Recruited to Health Inequalities outpatients team during 2023/24 and ensured that we are supporting families when our AI tool suggests they may not attend. Ensuring that feedback from these discussions is shared with the outpatients operational team to support service planning and development.

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

Actions:	Progress:
• We will foster a learning environment and develop the skills to engage, listen and act on voice well throughout our organisation, working with partners. This will work both at a patient facing level, developing coaching and co-decision-making skills for colleagues working with families. We will also develop more strategic level skills, including formal consideration of how we better incorporate voice into our governance structures and develop greater cultural competence and co-production skill sets in our leaders.	We have formalised the incorporation of patient and family stories into Trust board meetings and the care experience and engagement group. Our Listening, Involvement and co-production training is offered three times a year and this year 30 people have participated. Through the development of the Quality Promise there is a stronger emphasis on listening at all levels. The work of the network groups has included cultural understanding and engagement strategies rolled out to colleagues through webinars, virtual education sessions and face to face meeting during specific weeks.
• We will strengthen our infrastructure and governance for overseeing our approach to capturing the child, young person, and family voice. We will test, trial, and develop exemplar models of practice, which will then be spread more widely across the organisation.	We have recruited to the patient experience lead role and have two colleagues in post with extensive experience in engagement and experience work. They are working with colleagues across the Trust to bring together all the current work undertaken and map where the gaps are to develop the models required to capture all voices.
• We will reach out to existing partner, voluntary, faith and community groups, to work in partnership to most effectively reach out to communities that experience health inequalities focussing on those seldom heard voices so that we are attentive to their needs and are able to improve services with a particular focus on communities that experience Health Inequalities.	Though our clinical strategy we have recognised a number of inclusion groups including the Roma and Somali communities. Building on previous Roma awareness work, we delivered specific clinical settings training led by someone from the Roma Community and are working on a video reminder project sent via text. We have also spoken to Somali Young People and Mums in Burngreave through Reach Up Youth to understand their health needs and will build on this to co-design a project in 24/25. Our workshops with both Israac and Fir Vale Community Hub have led to specific actions such as welcome signs in other languages, improving GP blood test process and our communication while waiting work. A video feeding back to the communities is about to be released. The new Patient Experience Lead(s) and the Health Inequalities Programme Manager have been involved in city-wide engagement conversations about inclusion health of those most marginalised.
• We will continue to develop our Youth Forum to represent the diverse range of communities we serve and establish new routes to have conversations around 'what	The youth forum has increased in size over the last year and has a more diverse and inclusive membership, representative of the community and services offered by the Trust. They have set their

matters' to children and young people.	own priorities for work over the year and been involved in a number of activities including, colleagues recruitment interviews, back to the floor reviews with executive team members, lobbying the local authority on safety issues (zebra crossing between the Trusts and public car park), wayfinding signage review, story sharing for disability history month and involvement with Art+ work.
• We will strengthen our links with schools to connect with a diverse range of children and young people and meet them in their own environment.	We visit Trust career events in partnership with the South Yorkshire Regional Education and Careers (SYREC) and other trusts. We also work with the student facilitator leads in the Trust and communicate to other colleagues who do ambassadorial work at these events. This has been undertaken by IT, Clinical, Nursing and AHPs, apprentices from admin areas etc. Where able either attendance or resources have been sent to the Super Saturday events. Young people from diverse areas i.e., Roma, Somalian years 9 upwards have had facilitated visits to the Trust. We have some senior medical colleagues who interact with diverse agencies i.e., Endeavor that works with refugees. We do not at present run active work experience but now looking at how we can think about the placement capacity.
• We will advocate for Children and Young People working collaboratively with partners for innovative models of care to have the greatest impact.	The Trust Quality promise launched early 2024 puts the child and young person's voice at the heart of everything we do. It was produced in conjunction with our CYP and their families ensuring it captured their ideas and feedback on how services and care should be delivered. As part of the Children's Hospital Alliance, we are using our collective voice to promote the needs of CYP locally, regionally, and nationally. Involvement in other networks such as the MHLDA provider collaborative allow us to raise the profile and needs of children often overlooked in society.

