NHS
The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Quality Accounts 2021/22

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Part One: Statement on Quality from the Interim Chief Executive

The Rotherham NHS Foundation Trust's Quality Report provides details of the Trust's quality performance and improvement journey during 2021-22. We are proud of a number of significant achievements during the year but we also acknowledge that there are areas where further improvements are required to ensure the highest quality care and experience is available for our service users and the wider community.

Following triangulation of information from a broad range of sources, including from independent surveys and inspections, we have selected nine quality priorities for 2022-23, which we believe reflect the areas where greatest positive impact can be achieved for the patients in our care and their families. As part of our reporting process, we have also taken the opportunity to review our quality priorities for 2021-22 and will use the coming year to continue to build on the progress already made in these areas.

2021-22 continued to be dominated by Covid-19, which has had a massive impact on our services, colleagues, patients and the community we serve. The Trust was identified as the 13th most severely affected by Covid-19 in the country and yet despite this, we adapted and were able to make progress on our recovery plans whilst maintaining a focus on the quality and safety of care that our patients experience.

I would like to take the opportunity to highlight some of the many quality achievements this year that have contributed towards our improvement journey.

- New systems, processes and treatments in response to the pandemic were established rapidly, providing positive clinical outcomes across a range of services including vaccinations for 12-15 year old children, Covid Medicine Delivery Service for Clinically Extremely Vulnerable patients, Covid Oximetry Service within the Community and establishment of a Long Covid Clinic.
- Treatment for cancer has been an important focus for the Trust during the last year with a reduction seen in the backlog of patients waiting over 62 days, although further improvement is required. The Trust was identified nationally as one of the top performers in responding to the increased number of cancer referrals this year and has additional pathway improvement work commencing.
- Our elective recovery was seen to be performing as one of the top ten Trusts in the country with a continued reduction in patients waiting more than 52 weeks for treatment at the end of the year and no patients waiting more 78 weeks.
- Following a Care Quality Commission inspection in May/June 2021, the 29a Warning Notice previously issued to the Acute Medical Unit was closed in recognition of the broad range of improvement measures that had been embedded in this area. The Trust also submitted evidence to support the removal of the Section 31 condition applied to the Paediatric Emergency Care Centre in October 2018, and this was removed in May 2022.
- The Trust has seen sustained improvements to the Learning from Deaths programme and a reduction in mortality levels that are now within the statistically expected range. This work will continue to develop over the next year.
- A comprehensive improvement plan for Safeguarding was completed in 2021 that strengthened policies, processes and wide clinical engagement. Additional improvements will continue to be made to ensure we are protecting our most vulnerable service users.
- The Trust embarked on the early stages of our Quality Improvement journey with the appointment of two Quality Matrons and embedding of the widely utilised Tendable

clinical audit application. This has supported improvement work around areas including falls reduction, pressure ulcer prevention and medication safety.
- Engagement and Inclusion activities have seen a significant increase during the last year with the establishment of a People Panel being particularly positive. We will build on this during the coming year with increasing involvement from service users to help shape our plans and developments.
- A successful recruitment and retention campaign, particularly within Nursing, Midwifery and Allied Health Professionals, has supported the delivery of high quality patient care.
- The annual staff survey showed both an increased participation rate and a positive response rate placing us as one of the higher scoring Trusts within Yorkshire and Humber. Whilst this is encouraging, we hope to consolidate this with even better results in 2022-23.

Alongside these accomplishments, there are still areas where we recognise the opportunity for further improvement in the coming year and we will maintain our focus in these areas.

- Care Quality Commission inspections in the Urgent and Emergency Care Centre in May/June 2021 and again in March 2022 identified areas where further improvement is required. A comprehensive improvement strategy (Acute Care Transformation) was commenced to improve both performance and quality. It is expected that this will deliver positive outcomes during the forthcoming year.
- Patient experience surveys in Inpatient areas, Urgent and Emergency Care and Children and Young People's Services identified areas where improvement is required and a significant number of actions have already commenced to address areas of concern. Subsequently we have launched initiatives around reducing noise at night, nutrition and hydration and improved information resources for patients and carers. Conversely, the Maternity Care survey provided very positive results and learning from this is being applied to other areas to share good practice.

As Interim Chief Executive of The Rotherham NHS Foundation Trust, I am proud of the achievements we have made during 2021-22. Following the launch of our new five year strategy, titled 'Our new journey, together' in December 2021 and with the commencement of an exciting new Quality Improvement approach to ensure we are a learning organisation, I look forward to us achieving even greater success in 2022-23 for our service users and staff.

I am pleased to confirm that the information in this report has been reviewed by the Board of Directors who confirm that it provides an accurate and fair reflection on our performance during the reporting period and demonstrates our commitment to patient safety, patient experience and quality improvement.

R. Jenkins

Dr Richard Jenkins
Interim Chief Executive
June 2022

Part Two: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement during 2022/23

Our vision is to be an outstanding Trust, delivering excellent care at home, in our community and in hospital. To achieve this, every colleague and every team is expected to be involved in quality improvement seeing it as part of everyday business.

To embed this culture of quality improvement, the Trust creates conditions through its quality governance structures and processes to listen to and learn from the views of patients, their families, carers and colleagues. Above all, this means being open and honest even when something goes wrong.

The Trust ensures that it keeps up to date with any changes to Quality Account requirements (Chapter 2 of the Health Act 2009) through notifications from NHS Improvement (NHSI) and other sources. These are reviewed by those leading on developing the report where required, and the implementation of the actions are monitored by the Clinical Governance Committee and Quality Committee.

For 2022/23, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process, including communication with colleagues and governors, who were given the opportunity to comment on the draft proposals and shape how these priorities were delivered, along with using the findings from the recent Care Quality Commission (CQC) inspection, incidents, complaints and risks.

Delivering continuous improvement is the responsibility of all colleagues. Clinical Trust services are delivered through Clinical Divisions, each ultimately accountable to the Board of Directors for its contribution to the performance of the Trust as a whole. Each Division is led by a Divisional Director (a Senior Clinician), with support from a General Manager, a Head of Nursing, and Finance and Human Resources Business Partners. They are responsible for maintaining the clinical governance structures that keep an overview of patient safety, patient experience, clinical effectiveness and quality of services in every clinical area and department.

Delivering Quality Improvement is a continuous process. Each year provides an opportunity to reflect on success and continuing challenges but the Trust understands that achieving and sustaining improvement requires a long-term commitment. This year's priorities therefore reflect a mix of previous areas of focus where further quality improvements are needed and additional areas identified where improvements are required.

The quality priorities for 2022/23 are:

<u>Patient Safety</u>

- Improve medication management throughout the organisation
- Ensuring digitally requested investigations are reviewed and responded to appropriately
- Reduction in Hospital Acquired Infections

Patient Experience

- To develop and embed the Mental Health Strategy
- Develop a robust process to measure and improve following patient/user feedback
- Develop comprehensive and accessible patient information materials

Clinical Effectiveness

- Identify and develop a quality improvement tool for the organisation
- Clear digital identification of clinically unwell patients to drive quality improvements
- Continuation of mortality and learning from deaths improvement work

Domain: Patient Safety

Title* – *Improve medication management throughout the organisation

Executive Lead – Executive Medical Director
Operational Lead – Chief Pharmacist

Current position and why is it important?

Medicines are the most common intervention we make in treating, preventing and diagnosing ill health of our patients. High standards are set to ensure safe, effective use of medicines and the organisation needs responsive systems that meet regulatory and legal requirements. The consequences of failing to deliver an effective system are significant and include: exposure of patients to unnecessary risk and harm; failure of patients to get the benefits from the medicines they are prescribed; whole system inefficiency; unnecessary expenditure and other avoidable costs; poor patient experience; and loss of reputation.

Therefore, this work will focus on three main areas:

- Ensuring medicines are handled safely and securely
- Ensuring controlled drugs are used and managed in line with legal and professional standards
- Ensuring treatment with medicines, particularly critical medicines, occurs in a timely manner.

The aim and objective(s) (including the measures/metrics)

Aim:

- Improved medication safety throughout the organisation.
- Medication Safety Committee established, terms of reference and workplan determined, meetings well attended and senior representatives from each division help ensure everyone with medicines responsibilities delivers on their part
- Address issues raised by the CQC (and other external bodies)
- Staff educated, supported and trained to high standards of medicines usage
- Embedding of good practice

Objectives:

- Ensure medicines are stored safely and securely
- Improve completion of controlled drugs registers (and other associated documentation)
- Reduce missed doses of medicines, particularly critical medicines
- Reduce levels of harm from medication incidents
- Ensure regulatory standards are met

The planned activity to achieve this

- Establish Medication Safety Committee with appropriate representation to ensure medication is considered amongst the highest priorities for the organisation
- Deliver on Must Do and Should Do actions in the Medicines Improvement Plan
- Review, update and implement a training programme for medicines in the organisation
- Review and revisit initiatives taken during the year to repeat what worked well

How will progress be monitored and reported?

- Audits show medicines are stored correctly and securely
- Audits show controlled drugs are documented correctly
- EPMA data shows reduction in missed doses
- Incident data shows reduction in harm from medication incidents

Title – Ensuring digitally requested investigations are reviewed and responded to appropriately

Executive Lead – Executive Medical Director
Operational Lead – Deputy Medical Director for Quality

Current position and why is it important?

Patient investigations are requested electronically and the results should all be reviewed within Meditech as well. The Trust has received three prevention of future deaths reports and all of these demonstrate concerns with regards our ability to review results displayed in different electronic systems.

This work is aimed at ensuring that the Trust has processes in place for clinicians to review and action all patient results. This will improve the quality of patient care by ensuring that all investigations requested are reviewed and actioned where needed. This will prevent 'missed results' where investigations are ordered and completed but then not reviewed or actioned.

The aim and objective(s) (including the measures/metrics)

Aim:

- Ensure that all patient investigations are requested electronically
- Ensure robust processes are in place to review patient reports

- Improve the quality of patient care by ensuring that all investigations are reviewed and acted upon
- Prevent ‘missed results’

Objectives:

- To ensure that all requests are completed electronically via Meditech
- To ensure that all clinicians are trained in the use of the results acknowledgment modules of Meditech
- To ensure that clinicians use the ‘Physician care module’ on Meditech to review and action all patient results
- Where results cannot be reviewed on Meditech, ICE is used instead

The planned activity to achieve this

- The Deputy Medical Director Quality chairs the Trust Results Flagging and Acknowledgement Task and Finish Group – already established.
- The Trust Diagnostic testing policy to be reviewed and updated. The Standard Operating Procedure (SOP) for critically abnormal results has already been completed.
- The Power BI Results acknowledgment module to be reviewed and used to drive improvements
- Audits to be carried out for non–compliant areas

How will progress be monitored and reported?

- Improvements noted on Power BI with regards to acknowledgment of patient reports
- Measure the percentage compliance on Power BI – aim for 95% for all specialties

Title* - *Reduction in Hospital Acquired Infections

Executive Lead – Chief Nurse
Operational Lead – Lead Nurse/Assistant Director of Infection Prevention and Control

Current position and why is it important?

Health Care Associated Infections (HCAI) can have a severe impact on patient morbidity and mortality. Infections are classed as hospital acquired when they occur after admission and within defined timescales. The following infections are nationally mandated to be reported as hospital acquired if they occur two days or more after admission and the Trust has a maximum trajectory based on previous data that if breached may result in financial penalty if there are lapses in the quality of care identified during case review by the Rotherham Clinical Commissioning Group (RCCG):

MRSA bacteraemia, E.Coli bacteraemia, Pseudomonas aeruginosa bacteraemia, Klebsiella species bacteraemia, Clostridium difficile.

The following infections are not externally reportable however they are also being monitored internally:

- Glycopeptide Resistant Enteroccus (GRE) if causing infection (not colonisation) that occurs two days or more after admission.
- Carbapenamase Producing Enterobacteriaceae (CPE) if causing infection (not colonisation) two or more days after admission

The aim and objective(s) (including the measures/metrics)

Aim:

- Reduction in avoidable hospital acquired infections

Objectives:

- To have a reduction in preventable hospital acquired infections.
- To demonstrate compliance with the Infection Control Board Assurance Framework (against all domains that are within our control)
- To have a timely response to any changes in national IPC guidance where appropriate for the organization (and with rationale provided where deviation is required)
- To see an improvement in compliance with hand hygiene and Infection Control mandatory training

The planned activity to achieve this

- Review each case within 4 weeks of the infection being reported.
- Monitor monthly progress against the trajectory set for the Nationally reportable infections.
- Quarterly review of performance against Infection Control Board Assurance Framework
- Monitoring of mandatory training compliance with escalation to divisional leads as required if trajectories are not being met

How will progress be monitored and reported?

- Monthly reporting against all local and national hospital acquired infection trajectories
- Reduction in avoidable hospital acquired infections
- Improved compliance with mandatory training compared to baseline 2021/22 position

Domain: Clinical Effectiveness

Title* – *To develop and embed the Mental Health Strategy

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Mental Health care and provision in acute Trusts continues to be a challenge for the NHS. Physical and mental health care have traditionally been delivered separately. The CQC stated that: 'While investment and improvements in mental health services are welcome, physical and mental health services will only truly be equal when we stop viewing physical and mental health as distinct. Services need to be built around all of people's needs and

not determined by professional or interest groups. There is increasing recognition of the importance of integrating services across health and social care'.

Therefore, the Trust will aim to provide a mental health strategy that is reflective of the Rotherham Place, and provide strategic aims in terms of how we should deliver care to our patients.

The aim and objective(s) (including the measures/metrics)

Aim:

- The Trust will be clear on key areas of focus for mental health care provision
- There will be a clear measure of improvements against key metrics
- Improved health outcomes for patients
- Improved patient experience

Objectives:

- Provide data and analysis of current mental health requirements
- Review the PLACE data in terms of key challenges
- Identify key area of focus to improve care delivery
- To work in collaboration with RDASH

The planned activity to achieve this

- Scope of mental health prevalence and key areas of focus
- Engage key stakeholders to agree on strategic aims and objectives
- Develop mental health strategy
- Implement and embed strategy

How will progress be monitored and reported?

- Mental Health Strategy that reflects PLACE data
- Key metrics developed to deliver against that works in collaboration with RDASH
- The mental steering group will provide a forum to monitor and agree the strategic aims
- The safeguarding strategic group will monitor progress and ensure the strategy is agreed and escalated to Quality Committee and Trust Board

Title – Develop a robust process to measure and improve following patient/user feedback

Executive Lead – Chief Nurse
Operational Lead - Deputy Chief Nurse

Current position and why is it important?
Patients give us feedback through a variety of ways. These include the annual CQC surveys performed through Picker, the Friends and Family Test and complaints, concerns and compliments through the Patient Experience Team.

This work will focus on finding a way to bring together all the themes and trends from the existing data reported each month, as well as taking a more proactive approach with the current patients receiving care. The Tendable app will be refreshed with the CQC's patient experience questions to have more usable feedback each month and opportunity to feedback to Divisions whilst patients are still with us.

The aim and objective(s) (including the measures/metrics)

Aim:

- The Trust will be fully cited on patient feedback, themes and trends in advance of annual CQC surveys
- Quality improvement work will be based upon patient feedback and thematic analysis
- Patient experience whilst in hospital will improve

Objectives:

- Develop a monthly patient experience survey, updated to the latest CQC questions using the Tendable app for Inpatients, Children and Young People, Maternity and UECC
- Work with Governor volunteers to undertake monthly patient experience surveys to provide objectivity. Build relationships with ward managers to resolve issues as they are identified
- Rotherham CCG to confirm support in completing Tendable patient experience surveys each month
- Build a page per ward or clinical area on the Trust website to display the Tendable results
- Receive training and implement statistical process control (SPC)
- Thematically analyse themes and trends to help focus on patient experience improvement work

The planned activity to achieve this

- Review Tendable questions in line with CQC survey's and seek the support of governors to undertake the regular surveys for inpatients. Increase the number of patients being surveyed each month to 75% on survey day
- Organise SPC training and use this for measuring patient experience data. Design the division template for providing division activity. Re-design the quarterly patient experience report
- Reports delivered by Divisions into PEG and collated for the Quality Committee will include thematic analysis of all patient experience feedback and link directly to quality improvement plan
- Explore the possibility of building a new patient experience page on the Trust website, by ward or department area to publish Tendable results

How will progress be monitored and reported?

- Increased sample size using revised questions on the Tendable app to 75% of inpatients on the day of the survey on 6 nominated wards by the end of Q2 and then aim to improve by 10% from a new baseline score set in September 2022 and based on accurate data
- All inpatients to be achieving 75% of eligible patients surveyed each month on survey day by end of Q3

- By Q4, measurement of ‘overall experience in hospital’ improves by 10% based upon a score of 7:10 or greater from 1 October 2022

Title – Develop comprehensive and accessible patient information materials

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Through monitoring patient feedback, communication and information about health conditions is a recurring theme. To support this, a new bedside information folder will be developed, which will include everything a patient and their carer/family members need to know about an inpatient stay. This will be available digitally and in a hard copy by every patients bedside. Full translation of the editorial into following 5 languages: 1. Urdu 2. Arabic 3. Slovak 4. Chinese (Traditional for UK market) 5. Polish will be completed and also available digitally and as a hard copy (one copy of each language in every ward).

To compliment this further, new welcome boards will be designed, using QR codes to further signpost people to additional information, help, advice and support for their health needs. These will be placed outside of ward and department areas for visitors to revisit and understand where to get additional information about their treatment and condition from.

Communication stations will then be developed in all ward areas, including how to arrange translators, flash cards, LD resource folder, hearing aid batteries and the bedside information in different languages

The aim and objective(s) (including the measures/metrics)

Aim:

- Patient and carer communication and information will improve
- Patients and carers will have an improved patient experience

Objectives:

Develop a range of resources to improve communication and information or patients using:

- Bedside information folder
- Welcome boards and QR codes (over 33 designs and 90 boards planned)
- Communication stations for all inpatient areas
- Learning Disability Resource folder

The planned activity to achieve this

- Co-produce bedside information folder with experts in the Trust and patient involvement
- Co-produce 33 different welcome boards with clinical teams to include key information about a patients journey through hospital and where to signpost patients, families and carers for more information

- Learning Disability (LD) resource folder is co-produced, using photosymbols library for easy read photos of people with LD
- Communication stations will be introduced in all clinical areas to reduce health inequalities for patients

How will progress be monitored and reported?

- Question 25 'enough information on condition or treatment' and Q39 given enough written information about what to do after leaving hospital to be included in revised Tendable questions. New baseline to be set by end of Q2 with increased sample size.
- Seek feedback from service users on usefulness of resources and act upon feedback received. Analysis to be included in quarterly patient experience report.
- Increase in compliments to be recorded on Datix from July 2022. Aim to see an increased number of recorded compliments recorded each quarter from a baseline position of zero.

Ongoing monitoring will be reported through the Patient Experience Group, Patient Experience Committee and Quality Committee.

Domain: Patient Experience

Title – Identify and develop a quality improvement tool for the organisation

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Developing a QI approach and a network of quality champions to drive operational excellence at the Trust. Currently, there is no consistent approach to quality improvement in the organisation, and no coordinated systems, processes or governance supporting it, making it difficult to ascertain the effectiveness (and return on investment of time and money) of the many improvement initiatives underway.

The aim and objectives including the measures and metrics

Aim:

- Standardised approach to quality improvement
- Development of Quality Improvement faculty
- Delivery Quality Improvement training
- Develop Quality Improvement programme

Objectives:

- Develop a standardised Quality Improvement tool at the Trust.
- Standardise the methodology for quality improvement.
- Develop a cohort of staff to deliver quality improvement initiatives.
- Create a Quality Improvement faculty.

The planned activity to achieve this

- Identify current QI methodology
- Scope ICS QI methodology
- Agree on which methodology should be utilised at the Trust
- Publish Quality Improvement methodology and toolkit

How will progress be monitored and reported?

- Agreed QI methodology
- QI strategy and toolkit
- Key stakeholder feedback
- Delivery of QI training
- Development of Quality Improvement Strategy

Title – Clear digital identification of clinically unwell patients to drive quality improvements

Executive Lead – Executive Medical Director
Operational Lead – Deputy Medical Director for Quality and Deputy Chief Nurse

Current position and why is it important?

The identification of clinically unwell patients is an important step in identifying a deteriorating patient. The Trust aims to identify these patients in a digital manner by monitoring their National Early Warning Score (NEWS2), sepsis response, Acute Kidney Injury (AKI) and abnormal investigations. The aim of this quality priority is to ensure that we identify unwell patients early with systems in place to flag if a patient deteriorates and processes to respond in a timely manner to any patient deterioration. The Trust's NEWS2 policy should be followed.

The aim and objectives including the measures and metrics

Aim:

- Ensure that all deteriorating Patients are recognised and clinical escalation process followed
- Ensure that the NEWS2 escalation policy is followed in line with the National guidance

Objectives:

- The Trust's NEWS2 Policy to be updated and adherence monitored to ensure that all patients with an elevated NEWS2 score have their observations recorded appropriately on Meditech.
- The white boards on inpatient wards have a flag for patients who have had a deteriorating patient proforma completed within the preceding 12 hours
- To ensure that all patients with an elevated NEWS2 score have their observations recorded appropriately on Meditech
- To ensure that all patient flagged on the UECC Tracker or AMU Tracker are treated in a timely manner

- To appropriately respond to the deteriorating patient e.g. AKI, sepsis

The planned activity to achieve this

- The Deputy Medical Director Quality chairs the Deteriorating Patient and Sepsis Group which will oversee the developments needed
- The Trusts' NEWS2 Policy to be reviewed and updated
- The Power BI NEWS2 module to be reviewed and used to drive improvements
- White Boards on ward areas to be used to highlight any patient deterioration

How will progress be monitored and reported?

- Improvements noted on Power BI with regards to compliance with the NEWS2 Policy
- Measure the percentage compliance on Power BI – aim for 95% for all ward areas
- Measure adherence to Acute Kidney Injury pathway and Sepsis 6 pathway

Title – Continuation of mortality and learning from deaths improvement work

Executive Lead – Medical Director
Operational Lead – Learning from Deaths and Mortality Manager/Divisional Director for UECC and Division of Medicine

The Current position and why is it important?

A major component of the Learning from Deaths process is the Case Note Reviews of selected deaths. The Trust uses the Structured Judgement Review (SJR) method. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

The Trust's quality, consistency, completeness and timeliness of its SJRs needs improving; only the Phases of Care Score are routinely being completed, with very little supportive free text detail to provide detail of any good or bad care. Clinicians are choosing to add this crucial detail in local formats, whilst this enables discussion, this doesn't allow this information to be used for analysis and the identification of themes or trends.

The Trust is involved in a Learning from Deaths Improvements programme with NHS Improvement/England (NHSI/E). This programme will include an SJR training programme for Clinicians and adopting the SJR+ format, which encourages the use of crucial freetext judgment statements, from which learning is derived.

The aim and objectives including the measures and the metrics

Aim:

- Enhanced learning from the Learning from Deaths Program
- Better consistent presentation/review of the Trust's deaths
- Training time for Trust Clinicians
- Better timeliness for SJR completion

Objectives:

The objectives of this work is to increase the Learning from SJRs by:

- Enhancing & improving the quality, and consistency and completeness of its SJRs.
- Be able to analyse and determine trends and themes from SJRs
- Have the Trusts Divisions use SJRs to present Mortality Reviews
- Have timely SJRs which can highlight potential good or bad care close to the time that the care was delivered

The planned activity to achieve this

- An agreed timetabled programme/action plan, with NHSI/E.
- Joint working with NHSI/E to determine the detail needed to deliver the plan. Publication and awareness of the programme.
- Undertaking of the agreed implementation programme, including the introduction of SJR+, undertaking of the training programme and to gain an understanding of the SJR analysis tool.
- That SJRs are used for all in scope mortality reviews and used as the presentation format. To be using intelligence gathered from the SJRs to deliver learning, improvements and change.

How will progress be monitored and reported?

- Improve the number of engaged, willing trained Clinicians
- Increase in complete/detailed SJRs
- SJRs being used to present reviews at Divisional & Trust level
- 100% completed within 60 days. Standard with a 10% tolerance for late request SJRs i.e. Dr Foster Data, therefore 90% to measure against

2.2: Statements of Assurance from the Board of Directors

During 2021/22 The Trust provided and/or subcontracted 64 relevant health services, across community and acute services. The Rotherham NHS Foundation Trust has reviewed the data available to them on the quality of care in these relevant health services. The income generated by the relevant health services reviewed in 2021/22 represented 85% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2020/21.

Clinical Audit

During 2021/22, 44 national clinical audits and 8 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation Trust provides. Due to the pandemic, 1 national clinical audit did not take place. During that period, therefore, The Rotherham NHS Foundation Trust participated in 37 (86%) of national clinical audits and 8 (100%) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Rotherham NHS Foundation Trust participated in, and for which data collection was completed during

2021/22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
Case Mix Programme (CMP)	Yes	100%	NA
Elective Surgery (National PROMs Programme)	Yes	35.6%	NA
Emergency Medicine QIPs: Infection Control (care in emergency departments)	Yes	100%*	NA
Emergency Medicine QIPs: Pain in Children (care in emergency departments)	Yes	100%*	NA
Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	Yes	100%	NA
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls	Yes	100%	NA
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Yes	100%	NA
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Children & Young People's Asthma Secondary Care	Yes	100%	NA
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care	Yes	48%	NA
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): COPD	Yes	81%	N/A
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%	NA
National Audit of Cardiac Rehabilitation	Yes	100%	NA
National Audit of Care at the End of Life (NACEL)	Yes	100%	NA
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	100%	NA

National Cardiac Arrest Audit (NCAA)	Yes	100%*	NA
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	100%*	NA
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	100%*	NA
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%*	NA
National Diabetes Audit - Adults: National Diabetes Foot Care Audit	Yes	100%*	NA
National Diabetes Audit - Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	100%	NA
National Diabetes Audit - Adults: National Core Diabetes Audit	Yes	100%	NA
National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit	Yes	100%	NA
National Emergency Laparotomy Audit (NELA)	Yes	0%	NA
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA)	Yes	100%	NA
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA)	Yes	100%	NA
National Joint Registry (NJR)	Yes	100%	NA
National Lung Cancer Audit (NLCA)	Yes	100%	NA
National Maternity and Perinatal Audit (NMPA)	Yes	100%	NA
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%	NA
National Paediatric Diabetes Audit (NPDA)	Yes	100%	NA
National Perinatal Mortality Review Tool	Yes	100%	NA
National Prostate Cancer Audit	Yes	100%	NA
Respiratory Audits: National Outpatient Management of Pulmonary Embolisms Audit	Yes	100%	NA

Respiratory Audits: National Smoking Cessation Audit	Yes	100%	NA
Sentinel Stroke National Audit programme (SSNAP)	Yes	Band A 90+%	NA
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%	NA
Trauma Audit & Research Network (TARN)	Yes	31%*	NA

National Confidential Enquiry	**Work stream**	**Participation yes/no?**	**% Cases (of those required)**	**Reason for non-participation**
Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal Surveillance	Yes	100%	NA
Maternal, New-born and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	100%	NA
Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	100%	NA
Medical and Surgical Clinical Outcome Review Programme	Physical Health in Mental Health Hospitals	Yes	No cases identified for inclusion	NA
Child Health Outcomes Review Programme	Transition from child to adult health services	Yes	100%	NA
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Yes	Study has not yet commenced	NA
Medical and Surgical Clinical Outcome Review Programme	Epilepsy study	Yes	100%*	NA
Medical and Surgical Clinical Outcome Review Programme	Crohns disease	Yes	100%*	NA

(Source: Respective audit provider website and/or local tracking system)

*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 2022 and therefore final figures may change.*

The reports of 25 national audits/confidential enquiries were reviewed by the provider in 2021/22 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (where appropriate). There are a further 8 national audit reports published which have been circulated for review.

Title	**Published**	**Report Reviewed**	**Action(s) to improve quality of care**
Case Mix Programme (CMP) ICNARC (20/21)	Yes	Yes	Assess trends in mortality and feedback through performance / governance meeting.
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database (2019)	Yes	Yes	Extra clinics to be held in order to improve on the time to clinic for patients. Letter to be sent to patients to follow up progress, if unable to contact by phone for monitoring/follow up at 16 weeks post-op and 12 months.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit Inpatient Falls (2020)	Yes	Yes	Recommendations and appropriate actions are still under review
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (2020)	Yes	Yes	No actions required.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	Continued education around Oxygen Prescription is required. A working group to be set up to discuss the re-establishment of the Respiratory Support Unit to support Non-Invasive Ventilation (NIV) treatment within 2 hours of arrival. Discuss with Health Informatics regarding the identification of spirometry on Meditech and agree the process for ordering spirometry on Meditech. In relation to smoking cessation, liaise with the Healthy Hospitals Manager about how patients are picked up on admission and the possibility of a flag on Meditech to allow identification.

			Respiratory review within 24 hours – need to identify patients early with Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD) from admission clerking, clarify the potential number of patients this involves, look at how patients with AECOPD are coded, explore the capacity to review these patients by the Consultants, Respiratory Nurse etc and the pathway of these patients and look at job plans. Recruitment of 2 more COPD nurses and re-start of respiratory in-reach on the Acute Medical Unit (AMU). Discuss the progress of the discharge bundle and its inclusion on Meditech. Education required regarding its existence and how to use.
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Surveillance	Yes	Yes	Recommendations and appropriate actions are still under review
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal confidential enquiries	Yes	Yes	Recommendations and appropriate actions are still under review
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	Yes	Recommendations and appropriate actions are still under review
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Children & Young People's Asthma Secondary Care	Yes	Yes	Mandatory field for smoking history to be added onto Meditech. To arrange a Survey Monkey to establish knowledge of standards for Urgent & Emergency Care Centre (UECC) and Paediatric staff. Place quick Guide to Asthma Management on the wards / Children's Assessment Unit (CAU) and UECC. Contact Infection Control to discuss a plan to reintroduce Spirometry following COVID-19 restrictions.

National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	No actions required.
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM) (2019/20)	Yes	Yes	Further training is required with staff to ensure data fields are completed correctly. There are some issues about incomplete data entry e.g. New York Heart Association (NYHA), Left Fentricle (LV) function and ICD indication. This has been highlighted in previous years and needs to be improved. The report provides evidence that some information is frequently not provided pre implant, e.g. Left Ventricular Ejection Fraction (LVEF). More comprehensive data required for pre-assessment from neighbouring regional hospitals. An email will be sent to referrers requesting that relevant data is provided pre-implant. Data quality/completeness is reliant on manual data entry. A different electronic system is being considered which may improve this. General Medical Council (GMC) numbers for our implanters need to be confirmed as accurate on Tomcat. Consultants will be contacted via email for confirmation of GMC numbers. Data will be shared with the implanters to highlight sub-optimal compliance with NICE guidelines. An internal audit of complication rates to highlight areas for improvement will be undertaken.
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National audit Project (MINAP) (2019/20)	Yes	Yes	Recommendations and appropriate actions are still under review
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (2019/20)	Yes	Yes	All patients should have an Echo if admitted with decompensating or suspected Heart Failure (HF), unless they have had a prior Echo within 1 year or unless requested by cardiology. An audit is to be carried out looking at length of stay in hospital, re-admission time and the

			severity of disease, seen by which speciality, whether patients have been seen by a community HF nurse, were they discharged on the appropriate medication plus where were they managed i.e. ward. Consultant Cardiologist lead for heart failure is now in place. The ongoing National Heart Failure audit will identify when under cardiology/HF team patients are on the appropriate disease modifying drugs.
National Diabetes Audit - Adults: National Core Diabetes Audit	Yes	Yes	Transitional Care and Young Adults with Type 1 diabetes need a full Multi-Disciplinary Team (MDT) including access to Psychology. The adult service needs a strategy to address the 'revolving door' and 'frequent non-attenders' service users. A register of all type 1 diabetes patients attending the service will facilitate audit and monitor progress.
National Diabetes Audit – Adults: National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	Yes	Discussions are on-going with the Electronic Patient Record (EPR) team on how to use Meditech to interrogate GP systems (Emis & SystmOne) regarding established diagnoses of diabetes on admission. To develop an electronic system of triaging patients that need a diabetes specialist review. Establish a comprehensive peri-operative pathway for people with diabetes in line with National Confidentiality Enquiry into Patient Outcomes and Death (NCEPOD).
National Diabetes Audit – Adults: National Pregnancy in Diabetes Audit	Yes	Yes	Recommendations and appropriate actions are still under review
National Diabetes Audit – National paediatric Diabetes Audit (NPDA)	Yes	Yes	Recommendations and appropriate actions are still under review
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) 2020/2021	Yes	Yes	Introduce SOP and posters to raise awareness for Deferred cord clamping. Prepare a check list and reminders to juniors in daily handover and grand round for first consultation within 24 hrs. Make more consultants available in

			ward rounds, and discuss in consultant meeting for catching up with parents after grand round to meet documentation of Parental presence in ward round. Explore Meditech referral process so the babies can be referred at birth or at admission with a window of ROP screening dates. ATAIN reviews to reduce average separation days of Term/Late pre term babies. Awareness and educating all medical and nursing / midwifery staff about breast feeding and supporting mum during antenatal and postnatal period. Improving documentation when mouth care is given with colostrum. Continuous monitoring 6 monthly review of neonatal nurse staffing establishment Review QIS training programme annually.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	To establish transitional clinics/pathway to adult services. Electrocardiogram (ECG) for all patients with convulsive Seizures. First review by Specialists within 4 weeks of presentation.
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Recommendations and appropriate actions are still under review
National Lung Cancer Audit (2019 & 2020)	Yes	Yes	To continue to participate in the activities of the regional Cancer Alliance lung cancer delivery group, aiming to follow their recommendations and restore services post COVID-19 pandemic focusing on the optimal lung cancer pathway
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Recommendations and appropriate actions are still under review
National Perinatal Mortality Review Tool	Yes	Yes	Recommendations and appropriate actions are still under review
National Joint Registry (NJR)	Yes	Yes	No actions required
Royal College of Emergency Medicine (RCEM) Assessing Cognitive Impairment in Older People (Care	Yes	Yes	To implement the 4AT (rapid test for delirium detection) into the department.

in Emergency Departments) (19/20)			
Royal College of Emergency Medicine (RCEM) Care of Children (Care in Emergency Departments) (19/20)	Yes	Yes	Introduce a psycho social assessment tool into the department, to enable all adolescents to be opportunistically risk assessed. Escalation protocol to be highlighted to clinicians in the department.
Royal College of Emergency Medicine (RCEM) Mental Health (Care in Emergency Departments) (19/20)	Yes	Yes	The Adult Mental Health Triage Tool for use on arrival in the Emergency Department has been identified and embedded into Meditech.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	No action required. Ongoing reviews and training are taking place, the SHOT report has been distributed for review, a report is made on a monthly basis following the Hospital Transfusion Team (HTT) meeting where incidents are reviewed and provided to the Patient Safety Group.

Review of Local Clinical Audits

The reports of 130 clinical audits were reviewed by the provider in 2021-2022 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (See Appendix 1).

Participation in Clinical Research - The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2021/22 that were recruited to participate in research approved by a research ethics committee was 1933. A significant number of recruits (1454) are the result of participation in the Clinical Characterisation of Severe Emerging Infections, a COVID-19 observational study [data taken from the NIHR Open Data Platform 04 April 2022].

To be consistent with previous submissions, this data includes all participants (patients and staff) recruited to NIHR Portfolio research studies actively recruiting at The Rotherham NHS Foundation Trust i.e. included all studies that received Trust confirmation of “Capacity and Capability” as per Health Research Authority requirements. This includes studies that require research ethics approval and those that have no legal requirement to do so as per Governance Arrangements for Research Ethics Committees GAfREC (Department of Health, 2011).

The table below shows the total number of studies that have been supported by the Trust (i.e. actively recruiting or in follow up) during 2021/22

Study Type	Number of studies
NIHR Portfolio Commercially sponsored	1
NIHR Portfolio Non-commercial	28
NIHR Portfolio Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	1
Non-portfolio The Rotherham NHSFT Sponsored	8
Other Non-portfolio (supporting academic qualifications)	2
Studies undertaken at TRFT which required no Capacity & Capability review	0

(Source: TRFT Research Database)

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to patients and to making our contribution to wider health improvements.

CQUINs (Commissioning for Quality and Innovation)

Due to COVID-19 the 2021/22 CQUIN schemes were stood-down as per the guidance on finance and contracting arrangements. The block payments approach between NHS commissioners and NHS providers in England remains in place and these include CQUIN values as per the guidance. It has been confirmed that the CQUIN schemes will recommence in 2022/3.

Care Quality Commission Registration and Periodic Reviews/Specialist Reviews

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and ensure the registration status is accurate and updated as and when organisational changes affect the Trust Certificate of Registration.

The current registration status is 'Registered with Conditions'. The Trust received the following condition in October 2018:

The condition notified under Section 31 of the Health and Social Care Act 2008 was issued following a series of visits by CQC to the Urgent and Emergency Care Centre, requiring the Trust to mitigate the risks relating to the Paediatric Emergency Department, with a specific focus on medical and nurse staffing levels.

Immediate action was taken to address the concerns and a daily focus on the provision of Registered Sick Children's Nurses and oversight by senior medical colleagues is robustly monitored as part of the trust-wide staffing systems and processes.

The Trust is in the process of applying to have the condition removed and are working with CQC colleagues to ensure the application is fully supported by evidence to demonstrate that children attending the Paediatric Department are seen by appropriately trained and skilled clinicians.

CQC Inspection 2021

In line with the routine CQC Inspection cycle, the four core service areas of Urgent and Emergency Care, Medical Care (including care of the older person), Maternity and services for Children and Young People were visited through May and June 2021. The visit also incorporated the separate well-led assessment.

A Warning Notification under Section 29a of the Health and Social care Act 2008 was issued to Urgent and Emergency Care, in response to issues identified across the department. Progress in addressing the concerns is closely monitored and reviewed monthly through the Trust Quality Assurance and Governance framework and shared with CQC through the regular engagement meetings.

Following significant progress, as evidenced in the 2021 CQC visit to the Medical Care core service, the Section 29a Warning Notification issued to the Acute Medical Unit (AMU) in November 2020 was closed with no further reporting requirements to CQC.

There were some minor changes to the CQC ratings following the 2021 Inspection; however, the overall Trust rating remains as 'Requires Improvement'. The Trust ratings is illustrated in the table below:

Domain	Rating
Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well Led	Requires Improvement

The tables below show the detailed ratings by domain and by core service:

CQC ratings for the Trust Hospital services

	Safe	Effective	Caring	Responsive	Well led
Urgent & Emergency Services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate

Medical Care	Requires Improvement	Good	Good	Good	Requires Improvement
Surgery	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Good	Requires Improvement
Maternity*	Good	Good	Good	Good	Good
Children and young people	Requires Improvement	Good	Good	Good	Good
End of life care	Good	Requires Improvement	Good	Good	Good
Outpatients and diagnostic imaging	Good	(Inspected not rated)	Good	Good	Good

CQC ratings for Trust Community

	Safe	Effective	Caring	Responsive	Well led
Adults	Good	Requires Improvement	Good	Good	Requires Improvement
Children & young people	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Inpatients	Good	Good	Outstanding	Good	Good
End of life Care	Good	Requires Improvement	Good	Good	Requires Improvement
Dental	Good	Good	Good	Good	Good

(Source: Care Quality Commission)

All reports from the Trust's inspection are available from the CQC website at: www.cqc.org.uk

How the Trust makes use of the CQC Inspection report

The Chief Nurse is the Trust nominated individual for registration with the CQC. A copy of the Trust's Registration Certificate can be viewed at –

http://www.cqc.org.uk/provider/RFR/registration-info or alternatively by requesting a copy from the Trust Company Secretary at the address below:

Company Secretary
General Management Department, Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham, S60 2UD

Compliance with CQC standards is monitored internally through the Trust's clinical governance arrangements, which includes progress against all CQC Improvement Plans via the CQC Delivery Group, Clinical Governance Committee, the Quality Committee and the Board of Directors.