How Performance will be Monitored, Measured and Reported

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

Statements of Assurance from the Board

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

The Trust is commissioned to provide services by South Yorkshire Integrated Care Board and NHS England. Contract monitoring and quality monitoring meetings are held regularly with our commissioners.

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

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

National Clinical Audit and National Confidential Enquiry Assurance

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

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

National Clinical Audits and National Confidential Enquiries for which the Trust was Eligible to Participate	
Child Protection Service Delivery Standards Audit (CPSDSA)	National Comparative Audit of Blood Transfusion: Bedside Transfusion Audit
Epilepsy 12: National Audit of Seizures and Epilepsies for Children and Young People	National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Juvenile Idiopathic Arthritis
Improving Quality in Crohn's and Colitis (IQICC)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Transition from Child to Adult Health Services
LeDeR – Learning from Lives and Deaths of People with a Learning Disability and Autistic People	National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Testicular Torsion
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Confidential Enquiries	National Joint Registry
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Neurosurgical National Audit Programme
Mental Health Clinical Outcome Review Programme: Real Time Surveillance of Patient Suicide	National Paediatric Diabetes Audit
Mental Health Clinical Outcome Review Programme: Suicide (and Homicide) by People Under Mental Health Care	National Perinatal Mortality Review Tool
Mental Health Clinical Outcome Review Programme: Suicide (and Homicide) by People in Contact With Substance Misuse Services	Paediatric Intensive Care Audit Network (PICANet)

National Acute Kidney Injury Audit	Prescribing Observatory for Mental Health (POMH): Use of Melatonin
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	Royal College of Emergency Medicine Quality Improvement Programme: Infection Prevention and Control
National Bariatric Surgery Register	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
National Cardiac Arrest Audit	Trauma Audit & Research Network (TARN)
National Child Mortality Database	UK Cystic Fibrosis Registry
National Comparative Audit of Blood Transfusion: Audit of NICE Quality Standard QS138	UK Renal Registry Chronic Kidney Disease Audit
Data was not submitted for the following national audit projects in 2023-2024 due to operational/workforce challenges faced by the Trust:	
Epilepsy 12: National Audit of Seizures and Epilepsies for Children and Young People	
Prescribing Observatory for Mental Health (POMH): Use of Melatonin	
Royal College of Emergency Medicine Quality Improvement Programme: Infection Prevention and Control	

National Audit and Confidential Enquiry Reviews

The following reports were received and reviewed at the Clinical Audit and Effectiveness Committee during 2023-2024:

April:

- National Paediatric Diabetes Audit (NPDA).
- National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report.
- National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP): Clinical Outcomes Oct 2018 – March 2020 (Summary Report).
- Paediatric Intensive Care Audit Network: State of the National Report 2022.

August:

- Deaths of children and young people due to traumatic incidents (National Child Mortality Database (NCMD)).
- Epilepsy12 2023 combined organisational and clinical audits: Report for England and Wales Round 4, Cohort 4 (2020-2022).
- National Paediatric Diabetes Audit (NPDA): Report on hospital admissions of children and young people with diabetes, 2015-2020.

October:

- The Inbetweeners: A Review of the Barriers and Facilitators in the Process of the Transition of Children and Young people with Complex Chronic Health Conditions into Adult Health Services.

December:

- Child Death Review Data Release (National Child Mortality Database (NCMD).
- National Neonatal Audit Programme 2022.
- Learning from Lives and Deaths (LeDeR): People with a Learning Disability and Autistic People.

Local Audit and Service Evaluations

Trust wide colleagues are encouraged to set up and run local audits and evaluations with a view to evaluate, review and improve their own services. The motivation for these local projects is generated from the shared objective to ensure that the Trust is delivering outstanding care for our patients. The local audit and evaluation programme currently features 273 projects in which data collection is ongoing or the report is being written and 60 where actions are being implemented. A further 88 have had their actions fully implemented, while an additional 22 which have had their action plans abandoned. This is a reduction of 33% in abandoned action plans on 2022/2023.