CQC Reports are a useful reference source to not only identify possible poor performance but also to acknowledge where care provision is good and outstanding. It provides a framework to drive necessary changes and required improvements to practice, which in turn supports the overall direction of travel and the strategic clinical vision for the Trust.

Following the 2021 CQC Inspection a comprehensive Improvement Plan was developed in conjunction with each core service visited. The Plan incorporates the Must and Should take actions identified in the final CQC Inspection Report. Each action has been broken down into a number of sub-actions to ensure each concern is addressed in full. A separate Plan is also in place to address the issues identified within the Urgent and Emergency Care Section 29a Warning Notification.

Each core service presents progress against their actions at the monthly CQC Delivery Group, providing supporting evidence to demonstrate achievement. A robust confirm and challenge for each action is a key component of the CQC Delivery Group discussion, which is then summarised in the CQC Assurance Report to the Trust Quality Committee.

CQC Engagement

The Trust has a positive working relationship with the Trust CQC representatives. An engagement meeting takes place each month, attended by CQC colleagues, the Trust Executive and identified clinical teams. Issues and patient safety risks are discussed, in addition to opportunities for the clinical teams to present the work they are doing and the resulting improvements to patient care.

Due to the COVID-19 Pandemic, the Engagement meetings have been held virtually, but both the Trust and CQC colleagues are looking forward to an increased number of on-site visits from CQC to strengthen relationships further in the near future.

The Trust is also required to report any breaches of the **Ionising Radiation Regulations** to the CQC. Below is a summary of the radiation incidents that were reported to the CQC from 1st April 2021 to 31st March 2022.

	Reportable to				
Date	**MHRA**	**CQC**	**HSE**	**Dose (mSv)**	**Description**
20.11.21		Yes			Due to a software bug, the AGFA Radiology Information System (RIS) incorrectly transferred the imaging referral from Patient B's record onto Patient A's. Patient A then proceeded to have the scan incorrectly. The trust was aware of this bug and a hotfix had been downloaded onto all of the PC's running this software. Unfortunately, one of the PC's was replaced and the hotfix was not added. All the PC's in use have been checked and are running the correct software. CQC closed this incident on the 5th January 2022.
24.11.21		Yes		22mSv	Incorrect patient selected on MEDITECH for a chest abdomen and pelvis scan, unfortunately the error was not identified, and the patient underwent a CT scan. The referrer identified the error and informed the CT department the next day. The correct patient was identified and immediately scanned, the images were reported the same day. The CQC closed this incident on the 5th January 2022 on the understanding that the following actions were taken. The referrer should provide a reflective statement relating to the incident and identify learning outcomes an there should be evidence of shared learning. These actions are now closed. The incident will be included in the patient safety bulletin.

(Source: Datix and Radiation Protection Advisor's Report)

These incidents have been investigated and have been escalated through to the Clinical Support Services, Divisional Quality Governance Committee meetings and to the Trust's Clinical Governance Committee meeting, to provide assurance as to the quality of the investigation and the robustness off the remedial actions taken.

All Radiation incidents are recorded internally on DATIX and reported to the Radiation Protection Advisor (RPA) for a dose report and recommendations. All radiation incidents are investigated and learning outcomes identified and shared.

Special Reviews and Investigations

The Rotherham NHS Foundation Trust participated in one special review/investigation by the CQC during the reporting period.

- Medicines Management Review following CQC concerns commissioned from the NHSE/I Pharmacy Team in July 2021. A report with recommendations was received and is incorporated into the wider Medicines Management Improvement Plan, monitored via the Trust Medicines Safety Committee and CQC Delivery Group.

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

99.9% (99.9% for 2020/21) for admitted patient care
100.0% (100.00% for 2020/21) for outpatient care, and
99.9% (99.6% for 2020/21) for accident and emergency care.

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

100% (100% for 2021/22) for admitted patient care
100% (100% for 2021/22) for outpatient care, and
100% (100% for 2021/22) for accident and emergency care.

For both data set (years) the data is reported for the period April – November as this is the most up to date position that we have available at time of publication.

Information Governance Toolkit (DSPT) attainment levels

The replacement of the Information Governance Toolkit, with the Data Security and Protection Toolkit (DSPT) during 2018/19, means that the Trust, like other organisations, is no longer able to produce an Information Governance Assessment report.

The DSPT demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care.

Organisations are expected to achieve the 'standards met' assessment on the DSPT by 30 June each year.

The Trust will submit again by 30 June 2022 and is aiming for full compliance – assurance will also be sought from the auditors prior to the end of May 2022.

The Trust's Information Governance Assessment Report overall score for 2020/21 was 'Standards Fully Met'.

Payment by Results

The Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission. (Note: NHSI Comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHSI. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'coding audit', with error rates as envisaged by this time in the regulations. It is therefore likely that providers will be stating that they were not subject to "Payments by Results clinical coding audit".

The Trust will be taking the following actions to improve data quality and clinical coding. Each clinical specialty that requires input from Clinical Coding now has an assigned Clinical Coder that acts as a point of liaison with that specialty. They attend monthly meetings with the specialty and raise any quality concerns with that service and work with them to improve their understanding of what is required to ensure good quality, accurate coding can take place. The Trust has appointed a Band 7 Coding Manager to assist with improving standards and quality within the clinical coding department.

The Trust engaged in implementing the NHS Spine to the clinical information system Meditech in January 2018 and are the first Trust using Electronic Patient Record (EPR) (Meditech) to transition to the Patient Demographics Service in the country. It was anticipated that additional improvements would be seen, in particular in Emergency Care data which had recently migrated from a legacy system Symphony onto Meditech and this is now clearly evidenced in the external data quality dashboards that the Trust monitors. The Trust has been attaining data completeness rates well above the national average, across all of its core commissioning data set submissions, and the evidence of this can be seen via the NHS Digital Data Quality Dashboards.

The Trust was subject to the mandatory Clinical Coding Information Governance (IG) audit in January 2022, during the 2021/22 reporting period as required by NHS Digital. The Trust again achieved an IG rating of level three (Advisory), for the fifth year running, which is the highest possible rating that can be achieved. An aggregate percentage score of 98.975% was achieved across the four domains audited.

Data Quality Index (HRG4+ based)

As the Trust no longer utilises Comparative Health Knowledge System (CHKS) for its external monitoring of data quality the department has transitioned to utilising the Data Quality Maturity Index (DQMI), which is published by NHS Digital and is readily available for the public to access and review the data outputs. These measures are different to the CHKS indicators so a decision has been taken to establish a new baseline for measuring the data maturity, starting from last financial year 2020/21.

The Trust has been taking the following actions to improve data quality; development work in building commissioning data sets from a single source of data will be undertaken over the coming years to improve the quality of the data submitted from systems thus ensuring that additional data quality activities can be performed prior to submission.

As a team, the Data Quality Indicators are reviewed monthly both from a DQMI perspective and from the NHS Digital Data Quality Dashboard perspective. Any fluctuations in performance are identified and actions are put in place to resolve. If aide memoires, for staff understanding, are required the Data Quality Team will work with the Training Team to put the best possible processes in place to resolve these issues. The Data Quality Team also works closely with the reporting teams to ensure that they are aware of any errors that may be present from a submission perspective to ensure these are rectified at source, thus ensuring the Trust maintains its high standards with regards to the integrity of our data.

Clinical Coding

The Trust was subject to the external clinical coding audit during the reporting period and the compliance rates (%) reported for a sample of 200 sets of case notes for diagnosis and treatment coding were:

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	98.5%	97.9%	100%	99.5%

(Source: The Rotherham NHS FT Information Governance Audit Report 2021/2022)

These scores helped achieve assurance Level 3/Advisory of the Information Governance Toolkit for coding accuracy, this is the fifth consecutive year that the Trust has managed to achieve the highest grade for the Information Governance Audit.

In 2020/21 the Trust worked with the following actions to improve clinical coding and data quality and these continued throughout 2021/22:

- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable.

The Trust continues to be rated in the top quartile nationally for depth of coding, although this is not a clear indicator of clinical coding quality it does better demonstrate the complexity of the patients care for the respective episodes, and by also attaining the IG level 3/Advisory the auditors are of the opinion that we are also rated in the top quartile nationally from that perspective too. Combined these indicators demonstrate a continued improvement in the quality of the clinical coding.

Improvements and actions to further improve clinical coding during 2021/22 included:

- Reviewing the department structure against its peers and the Trust making the decision to invest significantly to bring us in line with our peer group. The Board of Directors acknowledged a need for a Senior Management Qualified Clinical Coding role and funding has been approved and appointed.

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2021-22	Qtr 2 2021-22	Qtr 3 2021-22	Qtr 4 2021-22	YTD 2021-22	Progress
IMPROVING DATA QUALITY	IDQ-1 DQMI ECDS*#	2020-21 **	74.2	Increase	75.30	74.30	72.5		72.5	
	IDQ-2 DQMI APC*	2020-21 **	95.8	Increase	98.4	98.9	98.9		98.9	
	IDQ-3 DQMI CSDS*	2020-21 **	75.8	Increase	89.0	89.3	89.4		89.3	
	IDQ-4 DQMI MSDS*	2020-21 **	95.9	Increase	99.7	99.7	99.7		99.7	
	IDQ-5 DQMI OP*	2020-21 **	91.1	Increase	99.9	99.9	99.4		99.4	
	IDQ-6 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015-16	99.8%	Increase	99.9%	99.9%	99.9%	99.9%	99.9%	
	IDQ-7 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015-16	100%	Maintain	100%	100%	100%	100%	100%	
	IDQ-8 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015-16	99.9%	Increase	100%	100%	100%	100%	100%	
	IDQ-9 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015-16	99.9%	Maintain	100%	100%	100%	100%	100%	
	IDQ-10 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015-16	86.6%	Increase	99.7%	99.7%	99.7%	99.9%	99.9%	
	IDQ-11 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.1%	Increase	100%	100%	100%	100%	100%	

* DQMI Data from external sources only available up to Dec 2021 in a complete state & IDQ6 to IDQ11 available to January 2022
# The Trust is building a new extract from our Data Warehouse for this data submission as it has been found the current system extract is not fit for purpose – this new extract should come into effect in the next 3 months and the DQMI values for this data set will improve significantly.

Learning from Deaths

The Rotherham NHS Foundation Trust's Learning from Deaths policy for identifying deaths for detailed case review is based on the framework set out in the National Quality Board's (NQB) publication, '*National guidance on learning from deaths'*, published in March 2017.

Detailed case record review is undertaken using the Royal College of Physician's Structured Judgement Review (SJR) methodology. Not all deaths have an SJR. SJRs should be completed for deaths which fit into nationally and/or locally defined criteria.

Deaths which require an SJR are either identified during the Medical Examiner (ME) Scrutiny, from locally held data, from Dr Foster Mortality data and/or after recommendation by any Trust Clinician/Clinical Team. SJRs are also requested when it is determined that they can add value to any other review, inquiry or inquest.

The Trust has also agreed an updated process for the review of 'alerting diagnostic groups', which are provided by our mortality data provider, Dr Foster Intelligence (DFI). DFI provide the Trust with information that highlights diagnostic groups where there appear to be a statistically significant level of excess deaths. Under this process, a case note review by a clinician is undertaken, alongside a coding review, to identify any themes and trends across

a patient cohort, which may help to identify any areas of concerns and improve the quality of care provided.

Learning From Deaths - Medical Examiner (ME) Scrutiny

The ME Service is now fully implemented and operational/functional. This service provides independent scrutiny of all Trust deaths and determines whether the record should be scrutinised in more depth by a multidisciplinary team from the individual divisions, via an SJR. From April 2022, the ME Service will also be expected to scrutinise Community deaths; work is being undertaken to prepare the service for this.

It has been a specific aim of the Trust to complete ME Scrutinies for all deaths (100%) within one month of death, with many deaths being scrutinised within 1 week of the death, despite the COVID-19 pandemic.

Due to staffing pressures within the Service, the 100% target hasn't been achieved. However, the recruitment of additional Medical Examiners to increase the capacity in the service is underway and appointments are expected in 2022/23.

ME Scrutiny Figures for 2021/22: Data not available for quarter 1

Month of Death	No of Adult Trust Deaths*	ME Scrutinies Completed	ME Scrutinies Outstanding	SJR Recommended
Jul-21	80	32	48	7
Aug-21	102	16	86	11
Sep-21	102	8	94	4
Oct-21	100	76	24	23
Nov-21	121	50	71	5
Dec-21	112	49	63	6
Jan-22	115	62	53	21
Feb-22	85	34	51	10
Mar-22	93	89	4	14
2021/22 Q2-4	**910**	**416**	**494**	**101**

Learning From Deaths – Structured Judgment Review (SJR)

The Trust aims to complete recommended SJRs within 60 days of death. This can only happen for those that are identified near the time of death via the ME Scrutiny or by a Clinician/clinical team.

Capacity issues within the ME Service and the absence of a tracking process for SJR recommendations, has meant that this aim has not been met. However, a tracking process is now in place at the Trust, where outstanding SJRs are discussed at Monthly Divisional Safe and Sound Mortality Sub-Group meetings and reported to the Trust's overall Safe and Sound Mortality Group Meeting each month.

SJR Figures for 2021/22

Month of Discharge	No of Adult Inpatient Deaths*	SJR Requested	SJRs Completed	SJRs Outstanding	Overall Care Score < 3	Avoidability Score < 4
Apr-21	69	19	16	3	2	0
May-21	71	22	19	3	0	0
Jun-21	66	14	12	2	2	1
Jul-21	71	19	16	3	0	0
Aug-21	91	23	16	7	0	0
Sep-21	89	22	17	5	0	0
Oct-21	83	34	15	19	1	0
Nov-21	108	21	13	8	1	0
Dec-21	96	18	15	3	0	0
Jan-22	100	30	17	13	0	0
Feb-22	80	15	5	10	0	0
Mar-22	81	15	6	9	0	0
2021/22	**1005**	**252**	**167**	**85**	**6**	**1**

* ME figures include both Inpatient and UECC deaths,
SJR figures include Inpatient deaths only

Care Score	1 - Very Poor	2 - Poor	3 - Adequate	4 - Good	5 - Excellent

Avoidability Score	1 - Definitely avoidable	2 - Strong evidence	3 - Probably (more than 50:50)	4 - Possibly (less than 50:50)	5 - Slight evidence	6 - Definitely not avoidable

SJRs with either an Overall Care Score of less than 3 or an Avoidability Score of less than 4 are presented at the Trust's Safe and Sound Mortality Group, which is chaired by the Trust's Medical Director. These are then reviewed or re-reviewed by the Serious Incident Panel.

In order to strengthen the Trust's Learning from Deaths, the Safe & Sound Mortality Group continues to meet monthly. A new Learning from Deaths and Mortality Manager has been appointed to further co-ordinate, facilitate and improve the Trust's Learning from Death Programme. Furthermore, the Mortality Improvement Group (MIG), set up by the interim Chief Executive Officer last year, continues to provide external support and scrutiny, in order to drive forward further improvements in mortality and learning from deaths; in particular, MIG focusses on making improvements around quality of care, coding, and the care and support of patients at the end of their lives.

The Trust's Medical Director continued to Chair both the Trust's Safe & Sound Deteriorating Patient and Sepsis Group, focussed on improving the recognition and management of acutely ill patients, and the Trust's Patient Safety Group for much of the last financial year, but this has now been picked up by the Trust's new Deputy Medical Director – Quality. Part of the quality improvement initiatives that have arisen from the learning from deaths, include the roll-out of electronic community-acquired pneumonia and revised acute kidney injury care bundles.

Learning From Deaths – Patients with Learning Disabilities and the Learning Disabilities Mortality Review Programme LeDer

The Trust's new policy is to complete SJRs for all deaths for patients with a Learning Disability and/or Autism.

To assist and support the Commissioner-led LeDer Project, the Trust's Matron for Learning Difficulties and Autism works in partnership with the Rotherham Clinical Commissioning Group (RCCG), and other CCGs.

LeDer and SJR Figures for Patients with Learning Difficulties 2021/22

Month of Discharge	SJR Requests	SJRs Completed	SJRs Outstanding	Overall Care Score < 3	Avoidability Score < 4	LeDer Requests
Apr-21	0	0	0	0	0	0
May-21	0	0	0	0	0	0
Jun-21	2	1	1	0	0	2
Jul-21	1	1	0	0	0	1
Aug-21	4	2	2	0	0	1
Sep-21	0	0	0	0	0	0
Oct-21	0	0	0	0	0	1
Nov-21	2	0	2	0	0	3
Dec-21	3	3	0	0	0	2
Jan-22	6	1	5	0	0	6
Feb-22	2	0	2	0	0	2
Mar-22	1	0	1	0	0	1
Total 2021/22	**21**	**8**	**13**	**0**	**0**	**19**

All LeDer requests go to the Trust's Matron for Learning Difficulties and Autism, who will assist the Rotherham CCG with the review. This consists of arranging on-site visits with the LeDer Review Team, to enable them to review appropriate Trust-held medical records, and supplying the team with a completed SJR, or requesting one if the patient died within 30 days of a Trust discharge.

The Trust's Health Informatics Team has worked with the Trust's Matron for Learning Difficulties and Autism to create a flag on the Trust's Medical Record System to identify deaths for patients with Learning Disabilities. This means that the Trust is no longer solely reliant on these deaths being identified during the Medical Examiner Scrutiny; this process is now being extended to patients with Autism, as these deaths are being included in the LeDer project for 2022/23.

2.3: Reporting against core indicators

The Department of Health asks all Trusts to include in their Quality Account information on a core set of indicators, including Patient Reported Outcome Measures (PROMS), using a standard format.

This data is made available by NHS Digital and in providing this information the most up to date benchmarked data available to the Trust has been used and is shown in the table below, enabling comparison with peer acute and community Trusts.

The Summary Hospital Level Mortality Indicator (SHMI) is a mortality measure produced by NHS Digital. The score is a ratio between the number of patients expected to die, based on England figures, and the actual number of deaths.

The SHMI takes account of a number of factors, including a patient's condition and age. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the England average, which is 100. Trusts are put into 3 bands based on statistical analysis of the score. Band 1 is 'Higher than Expected', Band 2 is 'As Expected', and Band 3 is 'Lower than Expected'.

SHMI figures are released monthly. These are reviewed by the Trust and discussed at the Trust's Safe and Sound Mortality Group. SHMI figures are broken down into diagnostic groups, of which 10 are given bandings. The Trust initiates a group review for any diagnostic groups of concern.

SHMI Quarterly Figures

12 Month Period End Month	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21
SHMI	117.76	113.41	109.58	111.02	109.35
Banding	Higher Than Expected	Higher Than Expected	As Expected	As Expected	As Expected
% of Deaths with Palliative Care Coding	29	27	28	32	34
% of Deaths with Palliative Care Coding England	36	37	38	39	39

The table above tells us that the Trust's SHMI has fallen during the period and is now in the 'As Expected' band.

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering hip replacement and knee replacement surgery, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

Patient Related Outcome Measures (PROMS)

DOMAIN	Indicator Title	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Domain 3 - Helping people to recover from episodes of ill health or following injury	**Primary hip replacement surgery (EQ-5D Index) - health gain**							
	1st April 2019 - 31st March 2020	84	0.203	0.788	0.585	74 (88.1%)	6 (7.1%)	4 (4.8%)
	1st April 2020 - 31st March 2021	6	0.301	0.655	0.354	5 (83.3%)	1 (16.7%)	0 (0.0%)
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2019 - 31st March 2020	75	0.369	0.692	0.324	61 (81.3%)	7 (9.3%)	7 (9.3%)

	1st April 2020 - 31st March 2021	3	0.304	0.661	0.358	3 (100.0%)	0 (0.0%)	0 (0.0%)
	On the 1st October 2017, PROMs data for varicose veins and groin hernia surgery ceased collection, following on from the NHS England Consultation on the future of PROMs							

Please note: Results in this document are provisional for April 20 - March 21 are finalised. Casemix-adjusted figures are calculated only where there are at least 30 modelled records

Domain4: Ensuring that people have a positive experience of care	**Indicator name**	**Latest & previous reporting periods**	**TRFT value**	**Acute Trust average**	**Acute Trust highest value**	**Acute Trust lowest value**
	*CQUIN: Responsiveness to patients personal needs	2017/18	68.6	68.6	85	60.5
		2018/19	64.9	67.2	85	58.9
	Staff who would recommend the Trust to their family or friends (Acute Trusts for comparison	July 18 - Sept 18	68%	81%	100%	39%
		July 19 - Sept 19	76%	81.00%	100%	50.00%

The indicators were postponed during the pandemic and so no up to date information is available.

Domain5: Treating and Caring for people in a safe place.	**Indicator name**	**Latest & previous reporting periods**	**TRFT value**	**Acute Trust average**	**Acute Trust highest value**	**Acute Trust lowest value**
	*Percentage of patients admitted to hospital and risk assessed for VTE	July 21 - Sept 21	96.55%	national data not yet available		
		Oct 21 - Dec 21	94.08%	national data not yet available		
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over (total cases)	Apr 19 - Mar 20	38.9	37.4	142.8	0
		Apr 20 - Mar 21	38.6	45.6	140.5	0
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison)	Apr 20 - March 21	47.07	national data not yet available		
		Apr 21 - March 22	51.88	national data not yet available		
	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	Apr 20 - March 21	0.15%	national data not yet available		
		Apr 21 - March 22	0.44%	national data not yet available		

***VTE No further national data to report as Collections were suspended March 2020 due to Covid-19**

*** C-diff next publication due Sept 22 for April 2021 to March 2022.**

*** Patient safety publication 21st May 2020 – this was suspended due to COVID-19, collection system has now changed and data is not comparable. No updated national data available for reporting by Trust**

The Trust considers the above data is as described for the following reasons, appearing in the (second column) of the table below.

The Trust intends to take the following actions (third column) to improve the outcomes above and so the quality of its services, a rationale for these figures is provided along with a brief description of proposed improvement actions as described in the table below.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
12a. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Data validated and published by NHS Digital. The Trust's SHMI value has been very close to the Band 1 (higher than exp) and Band 2 (as expected), boundary. The Trust currently sits in the 'as expected' band.	The Trust has a monthly Safe & Sound Mortality Group meeting and all Divisions within the Trust now hold regular mortality meetings, which feed into this overall Trust Group. This Group in turn reports to the Clinical Governance Committee, chaired by the Executive Medical Director. The Trust also has a time-limited Mortality Improvement Group, chaired by the Interim Chief Executive Officer, supported by a Mortality Analytics Group, with a view to driving improvements in the Trust's mortality data. Data (SHMI and HSMR) and incidents are reviewed to help identify trends and areas of concern. A summary of the Trust's performance and mitigating actions taken is shared in Board reports. Mortality data and actions being taken are reported monthly in the Mortality and Learning from Deaths Report to the Board.
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only	To improve the percentage score, the Trust's Consultant-led Specialist Palliative care Team continue to identify and assess all patients receiving palliative care. The

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
	patients receiving care from the team are included in the data.	Trust has also approved additional investment to increase the number of medical and nursing specialists in palliative care.
18. Patient Reported Outcome Measures scores for	The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital.	PROMS are measures recorded pre and postoperatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision.
(i) primary hip replacement surgery	The latest reporting periods vary between the types of surgery performed.	83.3% patients stated they noticed an improvement post-surgery.
(ii) primary knee replacement surgery during the reporting period.	Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement.	100% patients stated they noticed an improvement post-surgery.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 30 days of discharge from the Trust (as per national reporting and benchmarking consistency)	Internal Trust data is used for reporting of re admissions for the performance reports for the Board of Directors, the Divisions, the CSUs and for the Service Line Monitoring (SLMs) reports. The methodology has been matched to the Model Hospital methodology to ensure consistency in benchmarking with other organisations.	The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data. The Transfer of Care Team works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission of Care Home Patients and works with the sector to improve effectiveness. With observations and assessments now being recorded as non-elective admissions, there will be a natural increase in the number of reported readmissions each month. These are reviewed by divisional teams so the true readmissions can be investigated, and appropriate actions taken.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's performance is drawn from reviewing the position achieved, against the eight sections and the 43 questions asked in the CQC national Inpatient Survey. The survey is mandatory and undertaken annually, the most recent data is from the survey conducted with patients who had an overnight stay in the Trust in November 2020. Full results are available later in this report.	The CQC published the 2020 patient survey results in September 2021. Once received, the Trust has considered the results and identified the areas where improvement is required. Each bed-holding Division has also undertaken a review of their own area's performance and drafted their local action plans accordingly. The Trust's Patient Experience Group monitors the progress of the Division's individual actions each month, alongside the Trust wide improvement plan. Separately the use of an audit tool termed Tendable, has

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
		been employed to capture regular reviews using the same question set with current inpatients. Any weaknesses identified in the monthly audits receives focussed support; be that with staff, as an educational need or a change in ward routines etc. As an organisation, we aim to deliver all of the actions in their entirety by August 2022 and to be able to demonstrate that changes in practice have been fully adopted and embedded in to our everyday work.
21. 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.	Department of Health conduct an annual independent survey of staff opinion.	52% of colleagues would recommend the Trust as a provider of care to their family or friends, as detailed in the National Staff Survey
21.1 - Friends and Family Test (FFT) - embedding of new questions and process and FFT - improved evidence of learning from feedback, "you said we did" The NHS FFT is designed to be a quick and simple mechanism for patients and other service users of the NHS to give their feedback, which can then be used to identify what is working well, address what did not go as expected and thereby to improve the quality of any aspect of a patient's experience. The national change and required revisions to the	The aim and objective of this change is that anyone using any service should be able to give quick and easy feedback to the provider of that service. The FFT is designed to be a quick and simple mechanism for patients and users of NHS services to give their feedback, which will be in a format that enables the Trust as the provider, to hear what is working well and to focus upon all areas for attention that will improve the quality of an aspect of the patient's experience.	Examples of learning from patient experience and actions taken as a result of feedback are discussed and recorded as part of Divisional Governance Meetings. This includes the sharing of information and improvements "what's working better". Divisions have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any action required are developed and closely monitored to meet the expectations of their patients' feedback. Following the introduction of the new electronic survey a new report and dashboard

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
FFT are now made up of a single mandatory question, which is then to be followed by at least one open question to enable a free text response, so that users can provide their feedback in the detail they want and in their own words. Within the Trust, and in collaboration with stakeholders, the following questions were agreed. **1.** Overall, how was your experience of our service (mandatory question) **2.** What worked well? **3.** What could we do better?	In the three settings for which we have previously published Trust level response rates (general and acute inpatient, UECC and the second maternity touch point – Labour and Birth), this will no longer be possible because there is now no limit upon how often a patient or service user can give their feedback. Therefore, the numerical data from the 1 April 2020 was not comparable between NHS organisations; this was also a factor in the ending of national reporting on the percentage response rate achieved.	was created which will is used to provide data to the divisions, FFT Steering Group and the Patient Experience Group. The activity and learning will also feature within the Quarterly Patient Experience Report for Clinical Governance Committee and Quality Committee.
23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Data is validated and published by NHS DIGITAL	The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the Clinical Governance Committee.
24. The rate per 100,000 bed days of cases of C.Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period is expected to be confirmed in September 2022	Data is validated and published by NHS DIGITAL	The Trust will continue to monitor rates through Root Cause Analysis (RCA) and audits and report through local clinical governance structures to the Clinical Governance Committee; for further actions to reduce rate of C-difficile see Part 3.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
25. 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.	Data validated and published by NHS Digital (National Reporting and Learning System (NRLS)); latest data is for the period April 2021 to March 2022. This was the latest reporting period where the Trust has submitted its data and it has been validated by the NRLS Team. Number of NRLS reportable incidents occurring in this period was 9404. The percentage of severe harm or death was 0.62%.	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures.

(Source: Trust Information System)

Her Majesty's Coroner's Inquests 2021/22

During the relevant period the Trust received 58 referrals from HM Coroner, compared with 48 referrals from the previous year. These included both confirmed inquests and preliminary investigations. This represents only a slight increase compared with the previous financial year. We have not seen a surge in referrals following the re-opening of the courts after the height of the COVID-19 pandemic and we therefore anticipate we will receive in the region of 4-5 new referrals from HM Coroner each month moving forwards.

HM Coroner heard 39 inquests during the last financial year, 16 of which required attendance by the Trust. External solicitors were instructed to represent the Trust's interests in the latter matters. The majority of the attended inquests were listed for 1-2 days, the exception being a 5 day listing relating to the death of a baby in which there were adverse findings against the Trust in respect of communication failures.

HM Coroner exercised her powers under The Coroners (Investigation) Regulations 2013 to issue reports to the Trust asking for action to be taken to prevent future deaths. These centred around communication failures, disjointed records systems and staff members lack of familiarity with these and prioritisation of patients in AMU. Robust action plans were put in place to address the concerns raised.

There will be a focus in the next financial year on management oversight of inquests at an early stage at divisional level to ensure that key themes can be identified and that there is no delay in lessons being learned.

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2021/22

A summary of the Trust's nine quality priorities for 2021/22 is provided below.

Patient Safety

- Reduce HSMR and improve Learning from Deaths
- Reduction in Falls with harm and increased compliance with Falls Assessments
- Reduction in avoidable Pressure Ulcers

Patient Experience

- Increasing the numbers and contribution of Volunteers in the organisation
- Responding and Learning from The Friends and Family Test Patient Experience Survey
- Engagement with seldom heard groups with the aim of addressing any health inequalities

Clinical Effectiveness

- Triangulation of Learning
- NICE and Policy Compliance
- Research awareness - how does the organisation make research opportunity known to patients, the public and healthcare professionals?

Details of the achievement against these in the year are included below.

Domain: Patient Safety

Title – Reduce HSMR and improve Learning from Deaths

Executive Lead – Executive Medical Director
Operational Lead – Associate Medical Director (AMD) – Mortality & Learning from Deaths

Current position and why is it important?

Whilst this was also a Quality Priority for financial year 2020/21, the Trust remains a Band 1 Trust, with both HSMR and Summary Hospital-level Mortality Indicator (SHMI) remaining persistently high at 118.5 and 118.6 respectively (August 2020 and July 2020 data respectively). Furthermore, insufficient progress was made throughout 2020/21 towards the Trust's Key Performance Indicators (KPI) target of an HSMR of 110 (or less) by the end of Q4.

Although an overarching Mortality Improvement Task & Finish Group is now in place, chaired by the Trust's Interim Chief Executive, it is vitally important that mortality continues to receive a specific focus, that agreed actions to improve the '3 Cs' (Quality of Care; Case Mix; Coding) are completed within agreed timescales, and measurable improvements in outcomes are demonstrated.

The aim and objective(s) (including the measures/metrics)

- The Trust will improve its HSMR and SHMI to be within the accepted normal range, aiming for a target of 110 or less.
- The Trust will improve its Learning from Deaths by:

    - ensuring that regular, multi-disciplinary timetabled Structured Judgement Review (SJRs) take place within each relevant Division (medicine; surgery; family health; community; and Urgent and Emergency Care Centre (UECC) within 2 months of death, with appropriate monitoring of compliance via the Trust's new mortality dashboard and Safe & Sound Mortality Group. The outcomes of all respective divisional SJR's will be timetabled for presentation at the relevant Divisional Safe & Sound Mortality Sub-Group meeting (medicine; surgery) and/or Divisional Governance meetings (family health; Urgent and Community Care Centre (UECC); community), with agreement of any problems in care as outlined within the Standard Operation Procedure (SOP). Assurance will be provided to the Trust's Safe & Sound Mortality Group and Clinical Governance Committee via monthly submission of minutes.

    - ensuring and evidencing that the learning from the Trust's Stage 1 and Stage 2 mortality reviews is widely cascaded throughout the organisation, via a new fortnightly mortality bulletin, 'Mortality Matters' (alternating between a Medical Examiner (ME) bulletin and a case-example Learning from Deaths bulletin) - by Q1.

    - the creation (and appointment to) of a new AMD – Mortality & Learning from Deaths role, supported by the Clinical Effectiveness Department - by Q1.

    - ensuring that the Divisions of Surgery and Medicine have regular, separate mortality meetings ("Safe & Sound Mortality Sub-Groups"), the agendas for which mirror the Trust's overall Safe & Sound Mortality Group – by Q1.

    - full recruitment to the ME Service (2 MEs; Medical Examiner Office (MEOs) and administrative support) – by Q1.

    - the creation of a new Learning from Deaths Manager (subject to relevant Business Case approval) to work within the Clinical Effectiveness Department, supported by the new AMD – Mortality & Learning from Deaths – by Q2.

- The Trust will continue to focus on 3 key areas to improve quality of care, identified through recurrent mortality alerts:

- Sepsis:

    - Early and improved recognition of Sepsis – we aim to achieve 100%. However, we set a realistic goal of over 90% in the short term. Our recent audit showed we

are recognising them as infection (uncomplicated sepsis) but not using the word possible Severe Sepsis or red flag sepsis.
    - Timely application of Sepsis 6 tool and compliance with the Sepsis tool – Our recent audit showed we use the term sepsis in only 39% (22/56) of the cases but treated 100% (56/56) cases with antibiotics, of which 86% received antibiotics within an hour from the doctors' review.
    - We continue to improve both of the above figures by promoting and disseminating knowledge on Sepsis among our workforce by introducing a Sepsis mandatory training package.

- Community-acquired Pneumonia (CAP):

    - Ensure that the Trust's newly reintroduced CAP care bundle, including calculation of the national CAP CURB65 risk-stratification tool, is imbedded within the organisation, supported by regular communication and education - achieve utilisation in 25% of all cases by end of Q1; 50% by end of Q2; 75% by end Q3; and 95% of all cases by end of Q4.

- Improve End of Life Recognition and proactive implementation of appropriate ceilings of care:

    - Introduce palliative care training/End of Life training to all relevant medical staff with compliance of 25% by end of Q3; 50% by end of Q4.
    - Introduce Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documentation to organisation by end of Q2.

What did we achieve?

HSMR and SHMI to be within the accepted normal range, aiming for a target of 110 or less:

The Trust achieved its target. The Trust's values for the HSMR and SHMI data releases in March 2022 were 107.0 and 107.7 respectively. Both were within the expected range/band.

Whilst there is debate and to how much these metrics reflect quality of care, when broken down, they do highlight areas where the Trust needs to investigate and determine if there are opportunities for improvement in care or improvements in the capture and coding of clinical data.

The Mortality Improvement Group (MIG) chaired by the Interim Chief Executive Officer (CEO) and Executive Medical Director, has continued to meet and work through its action plan. The actions are now part of the standard business of the Mortality Safe & Sound Group, enabling the MIG to meet less frequently. It is expected this group will stand down after the first quarter of 2022/23.

Clinical coding have implemented a number of measures to improve the clinical recording of diagnoses and procedures. This enables the Trust's coding to accurately reflect the case-mix and clinical activity of its inpatient admissions. This includes a work programme with 3M Analytics to enhance the recording of co-morbidities.

Mortality figures are reported to the Quality Committee, the Clinical Effectiveness Committee and present in the Trust's Board Report.

How was progress monitored and reported?

HSMR and SHMI to be within the accepted normal range, aiming for a target of 110 or less:

The Trust regularly reviews the monthly releases of its HSMR and SHMI data. This is reviewed at the Safe & Sound Mortality Group meetings and at the Trust's Mortality Analytical Group. Both groups contain Clinical and Health Informatics representatives as well as representation from Dr Foster. The focus is on making sure areas which are highlighted as potential areas of concern are investigated. The Trust's process for these investigations is in place and monitored. This involves a trend analysis review, a coding review and the completion of SJRs for selected deaths, together with a summary.

Mortality figures are reported to the Quality Committee, the Clinical Effectiveness Committee and presented in the Trust's Board Report.

What further actions need to be undertaken?

HSMR and SHMI to be within the accepted normal range, aiming for a target of 110 or less:

- The continuation of review and analysis of Mortality Indicator information.
- The continuation of the investigations when mortality indicator data highlights an area of potential concern.
- Continue to commence new Patient Safety and Clinical Effectiveness Measure, which may reduce any avoidable deaths
- Develop and improve the trusts Learning from Deaths Programme.

What did we achieve?

Improving the Trusts Learning from Deaths Programme:

During 2021/22 the Trust appointed a new Assistant Medical Director with responsibility for Mortality and Learning from Deaths. The Trust also appointed to the new role of Learning from Deaths and Mortality Manager. Improvements have been seen in the programme, which will continue in 2022/23.

Structured Judgment Reviews (SJRs) are being completed by the divisions. 176 were completed of the 1100 adult inpatient deaths in 2021. This represents 16% and is in line which the % suggested by NHS Improvement & England Mortality/Learning from Deaths Leads.

Governance processes are being observed to ensure SJRs that had an overall care score of poor or very poor, or judged to have been likely avoidable (more than 50%) are now reviewed by the Divisional Safe & Sound Mortality Group and presented to the trust's Safe & Sound Mortality Group. These are considered for escalation by the Serious Incident Panel. This small number of SJRs are now brought in the open, reported and presented to the correct groups within the Trust.

There have been regular monthly meeting of the Divisional Safe & Sound Mortality Sub-Group for Medicine and Surgery. Reviews of inpatient deaths are presented at these meeting. The clinicians are not using SJRs to present the reviews, instead using local

formats to highlight potential problem in care and leading discussions for improvements. Outcomes from these discussed are taken to the Trust wide meeting.

Families Services continue to meet monthly and present to the Trust Safe & Sound Mortality Group meeting. Neonatal, stillbirth and maternal deaths continue to be reviewed in line with Child Death Statutory Guidance, Perinatal Mortality Review Tool (PMRT) and MBRACE recommendations. Child Deaths continue to follow the Child Death Overview (CDOP) review process. A Clinician in Family Services has attended SJR training, to be able to lead on the SJR process for deaths in the Gynaecology Service.

The Urgent and Emergency Care Service (UECC) review all deaths within the service. The UECC Mortality Lead now has access to inpatients deaths that occurred within 24 hours of discharge from UECC. These are now considered for a UECC review. These deaths together with any learning/actions are presented at the Trust Safe & Sound Mortality Group.

The Trust's Community Mortality lead continues to present service deaths to the Trust Safe & Sound Mortality Group. Issues around the earlier recognition of Palliative Care and some inappropriate inpatients admission for End of Life patients have been raised.

The Mortality Matters Newsletter have been published monthly, with contributions from the Divisions, Clinical Coding, the Learning from Deaths and Mortality Manager and the Medical Examiner Service.

How was progress monitored and reported?

Improving the Trusts Learning from Deaths Programme:

Progress was monitored and updates provided through the Trust Safe & Sound Mortality Group, the Deteriorating Patient and Sepsis Group and the Mortality Improvement Group, with ultimately responsibility through the Clinical Governance Committee.

A 360 Assurance completed a re-audit report in Jan 2022, to determine if the Trust has implemented actions resulting from the 2020 audit regarding the effectiveness of Governance relating to Learning from Deaths. There were 9 risks found, 2 deemed to be high risk, 3 medium and 4 low. Actions to remedy these risks have been agreed to be completed in 2022.