Research and Innovation

The past year has been an exciting one for Research and Innovation (R&I) at the Trust. We welcomed Dr Meena Balasubramanian as our Director of Research with Professor Paul Dimitri taking on the role of Director Innovation and Child Health Technology. This year has seen the launch of a new cross-institutional research network for South Yorkshire (SCYPHeR). We have published our 5-year strategy for R&I at the Trust. We are forging ahead with the development of the National Centre for Child Health Technology and looking forward to supporting our first ‘first in human’ gene therapy trial of our Clinical Research Facility.

At the end of March 2024, over 900 patients and healthy volunteers had taken part in research at our Trust. Our clinical trials portfolio has grown rapidly in recent years. Currently we have over 290 active research projects running across a wide range of clinical specialties and covering the full spectrum of research from non-interventional studies through to highly complex first in human clinical trials.

We have a sizable and varied portfolio of complex clinical trials for a specialist trust of our size. Through strategic partnerships with industry and by demonstrating excellence in the delivery of trials at our Trust, we are now considered a key centre for industry sponsored clinical trials across a number of specialties. This is evidenced by the fact that we currently support commercial trials in Neurology, Gastroenterology, Metabolic bone, Rheumatology, Respiratory, Dermatology, Diabetes and Endocrinology, Oncology and Haematology, Ophthalmology, Allergy and Nutrition. We also support many non-commercially funded clinical trials, mostly in Oncology.

Throughout this year, we have increased our portfolio of investigator led early phase research and currently as a Trust, we sponsor three investigator led clinical trials of medicinal products in Endocrinology, Metabolic Bone and Surgery. We are also the lead site for a large scale NIHR funded spinal research trial. We have been building on the infrastructure and governance structures that are necessary to support trials of gene therapies and we are looking forward to opening a first in human gene therapy trial in the field of neurology in Spring 2024.

Serious Incidents

Providing care that is safe, kind and outstanding is our number one priority. However, this is not always the experience for every one of our patients and their families. When things don't go according to plan, it is vital that we understand why, and learn from this experience so we move one step closer to the safe care for all that is central to our Quality Promise.

During the first part of the financial year 2023-2024, the Trust reported serious incidents (SIs) under the Serious Incident Framework published by NHS England. After October 2023, in line with national guidance, we switched to the new PSIRF methodology, reporting Patient Safety Incident Investigations (PSIIs) instead.

Between April and October 2023, the Trust reported a total of nine SIs. Between October 2023 and March 2024, the trust reported four PSIIs.

All incidents are scrutinised as part of our Safety Wednesday process by a weekly Patient Safety Panel meeting, with those identified as potentially more serious, or with more potential for learning, being escalated for discussion at a weekly Patient Safety Incident (formerly SI) Triage Panel. The Panel has wider membership than the previous SI Triage Panel including input from clinical care groups to understand incidents better.

Under PSIRF, the panel decide on the method of investigation, this may be a patient safety incident investigation (PSII) if it meets the national or local priorities or an alternative response may be undertaken such as an after-action review (AAR) swarm, multi-disciplinary team (MDT) meeting or a rapid learning review (RLR).

The Trust launched the new national Patient Safety Incident Response Framework (PSIRF) on 2nd October 2023 and have increased the number of professionally trained colleagues with funded time to undertake Patient Safety Investigations or Learning Responses. The Trust is monitored monthly by the ICB on its PSIRF implementation plan and its mobilisation and transition from National Reporting and Learning System (NRLS) to Learn from Patient Safety Events (LfPSE). The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. The four key aims of the PSIRF are:

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

Eight Learning response leads (LRL) have been recruited into the role of lead investigator for 12 months in addition to their existing clinical roles. They have all undertaken or are in the process of completing mandatory training in investigations to support them.