A monthly highlight report is submitted to the Trust Quality Committee and bi-monthly to Trust Board. The report relates to delivery of the Operational Plan 2021/22 Priorities and in this case – Mortality and summarises progress made against the milestones and performance targets.

What further actions need to be undertaken?

Improving the Trusts Learning from Deaths Programme:

Structure Judgment Reviews (SJRs) are being completed within the Trust, 16% of Adult inpatient deaths in 2021. However only the Phases of Care Score are routinely being completed, with very little free text detail to support the score and provide detail of any good or bad care. Clinicians are choosing to add this crucial detail in local formats, whilst this enables discussion, this does not allow this information to be used for analysis and the identification of themes or trends.

The Trust are confident that its current SJR format will identify clear problems in care for the individual death being reviewed. However the Trust is not confident that its completed SJRs can be used to identify themes and trends and drive wider learning within the Trust.

The Trust target of completing SJR within 2 months of the death has not been achieved. This is in part due to Medical Examiner (ME) Scrutinies not being completed in a timely manner and a lack of monitoring of SJR completion. Some SJR requests, such as those that are identified through Dr Foster Mortality Benchmarking data, will always be issued several months after the death.

In November 2021, the Trust approached NHS England/Improvement Mortality Leads and asked them to take part in their Better Tomorrow Improvement Plan for Learning from Deaths. This will involve training Rotherham's clinicians to complete good quality SJRs using their SJR+ system. SJR+ system also has an analytics function for theme/trend analysis. This work programme scheduled to start in May 2022. The Trust is fully committed to this programme and the improvements it will bring.

During January 2022, 360 Assurance completed a re-audit of the Trusts Governance structure and processes for the Learning from Death programme. Whilst the re-audit recognised improvements since the original 2021 audit, it has identified areas for improvement. These include having standardised reporting form the Divisional Safe & Sound Mortality Sub-Group. An action plan has been developed, with completion dates set between May 2022 and September 2022.

Full recruitment to the Medical Examiner Service has not been achieved. This is in part due to unforeseen and unavoidable absences within the service. Further recruitments are expected in the first few months of 2022/23.

<u>Sepsis:</u>

The Sepsis Improvement Group continues to work with health informatics to further develop the Sepsis dashboard. Until the dashboard is fully developed the percentage of early and improved recognition of sepsis (uncomplicated, severe or red flag) will not be available. A further clinical audit will need to be undertaken to benchmark results against the audit carried out last year.

The development of the dashboard will continue into 2022/23 and additional resources will need to be secured to complete its development.

The percentage of patients scoring a NEWS of 5 in UECC that had a sepsis bundle document created in Meditech has been between 40-60% for the latter half of 2021/22. This data can be built into the Sepsis dashboard development. There is currently no data available to confirm if patients received antibiotics within an hour of medical review as it is not possible to systematically determine the timeliness of the application of the sepsis tool. A further audit would need to be undertaken to benchmark the metrics against last year's audit.

<u>Community-acquired Pneumonia (CAP):</u>

CURB65 figures have not been available to the Trust, consistently throughout the year. Therefore, monitoring of this target has not been possible A new CURB65 reporting model

is being worked on by Health Informatics, which will allow the performance monitoring of this target.

Improve End of Life Recognition and proactive implementation of appropriate ceilings of care:

In 2021/22 there was not sufficient medical capacity to undertake Palliative Care/End of Life training.

An implementation plan for the introduction of ReSPECT documentation was not agreed in 2021/22.

Title - Reduction in Falls with harm and increased compliance with Falls Assessments

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

The Trust is committed to ensuring that patients have a safe environment free from avoidable slips, trips and falls and the associated harm. Slips, trips and falls continues to be the second highest reported incident for the Trust with repeated lapses in care being evident. As such, the required learning needs to be addressed and embedded into practice to improve the safety and quality of care for service users and the environment for patients.

The aim and objective(s) (including the measures/metrics)

What did we achieve?

The Trust has seen an overall reduction in the total number of falls per 1000 occupied bed days throughout 2021/22, and continued improvements in the number of falls resulting in moderate or above harm.

The Quality Improvement matron has worked alongside the patient safety team and medical lead for falls to implement a number of activities. This has included:

- Re-embedding of falls champions
- Falls competencies
- In patient falls leaflets
- Re-establishment of the falls group
- Improvements within the falls dashboard
- Equipment review and ensuring all inpatient areas have correct falls equipment
- Visible aids to identify patients who are at risk of falling
- Changes within Meditech
- Review of Datix reporting
- Medical engagement for falls reviews
- Tendable (Perfect Ward) audits
- EPIQ weeks on inpatient ward areas
- Falls policy

- National falls audit completion
- Estates review to ensure all handrails, floors, lighting and shower/ toilet facilities were in line with national requirements
- Noise assessments
- Falls risk care planning

The total number of falls is currently 7.58/1000bed days, which is currently just above the national average of 6.8/1000 bed days. However, the numbers of falls causing moderate of above harm is currently 0.16/1000 bed days, which is under the national average of 0.19/1000 bed days.

How was progress monitored and reported?

The Trust has now moved to the national requirement of reporting falls in per one thousand bed days. This is then reviewed against national average to determine areas of improvement and further actions required.

Tendable is a digital audit tool that assesses if areas are meeting quality standards by asking a series of questions. Tendable audit results are used as performance indicators throughout the Trust, in all live areas. From these results, themes and trends of good and sub-optimal performance across various subject areas can be identified. From this, identified areas of concern have been addressed through EPIQ (Enhancing Patient Care through Improvements in Quality) weeks.

Tendable is used as a tool for measuring progress and improvements in areas particularly during the EPIQ weeks. At the start of each week, a baseline audit is carried out by a member of staff, ideally one who does not belong to the area to ensure objectivity of the results. The audit report is reviewed with a view to identifying areas of concern and to highlight areas of good and acceptable practice.

What further actions need to be undertaken?

- Create a medical model for pre and post falls care.
- Continue with engagement with consultant falls lead.
- Implement medical assessment on Meditech.
- Create a post fall protocol where clinicians support the decisions.
- Discharge summary with falls risk sending referrals to primary settings.
- Implementation of residual falls risk factors.
- Identifying high risk patients, slipper socks colour changes to identify patients at risk- Red for all patients, yellow for patients identified as at risk from fall.
- Bed board information
- Sufficient identified falls champions in each area.
- Study day for falls champions.
- Available falls prevention equipment and storage facilities.
- Proportion of low height beds and floor mats, rail bumpers.
- Continue to work with therapy service for collaborative working.

Title - Reduction in avoidable Pressure Ulcers

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Pressure ulcers cause patients considerable pain and distress, increase the length of stay in hospital and increase the risk of complications (NHSI 2019).

The NHS spends £3.8 million on treating pressure ulcers every day (NHSI 2019).

In 2017-2018 litigation involving pressure ulcers cost the NHS £72.4 million.

December 2019 - December 2020 Community

54% of patient's community acquired deep pressure ulcers had lapses in care.

23.43% of community acquired pressure ulcers had lapses in care.

There have been 4 Serious Incidents (SI's) related to pressure ulceration.

Hospital

78% of patients with hospital acquired deep pressure ulcers had lapses in care.

63.16% of category 2 hospital acquired pressure ulcers had lapses in care.

50% of all deep pressure ulcers are related to the heels. There has been 1 SI related to pressure ulceration.

The aim and objective(s) (including the measures/metrics)

What did we achieve?

- Quality improvement projects now commenced in ward areas.
- Elements of Meditech now amended.
- Monthly data is published via the dashboard.
- Standards of care highlight report is now presented monthly to Quality Committee.

The number of confirmed deep pressure ulcers occurring under the Trust's care has shown a 35% reduction overall, however this is predominantly in the community area.

There has been a 54% reduction in deep pressure ulcers in the Trust.

How was progress monitored and reported?

- Monthly reporting from Root Cause Analysis (RCA) panels.
- Monthly reporting on Quality scorecard.

- Tendable (Perfect ward) audit.
- Monthly reporting via the Quality Priorities meeting
- Quarterly reporting to Clinical Governance Committee and Quality Committee

What further actions need to be undertaken?

There continues to be a national requirement for standardised Pressure Ulcer reporting which the Chief Nursing Officer for England has highlighted within her report. The Trust will continue to report on instances of all pressure ulcers, however there will be a move to report per 1000 bed days in line with the majority of all patient safety incidents.

There will be a Tissue Viability summit in May 2022 which will aim to review the current Trust position, key challenges and a programme of improvement that will be led by the Quality Improvement Matron and Tissue Viability Lead Nurse.

Domain: Patient Experience

Title - Increasing the numbers and contribution of Volunteers in the organisation

Executive Lead – Chief Nurse
Operational Lead – Head of Patient Experience

Current position and why is it important?

Volunteers are widely recognised as an enabler to promote healthy communities, as well as the improvement of healthcare services. Currently the Trust is passionate about maximising the potential of volunteers within the Trust, making sure that we make the most of their talents, offer of their time and that this is borne of a true commitment to help their local community and hospital. As a Trust we are doing all that we can to bring this generous offer of volunteering into our organisation.

We want to see more volunteers being placed across a wider range of wards and departments within our hospital and the community services, and to have the appropriate volunteer service infrastructure to support this. We want to become an inspirational Trust for NHS volunteering and for our patients and staff to recognise that wherever there are volunteers we are then able to provide an enhanced service.

We make a firm commitment to new and existing volunteers and as to what we will do to enhance and grow the volunteering opportunities. We aim to:

- Promote interesting and diverse volunteering opportunities.
- To engage and retain our volunteers.
- Ensure that there are clear standards of best practice and consistency in supporting volunteers.
- Respond to emerging trends and issues in the volunteer sector.
- Recognise and celebrate all volunteer contributions to this Trust.

The aim and objectives including the measures/metrics

We want to see more volunteers across a wider range of services within our hospital and community services. We want to have the necessary infrastructure to enable and support

the volunteers to realise their potential here and enjoy every placement they accept within this Trust. We want to become an inspiration for NHS volunteering and for our patients and the staff to know that wherever there are volunteers placed then we are providing an enhanced service with their input.

The volunteer service has been awarded 'Kitemark Plus Award' status, after 'Voluntary Action Rotherham' praised and championed the way the Trust's service is co-ordinated and managed, especially by ensuring that all volunteers have a rewarding experience here.

Many of our volunteers have been with the Trust for over 5 years, with several in excess of 15 years' service and they work from 4 to 12 hours each per week, often accepting 2 or 3 placements across our hospital sites; including Breathing Space, Park Rehabilitation Centre and the Community Hospital.

New volunteering opportunities are regularly being developed within our services. These are to support patents and staff in a variety of settings across the Trust, performing a range of roles including within Pharmacy, the Patients' Library, for ward support, in Chaplaincy and in Gardening. The vision for volunteers at our hospital and within the community is to have:

- An inclusive, comprehensive and flexible system of volunteering that encourages, enables and supports individuals, groups and other organisations to contribute to volunteer activity in the Trust.
- A fully integrated team of volunteers who contribute to the services we provide, who are drawn from the diverse population that we serve, who feel valued, recognised and find their volunteer experience to be personally rewarding.
- To further develop and champion a voluntary service that offers a wide range of benefits to patients, their families and friends, to staff and of course to our volunteers themselves.

The volunteers complement and enhance the services provided by Trust staff and can thereby improve the experience of all patients. Through our approach to volunteering we will increase the wider involvement of, and contribution to, our local communities.

<u>What did we achieve?</u>

Once COVID-19 pandemic restrictions were lifted volunteers began to return. New roles have been developed, and a recruitment drive undertaken which has seen a significant increase in new recruits from a broader age range and backgrounds.

Work is also ongoing with the Communications team to update the website and advertise vacancy's on social media. New uniforms have been purchased and promotional materials are also being sourced.

All volunteers are supported to have the best experience with one to ones offered to help shape growth and development, with changes in roles offered to enable volunteers to find the right role for them. To enable recruitment of a broader age range the Volunteer commitment of 12 month has been reduced to 3 months.

How was progress monitored and reported?

Progress was monitored and updates provided regularly through the Patient Experience Group and Patient Experience quarterly report.

What further actions need to be undertaken?

We will continue to develop new volunteering opportunities and recruitment. We will also support and encourage the remaining Volunteers who are still on a break to return.

Domain: Patient Experience

Title - Friends and Family Test (FFT) - embedding of new questions and process and FFT - improved evidence of learning from feedback, "you said we did"

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

The NHS FFT is designed to be a quick and simple mechanism for patients and other service users of the NHS to give their feedback, which can then be used to identify what is working well, address what did not go as expected and thereby to improve the quality of any aspect of a patient's experience.

The national change and required revisions to the FFT will now be made up of a single mandatory question, which is then to be followed by at least one open question to enable a free text response, so that users can provide their feedback in the detail they want and in their own words. Within the Trust, and in collaboration with stakeholders, the following questions have been agreed.

- Overall, how was your experience of our service (mandatory question)
- What worked well?
- What could we do better?

The aim and objective(s) (including the measures/metrics)

The aim and objective of this change is that anyone using any service should be able to give quick and easy feedback to the provider of that service. The FFT is designed to be a quick and simple mechanism for patients and users of NHS services to give their feedback, which will be in a format that enables the Trust as the provider, to hear what is working well and to focus upon all areas for attention that will improve the quality of an aspect of the patient's experience.

In the three settings for which we have previously published Trust level response rates (general and acute inpatient, UECC and the second maternity touch point – Labour and Birth), this will no longer be possible because there is now no limit upon how often a patient or service user can give their feedback. We will therefore no longer calculate or publish a 'response rate'. We will however continue to collect and submit the same data items and will continue to publish the number of responses received in the context of the size of the service concerned, so that an under representation of users can be identified from the

feedback received. It is intended that this will provide Trust teams with an indication on how well FFT is being promoted and taken up, and for Commissioners and Regulators it will give a sense of how effectively the FFT is being implemented by each provider.

From the inception of the FFT there has been a target of a 40% participation rate to be achieved, therefore Trust Boards and Commissioners have been previously focused on the number of responses collected and from this the percentage of positive or negative responses received. However, for the future this will change as it does not align with the revised guidance which commenced on the 1 April 2020. Henceforth, NHS England and NHSI stress that the most important element of the FFT, is encouraging the free text feedback, what responsive actions have occurred from this, and how Trusts are also identifying good practice and all opportunities to improve their services.

The numerical data from the 1 April 2020 will not therefore be comparable between NHS organisations; this was also a factor in the ending of national reporting on the percentage response rate achieved. Therefore, NHS England and NHSI are now considering producing an example of what a Board or Commissioner report on the FFT results might look like for the future. This will give each Trust a clear indication of the expectations of how the data is used and may provide a template for a standard Board or Commissioner report, to also help to steer their conversations away from focusing solely upon the 'numbers' and towards making the most use of the free text feedback received.

What did we achieve?

FFT was re-launched in December 2020. NHS England did not specify how to collect the responses, but the Trust chose to continue with the paper survey but also introduced an online survey via the Trust website or via a mobile phone QR code. The survey is now well established is all areas within the Trust and community setting. Posters and business cards are also provided to all in-patients and out-patients and the QR code has also been added to clinic letters.

How was progress monitored and reported?

Progress is monitored and updates provided regularly through the FFT Steering Group, Patient Experience Group and Patient Experience quarterly report. Quarterly equality reports are also produced which enables the Trust to identify respondent demographics.

The data is also available on the hub and is directly shared with all divisions, Power BI software has also been implemented to allow coherent and visually immersive and interactive insight if the FFT data.

Divisions provide examples of learning on a monthly basis through the FFT steering group and the sharing of learning and good practice are discussed at Divisional level. The Quality Nursing Information boards have been installed in all in-patient wards to provide visual evidence.

What further actions need to be undertaken?

The development of a new web page is currently in progress.

The monitoring of data will continue, and improvements made were identified.

<u>Title</u> - Engagement with seldom heard groups with the aim of addressing any health inequalities

Executive Lead – Chief Nurse
Operational Lead – The Engagement and Inclusion Lead

<u>Current position and why is it important?</u>

Co-production and inclusion is central to the successful delivery of high quality services to meet the needs of all patients.

Services are generally well-designed to meet the needs of people with protected characteristics; engagement with the LGBT+ community in March 2022 found our Trust to be trusted and responsive to this group's needs, FFT feedback obtained is very positive, however when undertaking engagement within communities in their own space it is clear that more could be done to improve care for certain groups such as the Muslim, Roma, Deaf and socio-economically deprived communities. This has prompted some key changes in staff training and patient information provision. Other areas for improvement is signage and wayfinding at the Trust, particularly for disabled visitors, as multiple engagement activities have shown, as well as improving our communication.

Deprivation in Rotherham has increased, with Rotherham now (2019) ranked as the 44th most deprived district compared to 52nd in 2015 (IMD).
40% of Rotherham are amongst the 20% most deprived of the UK.
57,560 Rotherham residents (22%) live in areas within the most deprived 10% of England.
36,530 residents (14%) live in the most deprived 5% of England in the neighbourhoods of Eastwood, East Herringthorpe, Ferham/Masbrough, Canklow, SE Maltby and parts of East Dene.
12,667 children in Rotherham were living in "absolute poverty" in 2018/19.
Differences in life expectancy in Rotherham compared to the rest of England remain stark:

Indicator	Period	Rotherham			Region	England		England	
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Infant mortality rate	2017 - 19	–	38	4.3	4.2	3.9	7.5		2.0
Life expectancy at 65 (Male)	2017 - 19	–	-	17.9	18.4	19.0	16.4		23.2
Life expectancy at 65 (Female)	2017 - 19	–	-	20.3	20.7	21.3	18.8		24.9
Healthy life expectancy at 65 (Male)	2017 - 19	–	-	8.4	9.9	10.6	6.1		16.0
Healthy life expectancy at 65 (Female)	2017 - 19	–	-	9.2	10.7	11.1	5.2		16.7
Life expectancy at birth (Male)	2017 - 19	–	-	77.9	78.8	79.8	74.4		84.9
Life expectancy at birth (Female)	2017 - 19	–	-	81.7	82.5	83.4	79.5		87.2
Healthy life expectancy at birth (Male)	2017 - 19	–	-	58.3	61.2	63.2	53.7		71.5
Healthy life expectancy at birth (Female)	2017 - 19	–	-	58.9	61.9	63.5	55.3		71.4
Inequality in life expectancy at birth (Male)	2017 - 19	–	-	8.8	10.4	9.4	14.8		2.9
Inequality in life expectancy at birth (Female)	2017 - 19	–	-	10.4	8.5	7.6	13.3		1.5

These figures are from 2017-2019; before the COVID-19 pandemic and cost of living rises.

It is important that we do not become complacent about inclusion; we need to ensure that all service users receive a fair and equitable service, taking into consideration their views and ensuring assessments are made to ensure no discriminatory practice occurs, and that indeed, we are addressing health inequalities by providing additional support to people at risk of poorer health outcomes. This will help us:

- Contribute towards improving the health of the Rotherham population
- Reduce 'Did not attends' and increase use of the right service first
- Increase community confidence in services
- Deliver an equitable service

The aim and objective(s) (including the measures/metrics)

Reduce local health inequalities through the delivery of the following:

- Set up a diverse Public Panel so that the Trust's teams can work with the group, as a sounding board on patient information and service provision.

  Measurement: regular contact with the Public Panel and evidence that they have a significant voice feeding into a variety of work streams across the Trust.

- Work with people whose preferred language is not English or are non-English speaking, to improve cultural sensitivity and translation services provided at the Trust.

  Measurement: Public satisfaction in subsequent engagement activities with this group. Increased use of real time and printed translation services, particularly in information provision.

What did we achieve?

Public Panel

- Regular monthly meetings have now been scheduled for the year and is being promoted widely. Public panel reports into Patient Experience Group and into the relevant divisional groups/work streams as lead by topics and discussions. The Web page https://www.therotherhamft.nhs.uk/Get_Involved/Public_Panel/ for Public Panel will display minutes and action taken from feedback.

  The Public Panel:
  - Shaped the Trust's 5 Year Strategy.
  - Reviews Trust Patient Information submitted to the Patient Information Group on a monthly basis.
  - Shapes work throughout the Trust e.g. the new bedside information folders, research design etc.

Supporting other patient or public panels to be set up or optimised:

- August 2021 - The Children's and Young People's Service is being supported to plan their own Patient and parent engagement activities, as well as planning training for staff on engagement, including engagement with seldom heard communities.
- September 2021 – Community division expressed an interest in setting up their own Patient Participation Group and will be assisted in ensuring seldom-heard groups are facilitated to be included in the offer.
- September 2021 - An Orthopaedic Planned Care Citizen's Panel has been formed looking to meet any unmet needs of people waiting extended amounts of time for orthopaedic surgery and shape how we keep people on waiting lists informed.
- November 2021 - A long-COVID patient engagement group is being planned.
- November 2021 - Rotherham Sexual Health Service is being supported to get

engagement via Facebook on research they are designing.

Migrants:

- Engagement and Inclusion Lead contributed towards the Yorkshire and the North East Migrant Health Group's 'Migrant Health Strategy' for the region.
- Individual departments such as Rotherham Sexual Health Service and Endoscopy, are planning how they will engage with seldom-heard communities, to ensure their needs are being met.
- Joint working with Healthwatch Rotherham and HARP (Health Access for Refugees) has ensured pre-operative Covid-19 swabbing was accessible to them via a bespoke pathway.
- July 2021 - Migrant Health section in development with resources for staff on the Equality, Diversity and Inclusion Hub page.
- TB specialist nurse engaging with migrants on use of a TB patient information app.
- The Red Cross has been invited to present at a Lunchtime Lecture and re. updating phrasebooks on wards.
- The Trust is working with Gateway surgery to ensure service provision at the Trust meets the needs of migrants, discuss joint event/information gathering.

May 2021 - Chaand Raat event:

- Feedback about getting interpreters included members of the Muslim population expressing that this was available but not always encouraged.
- Reports of decreased communication if they are wearing traditional Pakistani dress – information incorporated into Privilege training, spoken about at engagement training on reciprocal mentoring.

Communication, interpretation and translation services Hub page:

- Hub page created with details of booking interpreters and how to get information in other formats following engagement insights.
- Pre-existing translated resources being collated on this page.
- Reports on use to be generated and displayed, as well as being presented at meetings

Accessible Information Standard (AIS):

- July 2021 – The Trust's electronic patient record systems have been updated to better record patient communication needs.
- November 2021 – Staff feedback passed onto health informatics to make amends to the template for usability.
- December 2021 – Heard new AIS changes planned for 2022
- March 2022 – Engagement and Inclusion Lead meeting with Primary Care re. information on referrals e.g. communication needs.

Translation

- August 2021 - As part of the transfer of translation services to DA Languages messages have been shared amongst Rotherham Ethnic Minority Alliance (BAME) and Deaf communities locally.
- Community desire for input at service specification stage passed onto Deputy Head of Procurement for next translation service procurement.
- Work on resources such as language identification sheets etc. being provided to wards has been requested from the translation service provider. These have not been provided in over a year. Raised with procurement. No answer.

- Discussions re. translation of appointment letters have now taken place with Contact Centre, Obesity Service, 0-19s and Endoscopy
- September 2021 - Activity of translation/interpretation services will now be reported at EDI Steering Group to compare and monitor usage.
- Community dental refining their process for translated information production.
- Encouraged 0-19s service to Datix any translation issues.
- February 2022 – Funding approved for 'Communication Stations' containing resources to support communication. Engagement planned with local BAME communities to shape contents.
- February 2022- Funding approved for inpatient 'Bedside information folders' to be translated into the top 5 languages of Rotherham.

Deaf community

- In April 2020 provision of translation services went out to tender jointly with other local hospital Trusts, including BSL. This required close work with the local community to ensure that this does not lower the standard of service provided. Their needs have been communicated to procurement staff involved in this process.
- Deaf community have agreed that although they were accustomed to checking their interpreter booking with the previous translation provider, that the new process will be shared with community members and that if there are any issues that arise from this perceived change of process, they will make us aware.
- Monthly engagement with community representatives through end of 2020/early 2021 was undertaken.
- Personal Protective Equipment (PPE) to allow lip reading explored; use discussed with infection control and patient safety. No products have the appropriate safety standards. The issue was raised with NHSEI at equality meetings.
- Early clinic appointments implemented in outpatient departments to ensure interpreter booking time not missed
- 15/02/21 Funding approved for 20 screens clear screens; purchased and distributed (£3-4K).
- Poster produced for staff to have a concise source of the options to aid communication with deaf or hard of hearing people.
- Transcribing software approved by Information Governance and downloaded to tablets on the wards
- Video interpretation/consultation deemed suitable for some Deaf people dependent upon the circumstances, but face to face interpretation preferred by most.
- Google Live Transcribe approved by Information Governance for use throughout the Trust for anyone hard of hearing who can read transcribes verbal speech into text on screen. This can be used on tablets supplied to wards and departments through the pandemic, to aid communication as it has been impacted by the use of masks; lip-reading is often used to support many people who are hard of hearing or D/deaf.
- August 2021 – Communication Aids for people who are Deaf poster for staff circulated following engagement
- The Deaf community representative highlighted the poor mental health of the Deaf community as a whole in the current situation; access to services, out of funding for social activities, reduced benefits and higher cost of living has left members of the Deaf community feeling suicidal and they have already lost community members to suicide recently. The Engagement and Inclusion Lead has partnered with RDaSH, RMBC, RotherFed, Healthwatch and the Rotherham CCG to escalate the issue and discuss possible solutions.
- January 2022 - Support for community funding from Rotherham CCG was given.

Roma community

- 0-19 Roma Health Practitioners have been linked into strategic groups locally, and have offered an opportunity to engage with this group to look at how to improve health outcomes.
- Discussion re. survey to Roma community via the 0-19 health practitioners; to be discussed at the Trust's Board Level Health Inequalities Task and Finish Group to shape content.
- 0-19 Health Visitors are having appointment letters translated following engagement with patients who speak Slovak.
- December 2021 0-19 Roma Health Practitioners attended Doncaster's Roma health awareness event to research for possible replication in Rotherham. Meeting booked to plan event.

Training/dissemination

- October 2021 - PEIL met with PHE colleagues to help plan engagement with Migrant's regional event. This will pool knowledge on the best ways of engaging with seldom heard communities.
- December 2021 Deaf Awareness training completed in UECC, and booked in regularly via Lunchtime Lectures.
- Preceptorship and Healthcare Support Worker Care certificate training now includes 'Engagement and Inclusion'
- Instructions will be available in Communication Stations on how to book interpreters, as well as Learning Disability and Autism resources.

How was progress monitored and reported?

Progress was monitored and updates provided through the Quality Priority Group, Quarterly Patient Experience Report to Patient Experience Group, reports to the Equality, Diversity and Inclusion Steering Group and information shared with relevant parties for action.

Feedback was given to all members of the public who have contributed letting them know what happened as a result of their engagement with us.

What further actions need to be undertaken?

We could be reassured by our number of complaints being below the national average, but have to remember that this could also be due to a lower than average reading age, health literacy and community assertiveness within Rotherham. Feedback obtained via the national FFT survey methodology is positive with consistently good satisfaction scores, but feedback needs to be compared to the demographics of the people that we see, and completed at an appropriate time and place to ensure limitation of bias. That is why continuation of targeted engagement with seldom heard groups is so important.

- Patient Experience Strategy and Plan to be created taking into account the engagement with seldom heard communities that has been undertaken.
- New Patient and Public Involvement (PPI) strategy to be updated with accompanying action plan on how this will be achieved.
- All proposed service changes/developments need to include an equality impact assessment.

- To create a fully inclusive environment and to support the development of services that meet the needs of our diverse community.
- Promotion of the 'Call it out, Work it out' campaign to report all instances of discriminatory behaviour on Trust premises.
- Improving access to members of the public to contact their hospital Governor for their constituency.
- Increased outreach where we are going to the people that we want to hear from, instead of asking them to contact us or get involved in what we are offering.
- Growing the 'Public Panel', targeting groups that are underrepresented in the current membership.
- Further promotion of the Trust Staff Networks and engagement with these to benefit other staff and patient care.

Domain: Clinical Effectiveness

Title - Triangulation of Learning

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

The Trust is committed to learning and making changes as a result of incidents to improve the safety and quality of health services for service users and the environment for patients, colleagues and visitors. When adverse incidents occur, investigations are undertaken resulting in recommendations to prevent future lapses in care. It is important to ensure that any recommendations are acted upon in a timely manner and shared with colleagues across the Trust to ensure Trust wide learning.

The aim and objective(s) (including the measures/metrics)

To ensure that the organisation responds, learns and improves from the outcomes of adverse incidents, including Complaints, Inquests, Serious Incidents and SJRs.

What did we achieve?

93 members of staff have completed root cause analysis training which evaluated well. Assessment is currently being undertaken to identify any outstanding requirements within Divisions. This will be actioned during Q1.

Significant improvements have been made to reduce the number of overdue Serious Incident reports. At the end of March there were 40 out of date reports. At the end of February the number overdue is 9 and the Patient Safety Team are working with Divisions to address the individual circumstances leading to each delay.

The monthly Organisational Learning Action Forum (OLAF) continues to be well attended.

There is now a centrally managed action plan tracker which has been agreed and is being utilised for all Serious Incidents and Red Incidents. The new template format will be used for all new actions backdated to 1st January 2021.

Emerging themes and trends are already reviewed on a quarterly basis within the Patient Safety Report but this will be reviewed through OLAF and strengthened to provide clearer evidence of learning and impact of actions undertaken. Minutes from future OLAF meetings will be used to provide evidence.

The action tracker is now utilised to provide evidence of themes and trends for incidents across the Trust, and will be utilised to identify any potential quality improvement initiatives.

There is now a central repository for evidence of learning.

Patient Safety Bulletins are now being published weekly via Communications and these are also available on The Hub.

Learning events have been on hold due to COVID-19, other than divisional newsletters. Methods of doing this in a COVID secure way have commenced.

The Quality Improvement presentations within OLAF continue to provide a forum for sharing learning.

Patient Safety Bulletins and 5 in 5 learning communications are now being published weekly via Communications and these are also available on The Hub.

How was progress monitored and reported?

Progress was monitored and updates provided through weekly Divisional meetings with the patient safety team and monthly Divisional performance reports.

There is a monthly patient safety report delivered at the Trust meetings of Patient Safety Group, Clinical Governance Committee, Quality Committee and Trust Board.

There is a Trust action plan tracker that has been implemented which collates, monitors compliance and triangulates all learning from incidents, complaints, concerns and coroners investigations. Thematic analysis is completed through the patient safety team. This will then formulate the strategy for quality improvement initiatives throughout the Trust. Falls, pressure ulcers and medications management has been identified for the Q1 quality improvement plan.

What further actions need to be undertaken?

There will be a focus on ensuring further training for serious incident investigation is provided. This should incorporate the human factors element.

There will be work ongoing to ensure that the Patient Safety Incident Response Framework (PSIRF) is fully embedded within the Trust.

There will be further work to ensure that all incident reports and actions are completed within the appropriate timeframe.

There will be ongoing work through OLAF to ensure the triangulation of learning and ensure key actions are embedded throughout the Trust. All actions from complaints and Coronial Investigations will be implemented on the central action tracker.

Title - NICE and Policy Compliance

Executive Lead – Executive Medical Director and Chief Nurse
Operational Lead – Deputy Medical Director – Professional Standards and Quality Governance, Compliance and Risk Manager

Current position and why is it important?

NICE

To provide assurance regarding compliance by improving the responsiveness of NICE guidelines compliance reviews and the overall compliance/risk registration.

The aim and objective(s) (including the measures/metrics)

NICE

To reduce the number of reviews outstanding by <50% and to have none outstanding for more than 6 months. To reduce the number of actions outstanding for more than 6 months recorded against partial compliance by 30%. Increase the responsiveness to Trust-wide guidelines by ensuring that 100% have a nominated, up to date lead assigned and that there is auditable evidence of escalation for non-engagement, in line with the agreed Trust escalation process.

What did we achieve?

The 30% reduction in the number of actions outstanding for more than 6 months recorded against partial compliance has been achieved. Trust-wide guidelines currently registered as partially compliant all have a nominated lead, with oversight and progress monitored at the monthly Clinical Effectiveness and Research Group meeting. New guidelines are also discussed in this forum and those deemed applicable Trust-wide are allocated a lead for review. Escalations are carried out in line with the process agreed as part of the NICE policy and a date of each escalation is recorded in the NICE database within Clinical Effectiveness. Engagement with Clinical Leads and Clinical Effectiveness Leads regarding awareness of their responsibility and accountability has been carried out via the Clinical Effectiveness and Research Group and the Clinical Governance Committee. The 5 categories to which NICE guidance/guidelines are assigned to in terms of compliance/non-compliance, have been revised and the process for overview and overall agreement strengthened.

How was progress monitored and reported?

Progress has been monitored and reported through the Clinical Effectiveness and Research Group, and via reports to the Clinical Governance Committee and Quality Committee, reviewing achievement against the measures and required actions to be undertaken.

What further actions need to be undertaken?

Further work around responsiveness to guideline reviews is required, to help reduce the number of guideline reviews that go over their return date and to eradicate the number

outstanding over 6 months. This will be monitored closely going forwards via the Clinical Effectiveness and Research Group replacement, with escalations to the Clinical Effectiveness Committee. Options are being explored in respect of a new recording and tracking system for NICE in the Clinical Effectiveness Team, which would go some way to assist with this going forwards.

POLICIES

The 2017 CQC inspection identified a concern around staff working to out of date policies. This was confirmed as an issue as part of the preparation for the 2018, 2019 and 2020 CQC Inspections.

Whilst improvements have been made with the use of a new intranet site where documents can be located easier, there are still 21% of policies which are out of date. There is therefore a risk that staff could be following out of date processes.

The aim and objective(s) (including the measures/metrics)

POLICIES

The Trusts aim is to increase the number of in date policies to 95% (baseline is 79% of policies in date at 31 March 2020). There should also be no policies that are either out of date for more than 3 months and/or have had more than one 6 month approved extension

What did we achieve?

Current position is 96% compliance as of 31 March 2022.

There are currently 17 documents over 3 months out of date. This has reduced from a total of 124 in May 2021.

There has been the implementation of a new process for the oversight of all Trust documents, management of notification to Divisions and tracking through the Document Ratification Group.

How was progress monitored and reported?

Progress has been monitored and reported through the Document Ratification Group, Clinical Governance Committee and Quality Committee.

What further actions need to be undertaken?

Further work is required to ensure that there is clear guidance for policies, guidelines and standard operating procedures. There continues to be work to ensure where possible, the number of documents on the hub are reduced.

Title - Research awareness - how does the organisation make research opportunity known to patients, the public and healthcare professionals?

Executive Lead – Executive Medical Director
Operational Lead - Director of R&D/Lead Research Nurse

Current position and why is it important?

The R&D Department wanted to raise the awareness of the Research studies that are ongoing in the Trust. We are a research active organisation but we felt that patients and staff might be unaware of this.

The aim and objective(s) (including the measures/metrics)

1. The aim is to raise the level of awareness of the staff, patients and public that the Trust actively participates in research – including awareness of "who, where & what" the R&D Department do and publicising the ongoing research studies.
2. To obtain baseline information as to public and staff perceptions on ongoing Research activity within the Trust

What did we achieve?

As part of 'Best Patient Care, Clinical Research and You' NIHR pilot initiative, we have created a research website www.rftclinicalresearch.co.uk. This was launched in December 2021.

This is a staff and public facing website to increase awareness of both the R&D Department and for colleagues/patients/public to get more information about Research Trials happening within the Organisation.

We gathered patient baseline data, around a series of questions about Research within the Trust, via Survey Monkey and approaching people directly.

RESULTS:

Total responses: 100

Online Survey-Monkey responses: 62
Physical responses: 38

Are you aware that clinical research is carried out at The Rotherham NHS Foundation Trust?

Yes: 45
No: 55

Have you ever been offered the opportunity to be involved in research whilst at the Rotherham Hospital HNS Foundation Trust?

Yes: 15
No: 85

Have you ever been offered the opportunity to be involved in research elsewhere?

Yes: 28
No: 72

Have you or a family member ever been involved in a research study?

Yes: 36
No: 64

Do you want to receive information about clinical studies happening at The Rotherham NHS Foundation Trust as part of your care?

Yes: 72
No: 28

Given the right information and support, would you be willing to take part in clinical research if diagnosed with a medical condition?

Yes: 77
No: 8
Unsure: 15

How important is it that The Rotherham NHS Foundation Trust is involved in clinical research?

Very important: 61
Important: 22
Neither important or unimportant: 2
Unimportant: 1
Very unimportant: 14

Demographics: What age and do you fall within?

<21 years: 2
21-24 years: 3
25-34 years: 10
35 – 44 years: 14
45-54 years: 25
55-64 years: 18
>65 years: 28

How was progress monitored and reported? What further actions need to be undertaken?

We will repeat the patient and staff surveys in 2022 after some more publicity around the new website.

3.1.3 Additional information about how we provide care

Friends and Family Test

The survey is now well-established in all areas within the Trust and community setting.

The Trust chose to continue with the paper survey but also introduced an online survey via the Trust Website or via a mobile phone QR code. Posters and business cards (which both include the QR code) have been provided to all in-patient and out-patient areas. The QR code has also been added to clinic letters.

The information and data is available on the hub and is directly shared with all divisions. Power BI soft wear service has also been implemented to allow coherent and visually immersive and interactive insight of FFT data.

Divisions also provide examples of learning on a monthly basis through the FFT Steering Group and Patient Experience Group. This will continue and support is provided by the Head of Patient Experience to encourage and develop and learn from feedback. Sharing examples of learning and good practice are also discussed at Divisional level and Quality Nursing Information/ Patient Experience boards have been installed in all in-patient wards which are regularly updated.

Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and continues to have zero occurrences within inpatient wards, despite additional challenges presented by the pandemic.

In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit (HDU) level 2 care to base wards. The requirement to report this metric externally was paused from March 2020 until September 2021 (inclusive). Following this, there were 10 mixed sex step down breaches reported in January 2022. The cause of this was identified, a new Standard Operating Procedure and escalation process was created and there have been no further breaches reported for the reminder of the year.

There is also an internal process for monitoring and reporting ‘pass by’ breaches of mixed sex accommodation. In 2021/22 there were no reported breaches for pass-by of toilet facilities. When a bed area is reallocated to a different gender, the associated toilet facility and side room are also reallocated. This is monitored at ward and department level. The Trust has recommenced a programme of refurbishment of some wards which will improve toilet facilities which was paused due to the pandemic.

Never Events

The process for identification of a Never Event starts with the incident being identified on Datix. The Datix incident form has a specific section which identifies the list of Never Events which are on the NHSI Never Events policy and framework.

All Datix incidents are checked daily by the Patient Safety Team so any incident reported which has not been identified as a Never Event would be amended by the team.

Any incidents reported as Never Events are also reviewed daily to ensure they meet the criteria. Any incidents incorrectly reported as Never Events are amended and the reporter is informed of the changes.

All Never Event incidents are investigated as Serious Incidents and once these have been identified are presented at the weekly Serious Incident Panel for confirmation with the panel that this does meet the NHSI criteria.

During 2021/22 the Trust has reported two Never Events within the following categories:

- Retained swab post vaginal delivery - 1 event
- Incompatible blood component transfused – 1 event

A robust RCA is carried out for each Never Event and an action plan is created with monitoring through Divisional Governance processes to ensure completion. The Patient Safety newsletter is used to ensure Trust wide sharing of the learning from these incidents to improve the quality of care for patients and prevent future occurrences.