The Trust Patient Safety Incident Response Plan (PSIRP) is based on a thorough analysis of themes and trends from all incidents from 2021-2023 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Since the launch of PSIRF the Trust has undertaken four PSIIs, these are currently in the investigation phase and have been allocated an LRL. The PSIIs will continue to follow the same internal processes for sign off and assurance as a SI. We continue to share reports with the ICB, in the same way as under the SI framework.

Learning from PSII reports are shared with the families of the young person involved, and within the Care Group and Safety, Quality, Risk and Learning (SQRL)Ccommittee, which launched in September 2023. Learning is also shared widely across the organisation via executively sponsored monthly learning bulletins and learning workshop Q&A sessions as well as ward round patient safety huddles. The Executive Team

and Board are updated when there is any urgent learning that requires the immediate implementation of urgent actions.

Duty of Candour

The statutory duty is defined in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The introduction of Regulation 20 is in direct response to a recommendation in the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust (*Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, 2013*), which recommended that a statutory Duty of Candour be introduced for health and care providers, to ensure a more honest and open culture in the NHS. From October 2014 there was a statutory requirement for trusts to implement the Duty of Candour requirements.

The aim of the Duty of Candour is to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. It is a legal requirement for NHS Trusts to say sorry; it provides a clear structure for how to do this, both in person and in writing.

An audit of compliance with the Duty of Candour was undertaken in June 2023. As a result of this we have taken the following action:

- Strengthened our processes to identify incidents that meet the statutory Duty of Candour requirements.
- Undertaken various initiatives to raise awareness of the statutory Duty of Candour.
- Planned yearly audits.
- Updated our incident reporting system to capture statutory Duty of Candour requirements and compliance more effectively.
- Updated our Being Open and Duty of Candour Policy to ensure it reflects the latest guidance, is clear and states how we will support colleagues to feel safe and supported to act in accordance with this.
- Increased the availability of training.

Oversight of compliance with the statutory Duty of Candour is reported through to the Safety, Quality, Risk & Learning Committee and subsequently Quality Committee.

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

A proportion of the Trust's income is conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for quality and innovation payment framework (CQUIN).

Details of ICB and NHS England CQUINs are given below.

Page 35

CQUIN Reference/Title	Description of CQUIN	Target	Q1	Q2	Q3	Q4	Quarterly narrative
CQUIN01: Flu vaccinations for frontline healthcare workers	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	80%	N/A	N/A	62%		Data has been reported via the ImmForm portal. The active Vaccination Programme is complete though information regarding opt outs and vaccines given is still being collated weekly. The target has not been met however, there is a lot of evidence of work towards this and the ICB contract states "*The Commissioner agrees that, provided all reasonable endeavours to deliver the agreed CQUIN are used, not to recover any funding associated with under performance of CQUIN* " So there should be no financial penelties for this.
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message	1.5%	N/A	N/A	N/A		The EPMA system is being rolled out and DMS will be added when the system is embedded.
CQUIN15b: Routine outcome monitoring in CYP and community perinatal mental health services	Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	50%	9.70%	9.70%	9%		Performance is taken from MHSDS which isn't submitted until mid month following quarter end and the published figures following that. Q2 figure has now been updated to show the published figure. Internally the predicted position for Q3 is 9% (noting that this may not be a true picture as the outcome measures are often not added onto SystmOne until later in the month which is why MHSDS data is submitted min-month). We will report internally on a quarterly basis for monitoring purposes, however, the national CQUIN only needs to be submitted in Quarter 4 to avoid double counting. An action plan is in development to address this wor as the target has not been met and the ICB contract states *"The Commissioner agrees that, provided all reasonable endeavours to deliver the agreed CQUIN are used, not to recover any funding associated with under performance of CQUIN"* So there should be no financial penelties for this.

CQUIN Reference/Title	Description	Target	Q1	Q2	Q3	Q4	Quarterly narrative
CQUIN 11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	CQUIN achievement contingent on improvement to mean score between baseline data collection (in Q2) and subsequent data collection (in Q4), OR on maintenance of a score of 75% or above across the two collections.	75%	N/A	97.2%	N/A		It has been agreed that the CQUIN will be rolled out within the Spinal Surgery specialty. A child friendly version of the questionnaire has been approved for use. Although national reporting on the data is only due in Q2 and Q4, a narrative update for Q3 is due for submission to NHSE directly. Update embedded below.
CQUIN 16: Reducing the need for restrictive practice in CYPMH inpatient settings	This indicator asks that there is reflection on whether a blanket restriction was a precursor to the use of force every time a restrictive incident is recorded. Providers are asked to submit a quarterly report to their commissioner or Lead Provider as appropriate, detailing the number of records which meet the requirement	90%	N/A	86.9%	99.3%		To meet the requirements of this CQUIN an additional question has been built into the system which asks 'was a blanket restriction a precursor to this restraint?'. This requires both the incident reporter and post-incident reviewer to reflect on whether a blanket restriction contributed to this restraint.

The current proposal for 2024/25 is to not have CQUINs on a voluntary basis by Trust, with no financial consequences for non-achievement. Given the historic lack of paediatric focussed schemes, it is unlikely anything will be agreed locally for 2024/25.

Despite changing our approach to vaccine delivery we were able to only achieve 62% of colleagues vaccinated for flu as part of the autumn / winter vaccination programme. Ward managers and clinical educators were trained to vaccinate colleagues and early morning and late evening sessions were introduced to enable colleagues to be vaccinated before or after their shift. A comprehensive communications plan and an incentive scheme were incorporated into the approach which delivered weekly messages on the importance of being vaccinated. A working group for vaccinations met weekly throughout the programme to maintain a consistent approach and increase vaccine figures. Weekly trajectory figures were plotted and reviewed weekly to ensure we were on track to achieve 80%. Vaccination uptake was above target in the first month but steadily declined after this. Weekly vaccine figures were uploaded to the ImmForm portal. We have reflected on the vaccination programme for autumn/winter 2023/24 and will amend our approach based on this for the 2024/25 vaccination programme.

Registration with the Care Quality Commission

Sheffield Children's NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. The Care Quality Commission has not taken any enforcement action against the Trust during 2023/2024.

The Trust did not receive any unannounced risk-based inspections in 2023/2024.

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

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

Information on the Quality of Data

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

Sheffield Children's NHS Foundation Trust submitted records during 2023/24* to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data. The percentage of records in the published data which included:

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

**as at November 2023*

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

The Trust is committed to ensuring that it manages all the information it holds and processes in an efficient, effective and secure manner. This is achieved through the application of robust information governance policies and procedures, in accordance with legislation, and is supported by a range of training and awareness activities.

The Trust's most recent published assessment for Data Security and Protection Toolkit confirms all 'Standards Met'. The completed assessment for the period 1 July 2023 to 30 June 2024 is not due for submission until end June 2024.

Patient Experience and Involvement

We receive feedback from children, young people, families, and carers through a variety of different routes including:

- An active Youth Forum which meets regularly to discuss ideas for improvements and suggest developments.
- National surveys (the Children and Young People's Patient Experience Survey and the Under 16's Cancer Patient Experience Survey.
- The Friends and Family Test.
- Feedback given to our Patient Advice and Liaison Service (PALS). PALS support in a variety of ways, informally through liaison with departments and the family, support at appointments and consultations, signposting to services outside of the Trust and much more.
- Concerns raised through our complaints process.
- Feedback from partner organisations including Healthwatch.
- Patient experience audits and service evaluations.
- Patient stories to Board.
- Involving patients and families in service improvement projects.
- Online feedback on platforms such as Care Opinion and NHS UK.
- Engagement activities with community groups.

We are grateful to the people that share their experiences with us. We are particularly thankful to those who share their feedback after they have been through a difficult experience, as we know how hard this can be.

Our Care Experience and Engagement Group (CEEG) meets regularly to share what we are hearing about people's experiences of our services and what action we are taking in response. The Trust has embedded governance leads into each care group, and the attendance of these governance leads at CEEG has increased the focus on sharing feedback and learning across care groups. This helps us to ensure that people's experiences are heard across the Trust and that those experiences influence future developments. Patient experience is a standing agenda item on quality meetings in all care groups. Patient experience data is reported to the Trust's People and Engagement Committee, and complaints data is reviewed monthly through the Patient Safety Panel and the individual care groups quality and performance reviews.