Patient-led assessments of the care environment (PLACE)

NHSE/I took the decision to postpone the formal PLACE data gathering exercise for a second year covering 2021-2022 – this was due to pressures associated with managing the pandemic response. Technical audits continued to be completed by our facilities teams across site to provide assurance of cleanliness outcomes. These results are reported monthly to the IPCD Committee.

The National CQC Patient Experience Surveys for Acute Trusts

During the year 2021- 2022, the CQC sought to re-establish the schedule of Patient Experience sampling, across the four mandatory surveys for acute Trusts. The required surveys are for patients who have attended: as Inpatients, within UECC, used Children and Young People's services, or received Maternity Care from this Trust. For the Maternity Survey this was the first survey conducted for 2 years, as the 2020 survey was completely cancelled having been scheduled early in the pandemic.

All of the four sets of survey findings for each mandated patient experience enquiry, have been reported in the financial year 2021/22.

The first results to be published from this survey cycle, were for the patients who had attended UECC in September 2020. There were 1250 patients approached and 435 patients participated - 35%. The Trust's performance indicated that patients scored the service in line with other Trusts i.e. 'about the same' across 27 indicators; however the patient experience for 11 questions was worse than similar Trusts. The UECC service and leaders along with Executive support, undertook a considerable review of performance in the light of these findings and are now progressing well through a comprehensive work plan to address all of the identified areas for improvement.

The next reported was the Trust's Inpatient feedback results, which were published in October 2021.

The Trust's Inpatient survey results are drawn from the eight aspects of a patient's experience, this was a reduced focus from the 12 sections explored in previous years. This decrease occurred to reflect the high volume of medical and COVID-19 related admissions during the pandemic, for example, sections on the elective care pathway for surgical patients were reduced. The context of this survey still reflects the five key questions which the CQC utilise for all of their NHS Trust assessments. The most recent Inpatient data is from the survey conducted in November 2020. CQC surveyed 1250 of the Trust's patients and 497 responded on their experience –a response rate of 43% of those eligible.

The Trust's findings overall showed that the performance for inpatient experience was 'about the same' as other Trusts for 24 questions, however the performance for 19 questions, were below average and this gave a 2% fall in performance compared to the year before. The CQC uses the term '*about the same'* when reporting these areas, to show that this Trust is average for that particular question and in line with most other Trusts that took part in the survey. Within each of the eight aspects of a patient's experience there are additional sets of questions, which can be further reviewed to see what has led to the final score and any areas of particular note e.g. where this Trust's patients reported a *better or worse* experience than all other Trusts.

The Trust's top five scores were received for the following questions:

- How patients felt about their time on the waiting list before admission.
- Patients being prevented from sleeping at night by hospital lighting.
- Hospital staff explaining how the patient would feel after surgery/a procedure.
- After leaving hospital, getting enough support from health or social care services to help recovery or managing condition.
- Were patients given enough privacy when being examined or treated?

The questions responses which challenged the Trust's performance were:

- In your opinion, were there enough nurses on duty to care for you?
- Were you ever prevented from sleeping at night by noise from other patients?
- Were you able to get a member of staff to help you when you needed attention?
- Did hospital staff explain reasons for changing wards during the night in a way you understood?
- To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?

Overall performance showed that out of the total of 43 questions (previously 62) within the survey, the Trust received below average results in some key areas. However, the analysis and action planning resulting from this survey was also based upon a more longitudinal view of the Trust's performance over the 3 prior years, to determine ongoing areas of weakness or new concerns. This resulted in an action plan, which also considered all the marginal scores and potential areas for Trust-wide improvement across all of the bed-holding Divisions. In turn, each Division was also required to produce their own additional actions, where the particular question was likely to be most influenced with their service. The response for example has varied between medical and surgical patients and within some surgical specialities. The monitoring of the performance against these actions is

undertaken at the Patient Experience Group and within the individual Division's Clinical Governance meetings. The Trust's inpatients who used services in November 2021, have already been surveyed again using predominantly the same question bank; these results will be published in October 2022.

Maternity Care Experience - results from the survey of women who gave birth in February 2021, were published in January 2022. The survey was very detailed with 50 questions in eight sections. The Trust received a good response rate of 50%, with largely very positive feedback from women and families. Again, the survey was a reduced question bank compared to previous years and some COVID-19 restriction-specific questions were added. Praise was given for a number of aspects of maternity care and 31 questions were rated 'somewhat' or 'much better' than peer trusts. There were 19 questions scored as 'about the same' and no negative responses were received i.e. none were 'worse' than other trusts. The service has swiftly focused upon the 'average' performance questions and through their action planning and work plan to date, have already undertaken areas of remedial work with the clear expectation of a higher number of better than average scores this year.

Children and Young People's Inpatient Experience (C&YP) – children and their parents/carers responded in low numbers of just 124 responses, giving a 22% participation rate. This was quite a long survey with sections for parents of under 8 year old, and surveys for children and young people in two age groups of 8 – 11 years and those 12 – 15 years. The results showed that two questions received a 'better' than average response, 54 questions were 'about the same' as other Trusts and six questions were worse than the average. The service immediately reviewed their position against peer Trusts and their own past performance. Local action planning was in place swiftly and good progress is being reported.

The timetable for the four national CQC surveys is now as follows:

UECC – a biennial survey: patients who received care in September 2020 were surveyed on their experiences and the results were published in September 2021. The next survey will be conducted with UECC patients from September 2022 and published in September 2023.

Children and Young People – a biennial survey: the young people and parents of children who used Trust inpatient services in December - January 2021, were surveyed on their experiences three months later. The findings were published in November 2021. The longer recruitment period reflected lower levels of inpatient activity in the pandemic. The next survey will be conducted with patients from December 2022 – January 2023, no date for publication is available yet.

Maternity – an annual survey: the women who gave birth in February 2021 were surveyed last summer and the results published in January 2022. The women who used services this February 2022, will be surveyed shortly and the results published in January 2023.

Inpatients – an annual survey: the patients who received Trust care in November 2021 are currently being surveyed on their experience and the findings will be published in October 2022.

Findings from all of these surveys are triangulated against other sources of patient feedback including patient's giving compliments, raising concerns or complaints, data from the Friends and Family Test (FFT), feedback from local and national advocacy services,

healthcare experience websites and social media. Detailed action plans are created following each national publication, primarily created by the Divisional leadership and staff teams and delivering by the named service. However, for the much wider ranging Inpatient's survey, a separate Trust-wide action plan is also produced from the Divisional contributions and broader awareness of the issues. A central oversight is then applied to track realisation, by measuring regular and consistent progress and sampling current experience from our patients each month through the Tendable audit work.

For all of the four surveys, each service is monitored between monthly and quarterly, depending upon progress and the range of actions still to be achieved, through the Patient Experience Group. A summary of the above findings and work streams underway is included in the quarterly Patient Experience Report, which is shared with the monthly Clinical Governance Committee and the Quality Committee.

Healthcare Associated Infections

The Chief Nurse is the Director of Infection Prevention and Control (DIPC) and published the annual infection prevention and control report in June 2021.

Throughout the year detailed updates on the incidence of healthcare associated infections have been provided to the Infection Prevention and Control and Decontamination Committee which reports to the Quality Committee.

The substantive consultant microbiologist left the Trust in July 2019; Locum Consultant Microbiologists have, alongside the Associate Specialist in Microbiology, covered the role since until a new member of the team, a consultant clinical scientist joined the associate specialist to cover the Trust. There are two posts advertised for substantive Consultant Medical Microbiologists. Cross cover Microbiologist support continues with Barnsley.

Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridioides Difficile (C-difficile) are both alert organisms subject to annual improvement targets. The MRSA bacteraemia target for 2021/22 was 'zero preventable cases' which was not achieved due to two unrelated cases in July 2021 which were reviewed by the CCG.

The C-difficile trajectory was 22 cases to year-end which has been breached with 25 cases. Any case where the patient had been in the hospital within the 4 weeks prior to the sample is also classed as hospital acquired.

Number of reported cases of MRSA bacteraemia													
Target = 0	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**0**	0	0	0	0	0	0	0	0	0	0	0	0
2021/22	**2**	0	0	0	2	0	0	0	0	0	0	0	0

Number of reported cases of C.diff													
Target = <24	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**22**	1	1	2	2	1	1	4	3	4	2	0	1
2021/22	**26**	2	1	3	2	0	1	2	2	6	3	2	2

(Source: Trust Winpath System)

All cases of hospital acquired Clostridioides Difficile (C. difficile) have been cross referenced using time/space and Ribotype including where relevant enhanced DNA fingerprinting of the Ribotype, and there are no cases of cross infection. Shared ownership of completion of the RCA investigation with the clinical divisions has greatly been challenged due to the impact on COVID-19 management. A comparison with 2019/20 needs to be taken with caution as there have been periods of different capacity within the hospital, increased remote GP assessment/prescribing and an increase in antibiotics for respiratory infection.

The post-infection review (PIR) process done jointly with the Clinical Commissioning Group (CCG) Lead IPC Nurse has been on hold due to COVID-19 management and is planned to be restarted as the COVID-19 impact reduces.

National mandatory reporting for Gram-negative bacteraemia commenced in April 2017, Gram-negative bacteraemia includes E-coli, Pseudomonas aeruginosa and Klebsiella species.

From February 2020 onwards there has been the challenge of COVID-19 pandemic management, which continues to put pressure on the whole system with high in-patient capacity, cohorted isolation wards and reduced staffing levels. All changes in practice are communicated out based on the changes in National guidance alongside local COVID prevalence and knowledge of the built environment where clinical care is provided.

Staff vaccination for COVID and Influenza has been completed under the leadership of the Head of Engagement.

Influenza cases have remained very low across the region.

Cases of Norovirus and Rotavirus gastroenteritis have been very low which mirrors the regional and national picture.

There have been additional challenges during the year of infections with potential public health impact; this has included Carbapenemase Producing Enterobacterales (CPE) which is an antimicrobial resistant finding for some bowel organisms, all cases are under review with support from the UK Health Security Agency Field Epidemiology Team and advice has been sought and shared with colleagues in other Trusts.

In summary, whilst the Trust has stepped up to the challenge of a global pandemic of respiratory illness, the management of the pandemic has reduced the ability to investigate all alert organisms in depth in the usually timely way.

The trajectories for 2022/23 are as follows:

- Clostridioides Difficile (C. difficile) -19 cases
- MRSA bacteraemia - 0 cases
- E.coli bacteraemia - 57 cases
- Klebsiella bacteraemia - 12 cases
- Pseudomonas aeruginosa bacteraemia - 6 cases

Reducing the incidence of Falls with Harm

A fall in hospital can be devastating. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also

affects the family members and carers of people who fall, and has an impact on quality of life, health and social care costs. Falls represent significant cost to Trusts and the wider healthcare system, with annual total costs to the NHS alone from falls among older people estimated by the National Institute for Health and Care Excellence (NICE) in 2015 at £2.3 billion.

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Falls	741	799	796	892	921	1048
Bed Days	144,505	145,153	132,557	158,207	118,098	151, 353
Falls Rate per 1000 Bed Days	**5.12**	**5.50**	**6.00**	**5.63**	**7.79**	**6.92**

Monitoring of all falls is undertaken daily by the Patient Safety Team and the clinical areas are provided with data using a falls performance dashboard from Datix. Falls prevention and improvement is also monitored through the Trusts Falls Group who report into the Patient Safety Group.

The Trust continues to participate in the mandatory National Inpatient Falls Survey, the results of which are used to inform the Falls group action plan, which is continually being amended to reflect the most recent falls management initiatives. The Trust has reviewed its current falls assessment documents and released them as electronic forms, which include mandatory fields such as completion of Lying and Standing blood pressure. This will not only improve patient care but facilitate completion of national Commissioning for Quality and Innovation (CQUIN) targets. The Trust's Falls policy has been reviewed to reflect all changes to the way falls are managed and has been uploaded on the Patient Safety Page of the HUB.

Duty of Candour

'Duty of Candour' requirements are set out in the Health and Social Care Act Regulation 20: Duty of Candour (Health and Social Care Act (2008)). The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust (Report of the Mid Staffordshire NHS Foundation Trust 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.

An audit of compliance regarding the Duty of Candour discussion being undertaken and recorded in the patient's records was undertaken for incidences that occurred during 2021-22. The results showed 100% compliance with the policy. Ongoing compliance is being supported by a rolling training programme delivered by the Patient Safety Team and increased monitoring of compliance against moderate incidents. A repeat audit will be undertaken in 6 months.

Safe and Sound Framework

The Trust is committed to delivering consistently safe care and taking action to reduce harm. The Chief Nurse and Medical Director previously developed the Safe and Sound Framework to support high quality, safe patient care. This is now evolving to the next stage, with a focus on continuous quality improvement, supported by robust governance and assurance processes.

This continues to build upon the pillars of safety, effectiveness and experience, and emphasises the importance of behaviours, culture and leadership to positively influence outcomes.

Safeguarding Vulnerable Service Users

The Trust remains committed to ensuring Safeguarding is an absolute priority. The Chief Nurse is the Trust's Executive Lead for Safeguarding. The Chief Nurse is supported by the Deputy Chief Nurse and the Head of Safeguarding, who manages the Safeguarding Team. The Safeguarding Team provide specialist input and advice regarding Adult and Children's Safeguarding. The Team also includes a Learning Disabilities & Autism Matron, a Lead Nurse for Child Death Review (CDR) and a Paediatric Liaison Nurse who provides specialist input and support in relation to children's safeguarding within the Emergency Department, the Children's Ward and Community Services, including General Practitioners.

In addition to the integrated and co-located team there are also safeguarding colleagues based in services outside of the Trust:

- A Trust Safeguarding Nurse Advisor is based in the Multi-Agency Safeguarding Hub (MASH) at Riverside House. This team responds to all children safeguarding referrals. This allows The Rotherham NHS Foundation Trust (TRFT) to share appropriate information in a timely way and supports the achievement of good outcomes for children.
- A Specialist Child Sexual Exploitation (CSE) Nurse is based in the Evolve Team in the Eric Mann building which provides services for survivors of Child Sexual Exploitation cases and is aligned to the Family Health Division.

In relation to adult vulnerability and adults at risk, the work and support by the team includes the work streams of Domestic Abuse, Multi-agency public protection arrangements (MAPPA), Mental Health Act, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The year has seen a continued increase in activity across all work streams with sustained challenges posed by the embedding and implementation of the Care Act 2014, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Work had begun to ensure the changes made to the MCA, introducing the Liberty Protection Safeguards and phasing out DoLS throughout the acute Trust, was progressed, however, this was delayed pending the release of the updated Code of Practice. This has recently been published, so this work stream will be resumed forthwith.

The Trust continues to be an active partner in the Rotherham Safeguarding Children Partnership (RSCP), the Rotherham Safeguarding Adult Board (RSAB) and the Rotherham Health and Wellbeing Board. In addition, robust governance structures are in place to ensure the Trust has representation on a large number of external Safeguarding strategic

and operational groups. This ensures partnership working is embedded across the wider Rotherham Health and Social Care economies.

The Adult Safeguarding Team continues to work in partnership with the Rotherham Metropolitan Borough Council (RMBC) to provide 'health' input for safeguarding investigations. This involves offering support to the RMBC Adult Social Care teams around investigations and preparations for Outcomes Meetings even where there is no Trust involvement in the provision of care. This highlights the Trust's continued commitment to partnership working. The Trust provides representation from both Adult and Children's practitioners at the Multi Agency Risk Assessment Conference (MARAC) meetings.

There is continued review of the allocation of competency levels and Mandatory and Statutory Training (MaST) requirements. There have been regular meetings with the Learning and Development Team to ensure that all staff are allocated the appropriate requirements in line with the Safeguarding Adults' and Safeguarding Children's Intercollegiate Documents. Training compliance is monitored via Safeguarding Key Performance Indicators and reviewed at the Safeguarding Operational Group, reporting in turn to the Strategic Safeguarding Group.

The recording of training on ESR is overseen by the Learning and Development Team. A variety of alternative training media, developed during the initial response to COVID working arrangements, has enhanced the offer. Face-to-face training had been resumed. The Trust implemented a 'Think Family' strategy, and training provision reflects this model. Other e-Learning has been developed, with voice-over attached, to support our staff in achieving their MaST requirements. This offers staff a blended approach to learning.

On-going training and supervision is provided to support practice in embedding the implementation of the MCA and DoLS procedures. The MCA (2005) has been amended and introduced the Liberty Protection Safeguards (LPS), which will replace the DoLS. The requirement set for this to be fully implemented by March 2022 was deferred by the Department of Health & Social Care who have recently launched the consultation process, however it acknowledges that the consultation will not set a target date for implementation. This is to allow the Government to consider the responses carefully before making final decisions about the design, implementation plans and funding of the scheme.

The Trust will continue to work with partner agencies to develop a structure to support this when final arrangements are announced. In the meantime, the Safeguarding Team are continuing to offer MCA training, and are progressing the MCA & Safeguarding Champions network to ensure staff are confident and competent to discharge their responsibilities under the MCA.

A robust training programme is in place for Prevent, which is included in the Trust induction programme and is part of the MaST offering. Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved in/or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity. The Trust is represented at the Channel meetings, where all cases of those suspected of being exploited, whether adult or child, are heard.

The Trust's Safeguarding Vulnerable Service Users Strategy, alongside our strategies for working with those with poor mental health and those with a learning disability, are embedded in the organisation. Key performance indicators, against which safeguarding

performance is monitored, are in place and reported, via the Strategic Safeguarding Group, to the Quality Committee. In addition, a number of safeguarding standards are in place and monitored externally via NHS Rotherham Clinical Commissioning Group (CCG).

The Trust has two specific Safeguarding meetings; a monthly Safeguarding Operational Group chaired by the Deputy Chief Nurse and a quarterly Safeguarding Strategic Group, chaired by the Chief Nurse, with the Head of Safeguarding as deputy chair.

The Trust has initiated a Mental Health Steering Group, which has overseen the review of our Mental Health Strategy. A work-group sits under this to address the key issues and implement a comprehensive work-plan which underpins the strategy.

A quarterly Safeguarding Report is provided to the Board of Directors and presented by the Chief Nurse.

Responsibilities of all staff employed by the Trust for safeguarding vulnerable people are documented in Trust Safeguarding policies.

An annual work plan is in place and monitored by the Trust's Safeguarding Operational Group to ensure all plans progress.

The Care Quality Commission's (CQC) targeted inspection in 2020 resulted in a comprehensive improvement plan which was fully completed in 2021. A subsequent inspection highlighted areas for further development which are being progressed.

Improvements include the safeguarding safety huddles, now embedded across the children's pathway, the development of new policies and review of existing policies, which are reviewed and updated in line with any changes to legislation and guidance. Stronger governance arrangements have been put in place and there is now increased engagement in improving MaST compliance rates across the Trust.

The Trust will continue to strive to develop and further improve safeguarding systems and processes in order to protect vulnerable children, young people and adults at risk.

Dementia Care

The Trust continues to review the strategy for the provision of care supporting people living with dementia within a context of person-centred care across the organisation;

<u>Dementia & Delirium Screening</u>

The Dementia and Delirium screening tool is undertaken electronically by our Meditech system and this utilises the Find, Assess, Investigate and refer tool. This tool is part of the inpatients assessment document across the organisation, this is a mandatory screening tool for all patients and supports us in assessing, investigating and where appropriate onward referral for our patients

<u>Hospital Accreditation and Frailty Service</u>

Unfortunately, due to the impact of COVID-19, we have seen a reduced Frailty Nurse Service, however the team have continued to provide a safe, effective, holistic service to

our frail, elderly patients, with a continued reduction in their length of stay, working together to effectively provide a multi professional team approach to our patients. We are currently providing in reach frailty service to patients through our emergency and short stay pathway and exploring future options.