In January 2024 we appointed to a new Patient Experience Lead role. The purpose of this new role is to strengthen and coordinate patient experience and engagement activity, enabling shared learning and ensuring that patient voice is heard and influences service development. Work is underway to scope experience and engagement activities across the Trust, mapping what works well, where there are gaps and how to involve a wider cross section of the Trust. A work plan is being developed which will set out how we will meet the commitments we have made in our Quality Promise to 'listen and involve'.

The Trust has an active play service but currently this does not operate across all departments. A service review by the Starlight Foundation has been undertaken and this will inform the service review taking place in the coming months. Where play is used for distraction and reasonable adjustment requests, the patient outcomes are very positive (LDA strategy patient stories).

We recognise that health inequalities play a major part in influencing how people engage with our services and the Trust is actively seeking opportunities to listen to marginalised communities to better understand people's experiences and needs. A general listening approach has been used, enabling people to tell us about the issues that are important to them, rather than us asking for their views on particular topics. To help with this, we commissioned Co-Create to provide training for staff on appropriate engagement strategies.

Complaints

The Trust received 196 formal complaints in 2023-24, compared with 204 in the previous year. The top themes were clinical treatment, waiting times, communication, access to treatment or drugs, patient care. Of the complaints that were due to be responded to during 2023-24, 63% were responded to within the target timeframe agreed with the complainant, compared to 66% in the previous year. This slight drop in response times was due to a temporary drop in capacity in the complaints team.

Quality improvement

Quality Improvement principles and tools are embedded into a range of improvement methodologies at the Trust. Methods include Microsystem improvement groups, Coach-as-you-go, Rapid Improvement Events, Project Management and Analytical Deep Dives.

At anyone time the service improvement team has been supporting 50 projects ranging from the large Trust-Wide Programmes (Waiting List (Well Prepared Out-patients and Well-Prepared Surgery), Care Where Needed, Health Inequalities, Healthy Lives and Green), Enabling Programmes (Estates, Research and Innovation and People), Care Group and Corporate projects.

Our Quality Improvement methodology and approach is being promoted so that all colleagues have an awareness and can access support. We have a well-established QI Community of over 100 colleagues using Microsoft Teams to share their improvement ideas, tips and tools, QI training and recently launched a Quality Improvement Live Hour. The Service Improvement team run these informal sessions to give colleagues and teams all the tools they need to make improvements to the way they do things.

Improvements to the Quality of Data

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

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

Learning from deaths

During 2023/24 41 of Sheffield Children's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Quarter 1	12
Quarter 2	8
Quarter 3	10
Quarter 4	11

By the 31st March 2024, 18 joint agency response investigations, 28 hospital case reviews and three patient safety incident investigations have been carried out in relation to the deaths. All deaths are subject to a full case review as part of Child Death Overview Panel procedures. The table below confirms the grading of care for all of the deaths which have been reviewed.

Many reviews reveal elements of learning to improve care, even if the cause of death is not directly attributable to our care.

All deaths are reviewed to see whether there were any modifiable factors. Modifiable factors are factors which if modified would alter the outcome of death. Modifiable factors may be factors in the care delivered or other factors not related to care delivered. No deaths had modifiable factors related to care delivered.

During 2023/24 the reviews were graded using NCEPOD grading as follows:

	TOTAL
Grade 1 Good Practice. A Standard that you would accept from yourself, your trainees and your institution	24
Grade 2 Room for improvement. Aspects of clinical care that could have been better.	1
Grade 3 Room for improvement. Aspects of organisational care that could have been better.	2
Grade 4 Room for improvement. Aspects of organisational and clinical care that could have been better	1
TOTAL	28

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

- Recognition of increased rate of Sudden Infant Death Syndrome (SIDS) in the city in babies and toddlers with safe sleep risk factors. Issue were highlighted to the citywide safe sleep group.
- Need to establish cross trust pathways with Sheffield Teaching Hospitals (STH) for joint agency response and child death review when a child 16-18 years dies at STH. Meetings held with STH, key stake holders informed of process and SOPs in progress.
- Need to ensure samples are sent to the labs in the correct bottles for specialist tests. Joint work between clinical team and labs in progress.
- Recognised that families who are staying in hospital accommodation whilst their child is in the mortuary may need additional support. Need to formalise an additional support system for bereaved families staying in the hospital while their child is in the mortuary. Support options explored by the family care sister with update to departmental process.
- Recognised that the Trust needs a formal bereavement pathway to ensure support is equitable and accessible. Development of a local bereavement care pathway. This is an ongoing area of work and one of this year's Quality Priorities. Funding for additional keyworker and co-ordinator posts agreed with job descriptions currently being written. SOPs completed and due for publication. Bereavement support for families is now available through Bluebell Wood Children's Hospice, funded by SCHFT.
- Education for key staff groups on concentrating infusions on PCCU and maximising parental nutrition undertaken. Information will now be included in pharmacy induction packs, nurse study day and pharmacy competency package for junior doctors.
- Reminders to key colleagues about use of the existing guidelines for temperature control and out of hospital arrest guideline undertaken.
- Guideline for limited hospital postmortem examination for some children when a coroner's PM is not required in development.

Reporting against Core Indicators

Patients readmitted to a hospital within 30 days of being discharged. (i) 0 to 15				
	trust	*National*		
financial year	%	*Average*	*Maximum*	*Minimum*
2022/23	9.5	*11.8*	*19*	*3.7*
2021/22	9.9	*11.7*	*18.4*	*3.4*
2020/21	9.9	*11.4*	*19.7*	*6.2*
2019/20	9.7	*11.8*	*56.7*	*2.4*

Patients readmitted to a hospital within 30 days of being discharged. (ii) 16 or over				
	trust	*National*		
financial year	%	*Average*	*Maximum*	*Minimum*
2022/23	11.3	*11.4*	*21.7*	*3*
2021/22	13.9	*11.8*	*18.7*	*2.1*
2020/21	12.6	*12.6*	*30.6*	*1*
2019/20	16.8	*12*	*24.5*	*4.1*

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

* Please note further consideration is being given to the data used in this table given the last data is from 2021/22.

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

Data for C-difficile infection indicator is taken from the UKHSA Fingertips database. Data for 2022/2023 and 2023/24 is not available for this reporting indicator.

The Trust has a very stringent approach to testing all symptomatic children aged two years old and over for *C-difficile* toxin production. Comparison of the infective strains of *C. difficile* in this group of patient did not highlight any concerns for cross-infection. No specific IPC concerns have been identified so far.

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

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

Patient safety incidents					
Patient safety incidents	*2019/20*	*2021/21*	*2021/22*	*2022/23*	*2023/24*
Total number of patient safety incidents	4,404	4,725	5,743	5,607	6,280
Total number of patient safety incidents leading to severe harm or death	4	4	3	14	10
Percentage of patient safety incidents leading to severe harm or death	0.09	0.08	0.05	0.25	0.16
Rate of patient safety incidents per 1,000 bed days	107.39	118.64	178.48	109.28	152.05
Bed days	41,011	39,826	32,177	51,307	41,301

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

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

The Trust has a very low number of incidents that have resulted in severe harm or death. All incidents are reviewed weekly as part of Safety Wednesday, with both Patient Safety Panel and PSI Triage Panel chaired either by the Chief Nurse or Executive Medical Director.

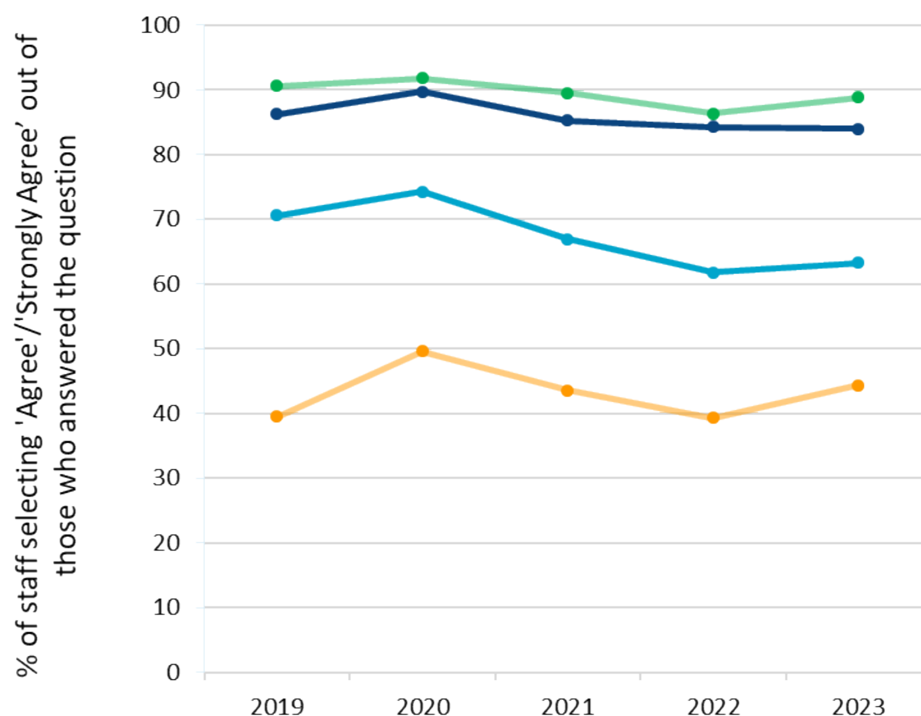
The Trust intends to take the following actions to improve this percentage, and so the quality of its services:

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

National NHS Patient Safety Strategy

In line with the National NHS Patient Safety Strategy the Trust has a Patient Safety Specialist who attends NHS England led National Patient Safety Meetings to ensure learning from other organisations is identified and implemented as required. The Patient Safety Specialist has delivered the Patient Safety Incident Response Plan and PSIRF Policy, with both published and approved by Board in 2023/2024. The Trust is rolling out the NHS Patient Safety Syllabus training programme.

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



	2019	2020	2021	2022	2023
Your org	86.29%	89.76%	85.27%	84.26%	84.02%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	1957	1446	1555	1587	1745

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

Sheffield Children's NHS Foundation Trust staff survey report is available on the NHS staff survey website. The data is selected from this official source. The results show a decrease from 84.26% to 84.02% however, the Trust is well above the NHS average for its comparator group of 63.32%.

We have also seen a positive trend in the following areas of the staff survey:

- I feel that my role makes a difference to patients / service users.
- Care of patients / service users is my organisation's top priority.
- My organisation acts on concerns raised by patients / service users.
- My organisation encourages us to report errors, near misses or incidents.

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

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

Consulted Agencies or Groups

Sheffield Integrated Care Board

The draft report was provided to NHS Sheffield on XXXXX. The following response was received on XXXX.

Sheffield Healthwatch

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

Sheffield City Council Healthier Communities Scrutiny Committee

The first draft report was provided to Sheffield City Council Healthier Communities Scrutiny Committee and considered at their meeting on XXXXX. The following response was received on XXXX

Council of Governors, Sheffield Children’s NHS Foundation Trust

The following is a minute extract from the meeting of the Trust’s Council of Governors held on 14 May 2024:

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

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

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

- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to March 2024.
    - papers relating to quality reported to the board over the period April 2023 to March 2024.
    - feedback from commissioners dated XXXXX.
    - feedback from governors dated 14 May 2024.
    - feedback from local Health watch organisations on XXXXX
    - feedback from Overview and Scrutiny Committee on XXXX.
    - latest national staff survey dated March 2024.
- The Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations).

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

By order of the board.

Ruth Brown, Chief Executive
Professor Laura Serrant, OBE, Chair

Date: XXXXXX

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