Dementia, Delirium & Person-Centred Training

The team have previously delivered Dementia, delirium and person-centred training, this education and training package for colleagues is currently under review. As part of our quality improvement programme pan Trust, there has been a focus on the fundamental of care for our patients including falls prevention, skin integrity and person centred care.

Dementia Group

The dementia, delirium and person-centred care group has not taken place due to the COVID-19 restrictions. This will be re-established.

Learning Disability and Autism Team

The Rotherham NHS Foundation Trust is committed to improving the experience for people who have learning disabilities and Autism. The Trust has a Matron in Learning Disabilities and Autism and currently one Nursing Associate specialising in Learning Disabilities. The team is currently under review to assess this staffing level and service need. The team focus on all aspects of the patient care pathway and experience within the Trust. Visiting patients as an outpatient, inpatient, planned surgery, or are admitted through the UECC. The team also has a role to play in the prevention of re-admissions to hospital; visiting patients in the community to assess their needs whilst liaising with Community Services to prevent admission to hospital where possible. The Learning Disability and Autism team ensure that the Trust are making reasonable adjustments for people with additional needs by undertaking the following:

- Using an electronic flagging system to identify that a person has a learning disability from their medical records. This information then populates a live database for the Learning Disability team to access.
- Championing the use of the 'Traffic Light System', which is a person-centred assessment tool for people with Learning Disabilities and Autism, which helps staff to learn about how to care appropriately for each individual. The 'Traffic Light System' is also used through magnet symbols on patient headboards, ward boards and medical notes.
- Providing bespoke training regarding learning disabilities and Autism in conjunction with the local advocacy organisation. This is delivered where possible by experts by experience.
- Continuing to build links with established organisations to support learning, such as Speak Up, CHANGE organisation and Health Education England.
- Facilitating a programme of mentorship for Learning Disability Nurse/Generic Social Work Students at Sheffield Hallam University, providing shadowing and training opportunities to the Trust's Trainee Nurse Associates.
- Providing bespoke training for the Undergraduate Adult Branch Nurses at Sheffield University.
- Facilitating a Learning Disability/Autism Patient Experience Sub Group. This has members from Community Learning Disability Teams, care providers for people with Learning Disability, such as Mencap, Voyage and Exemplar Health care, the Local

Authority and Healthwatch. This enables the Trust to directly learn from patient experience in order to improve practice/systems and pathways.

- Working closely with the Volunteer Coordinator to mentor and support volunteers in the Trust who have a Learning Disability/Autism.
- Working with the wider equality and diversity agenda around health inequalities work for this patient group.
- Working closely with colleagues within the Trust's Community Teams, such as Community Matrons, Fast Response and District Nurses, to ensure community care plans are in place for people with a Learning Disability and/or Autism, to minimise frequent admissions to hospital services.
- Working with complex care colleagues around the transition of young people from child to adult services within the Trust. This transition work involves acute colleagues in Sheffield Teaching Hospitals and the Sheffield Children's Hospital.
- Implementing relevant Learning Disability and Autism strategies within the Trust and working in conjunction with partnership organisations borough wide.
- Continued work around the implementation of the Accessible Information Standard with the Trust's Equality and Diversity Leads.
- Championing and using the Learning Disability Mortality Review programme (LeDeR) process, in conjunction with the Clinical Commissioning Group (CCG) leads. This process is across agencies to learn from the deaths of people with a Learning Disability.
- Ensuring that reasonable adjustments are made to Trust care pathways.
- Championing the use of the Mental Capacity Act (MCA), assisting with best interest processes and the use of Deprivation of Liberty Standards (DoLS) where appropriate.
- Helping to reduce the length of stay in hospital by working with Medical Professionals, Allied Health Professionals and Social Care Professionals (on average a person with a learning disability and or Autism, may have a longer than average inpatient stay compared to the general population).

<u>Future plans:</u>

- To work with the CCG and Local Authority to look at an electronic flagging system to identify people with Autism with an electronic flag on their medical records (with obtained patient consent). Or, to work around how these reasonable adjustments can be made for people with Autism.
- To expand the use of Nurse Associates within the Learning Disability Team working throughout the Trust.
- Looking at different ways of working and increasing the capacity of the Learning Disability team in order to more effectively meet the needs of people with a Learning Disability and/or Autism within the Trust.
- Explore further Learning Disability specific roles with Health Education England.
- Continue to encourage the role of the Learning Disability Champion on all wards and departments.
- To work with the Trust's Equality and Diversity Steering Group to look at how the Trust can actively encourage people with Learning Disabilities and/or Autism to take on voluntary or paid roles at the Trust.
- Focusing on specific care planning tools for people with Learning disabilities and/or Autism, to help improve individual patient pathways and the responsiveness of the Trust.

- The Lead Learning Disability Nurse will look at reducing unnecessary admissions to hospital for people with Learning Disability utilising their non-medical prescribing qualification and working with local GPs and Trust Community Practitioners.
- To engage the Trust in the Autism accreditation process, through the National Autistic Society. On all appropriate wards and department. To ensure the Hospital moves forward to be more inclusive and accessible to this patient group.
- Further work around reducing re-admissions to hospital and increased support from the Learning Disability and Autism team. Liaising with the Trust's Home First Lead, local GPs and Community Services.
- Continued work around the Learning Disability Mortality Review (LeDeR) programme and how this works within the Trust's Structured judgement review and Death processes. This process from February 2022 will also include the reviews of deaths of people with Autism.

Engaging with Colleagues

In response to the pandemic the Trust realigned its resources to focus on supporting colleagues with their wellbeing and protection and latterly wellbeing recovery. A colleague COVID-19 helpline was established seven days a week. This service co-ordinated COVID-19 queries, COVID-19 testing, absence management, antibody testing and signposting staff to wellbeing support and other wellbeing offers. As we emerge from the pandemic, we will reinstate a range of strategies to engage with colleagues.

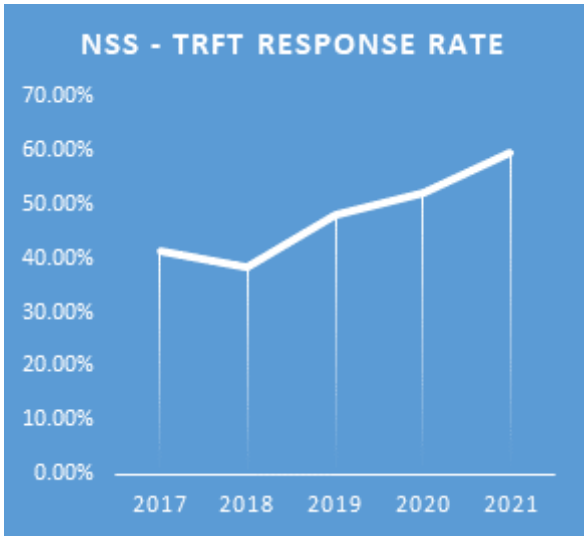
National Staff Survey 2021

The NHS staff survey is conducted annually. The table below provides a high-level overview of the National Staff Survey results; this year saw significant change in the analysis and format of the data. This was to ensure that there was alignment with the new seven elements of the NHS People Promise. The remaining two domains, staff engagement and morale continue to be benchmarked. Despite the ongoing challenges faced by all NHS organisations including TRFT; the Trust maintained its position amongst peer organisations. The Trust recognises that in order to drive continuous improvements for the benefit of both patients and staff, further work to engage with colleagues and build on the progress made in relation to the NHS People Promises will remain a key priority throughout 2022-23.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.2	5.9	6.7	6.0	5.3	6.0	6.7	6.7	5.8
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,735	2,754	2,675	2,686	2,597	2,727	2,728	2,761	2,753

NHS Response Rate

Our ambition to maximise our staff voice and engagement across the organisation has been reflected in the significant participation and feedback received through the staff survey. The table below highlights the improvement journey from 2017 to date.



The table below highlights the Trust performance in relation to peer organisations (Acute and Community Trust).

	2017	2018	2019	2020	2021
Best	72.6%	71.6%	76.0%	79.8%	79.4%
TRFT	41.5%	38.5%	48.0%	52.2%	59.7%
Median	43.9%	43.6%	46.9%	45.4%	51.1%
Worst	27.3%	24.6%	27.2%	28.1%	36.5%

Areas of improvement

Top 5 scores vs Picker Average	Trust	Picker Avg
q19a. Received appraisal in the past 12 months	90%	82%
q9b. Immediate manager gives clear feedback on my work	65%	61%
q14c. Not experienced harassment, bullying or abuse from other colleagues	85%	82%
q4c. Satisfied with level of pay	35%	32%
q15. Organisation acts fairly: career progression	59%	56%

Most improved scores	Trust 2021	Trust 2020
q13d. Last experience of physical violence reported	69%	62%
q14d. Last experience of harassment/bullying/abuse reported	48%	45%
q17a. Would feel secure raising concerns about unsafe clinical practice	75%	72%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	47%	44%
q9b. Immediate manager gives clear feedback on my work	65%	62%

Key areas for improvement and future priorities

Bottom 5 scores vs Picker Average	Trust	Picker Avg
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	52%	66%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	34%	45%
q21a. Care of patients/service users is organisation's top priority	68%	76%
q21c. Would recommend organisation as place to work	54%	59%
q21b. Organisation acts on concerns raised by patients/service users	68%	71%

Most declined scores	Trust 2021	Trust 2020
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	52%	63%
q21c. Would recommend organisation as place to work	54%	64%
q22c. I am not planning on leaving this organisation	58%	66%
q22b. I am unlikely to look for a job at a new organisation in the next 12 months	52%	59%
q22a. I don't often think about leaving this organisation	42%	49%

As the Trust moves towards recovery from the pandemic the key areas of focus and priority for 2022-23 will be:

- Continue to prioritise staff wellbeing and recovery through meaningful engagement and health management e.g. new Occupational Health provision, enhanced Employee Assistance Programmes, develop fast track internal support mechanisms to maintain good health
- Enhance our appraisal process from a qualitative perspective to better understand the challenges of our workforce and to inform our improvement strategies in making the Trust a better place to work.
- Be an employer of choice recognising the talent across Rotherham whilst supporting staff and the wider population develop career pathways in healthcare.

Monitoring arrangements - future priorities and how they will be measured

The Board of Directors will agree key milestones and delivery targets for the Trust; however, workforce related performance and people objectives will be monitored through the governance structures in place including the Operational Workforce Group, People Committee, the Executive Team and ultimately the Board of Directors.

Locally each Division will develop improvement plans using key information from the national staff survey results, CQC feedback, People Pulse survey and other key Trust metrics. These will be managed through a monthly divisional performance meeting and dashboards, providing assurance to the Executive Team and Board of Directors.

The wider workforce and engagement activities will be monitored through the Operational Workforce Group chaired by the Director of Workforce. The actions of this group and any associated work plans will provide the appropriate levels of assurance to the People Committee.

Staff Friends and Family Test

NHSE/I replaced the staff friends and family survey with the National Quarterly Pulse Survey (NQOPS) which was formally launched in Q4. Our response rates were low. A key priority for next year (2022/23) will be to increase the staff engagement and response rates.

Freedom to Speak up (FTSU) Guardians

The FTSU Guardian (FTSU) role was first introduced at the Trust in July 2015 in response to the Francis report, with the appointment of six FTSU Guardians (FTSUG). In September 2016 a Lead Guardian was appointed, which enabled the separation of the FTSUGs from the HR functions of the organisation. Subsequent to this appointment twelve further FTSUGs have been recruited to ensure that all Divisions have representation. All the FTSUGs have a suitability interview and undertake the role on a voluntary basis in addition to their substantive post; two of these have also attended the National Guardians Office (NGO) training session. Tony Bennett, the current FTSU lead, was appointed in January 2019, and the time dedicated to the role increased to 0.2WTE. As the post holder is already a Trust employee this time is spread over the week to increase staff access to the FTSU lead.

Since the appointment of a National Guardian there has been increased direction from the National Office regarding the role of FTSUG. As a result of COVID the regional network now meets virtually every two months and the annual national event was also held virtually;

our FTSUG has been supported to attend. The FTSUG month In October 2021 aimed to raise the profile of FTSUGs across the Trust and saw several events including the lighting up in green of RCHC and Breathing Space and all the executive team wearing green 'speak up to me' lanyards. The Rotherham NHS Foundation Trust remains one of the only Trusts in the region to have completed the new FTSU self–assessment tool and adopt the new FTSU training as a MaST subject with a 97.23 % compliance rating.

The FTSU Guardian Lead has direct access to the Interim Chief Executive and other Board members and is now line managed by the Chief Nurse. They have continued to meet quarterly via teams, together with the Senior Independent Director and Executive Director of Workforce.

In its response to the Gosport Independent Panel Report (2018), the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up. Staff at the Trust can raise concerns with their Trade Unions, line managers, colleagues or other supervisors, health and safety, security manager, Human Resources, professional regulator, Trust chaplains and to any of the FTSU team via face to face, telephone (including voicemail linked to e-mail address), e-mail, drop in clinic once a month at each site and anonymously via letter in the drop boxes to the FTSU Lead.

All concerns receive an initial response within 5 working days. If colleagues wish to meet with a guardian to discuss their concerns, meetings are arranged at a time and venue convenient to the person raising the concern. All staff who raise a concern with the FTSU team are contacted three months after a concern is raised to see if they have suffered a detriment as a result. The wellbeing check also requests feedback from concern raisers on the service provided by the FTSUGs. To date feedback has been mainly positive with colleagues finding it easy to contact a FTSUG and pleased with the support that has been received.

During 2021/22, the FTSUGs have received 45 concerns. The majority of the concerns have related to attitudes and behaviour (25), with colleagues being directed to HR or union support for further advice. The number of concerns shows a year on year increase which may be linked to the increased time dedicated to the role and staff experience from those who have accessed the service. It may also be due to The Rotherham NHS Foundation Trust being one of the only Trusts nationally to have FTSU as a mandatory training subject; this training ensures staff are aware of FTSU and what to do if they suffer a detriment and how to escalate it, if it does indeed occur. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors.

Key learning from the national reviews and cases raised locally have informed the content of our current approach.

Proud Awards: recognising the contribution of colleagues at The Rotherham NHS Foundation Trust

On 19 November 2021, The Trust's annual Proud Awards took place to celebrate dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

More than 430 nominations were received for the 2021 Proud Awards. Usually held at Magna, the 2021 ceremony was held virtually due to the COVID-19 pandemic. The event, hosted live by Heart Yorkshire's Dixie and streamed on YouTube, consisted of pre-recorded 'Thank You' messages and entertainment alongside the awards. The award categories were announced by members of the Executive Team, Chairman and Lead Governor in pre-recorded segments. More than 1,600 people have watched the awards, with around 350 colleagues and partner organisations watching it live.

Interim Chief Executive, Dr Richard Jenkins, was joined by the Chairman, Martin Havenhand, the Executive Team, Governors and Non-Executive Directors, as well as representatives from partner organisations watching the event and joining in with the live chat.

The 2021 winners are:

Values Award
Tony Bennett - Security

Outstanding Volunteer Award
Visiting Booking Line

Apprentice of the Year Award
Claire Wilson - Estates

Inspiring Leader Award
Sarah Newbold – Staff Engagement

Diversity and Inclusion Award
Paul Stewart and Gail Smith - Medicine

Safe and Sound Award
Security and Children's Ward

Unsung Hero Award
Lisa Kerry - Stroke

Innovation and Improvement Award
Hip and Knee School

Clinical Team of the Year Award
Supportive / Palliative Care Team

Non-Clinical Team of the Year Award
Isolation and Curtain Team

Public Recognition Award
John Brammer - Theatres

Governors' Award for Outstanding Colleagues
Sheron Ducker – Therapy Services

Special Recognition Award
Thunder the Therapy Dog

Interim Chief Executive's Award
Critical Care

Chairman's Award
Maternity

Implementing the priority clinical standards for 7-day hospital services

Reporting against 7-day services remains suspended. The last audit was completed in 2019.

Management of Rota Gaps – Doctors in Training

Gaps in Junior Doctor rotas can occur for a number of reasons, often vacancies but, over the past year, due to a very high number of COVID and sickness absences. The current vacancy rate for training grades is 9.5%; the equivalent of 14.5 posts out of an establishment of 158 across all training grades and specialties. Rotas are issued to individuals at least 6 weeks in advance and there are a number of shifts, designated Red Flag Shifts, that must be filled, e.g. Medical Registrar On-Call. In addition, minimum staffing levels have been set for ward areas to ensure sufficient junior doctors are available to maintain patient care and safety. In April 2021, the Trust agreed to centralise the rota co-ordination function. This function currently covers rotas across Medicine, General Surgery, Urology and the UECC, providing business resilience in terms of rota co-ordination across the Divisions.

Management of gaps occurs on a daily basis with Rota Co-ordinators taking a pro-active approach to ensure gaps are filled in a timely manner. If a gap is not filled by a substantive member of staff, the process is to look to fill from the Trust's Internal Bank or via Agency if internal cover cannot be sourced. Other staff can also be utilised, such as an Advanced Nurse Practitioner (ANP) for an F1 gap. Rota design also plays an important part to ensure optimum cover is provided; any change to rotas fully involves the junior doctors in the design of the rota and their agreement to undertake the revised work pattern. The Trust has also adopted Good Rostering Guidance, produced jointly by NHS Employers and the BMA in May 2018, along with adherence with contractual requirements of the 2016 Doctors in Training contract. Rota issues are a standing agenda item at the monthly Junior Doctor Forum, chaired by the Director of Medical Education, and attended by junior doctors across the Trust, along with various management representatives.

External Agency Visits, Inspections or Accreditations –

During 2021/22 there have been 10 external agency visits. Details of these visits are included in Appendix 3. Action plans are developed, where required, and monitored through the Clinical Governance Committee.

3.2: Performance against relevant indicators

The Trust is required to report performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHSI, for 2019/20 these are:

i. The Risk Assessment Framework
ii. The Single Oversight Framework

For the purposes of this Report, only the indicators that appear on both the lists above, are required. For The Rotherham NHS Foundation Trust therefore, the five following indicators are reported:

1. Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway.
2. A&E: maximum waiting time of four hours from arrival to admission/ transfer/Discharge.
3. All cancers: 62-day wait for first treatment from:
   - urgent GP referral for suspected cancer
   - NHS Cancer Screening Service referral
4. Cancelled Operations.
5. C.Difficile.

18 weeks from point of referral to treatment (RTT)

Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

% of patients waiting less than 18 weeks - Incomplete	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=92%													
2020/21	**65.23%**	77.06%	67.10%	53.39%	46.77%	53.26%	61.48%	66.38%	68.82%	69.24%	70.20%	72.41%	76.56%
2021/22	**81.10%**	82.42%	84.45%	85.12%	84.72%	83.21%	82.46%	83.18%	81.93%	80.44%	77.17%	76.20%	74.80%

(Source: Meditech and SystmOne)

The criteria for this indicator are defined in NHS guidance. These are used by the Trust and for ease of reference these are:

“The percentage of patients waiting to start non-emergency consultant led treatment who were waiting less than 18 weeks at the end of the reporting period. Numerator is the number of incomplete pathways within 18 weeks at the end of the reporting period. Denominator is the total number of incomplete pathways at the end of the reporting period. Indicator is numerator/denominator expressed as a percentage.

RTT (referral to treatment) consultant-led waiting times only apply to services commissioned by English NHS commissioners and for those patients that English commissioners are responsible. Therefore, RTT pathways commissioned by non-English commissioners are excluded from the calculation.”

A number of the Trust's specialties are currently excluded from 18 weeks RTT report. These are excluded because (as per national guidance) the Trust do not provide these services or they are non-consultant led activity.

Given the COVID-19 pandemic and reduction in activity within the NHS throughout the last year at particular times, performance against the Referral to Treatment time standard declined nationally in 2021/22. At the Trust, progress against recovery from earlier in the pandemic stalled, with the end of year performance at 74.8%, down from 76.6% a year earlier. This reflected a more than 50% increase in the number of patients waiting over 18 weeks for their treatment following a referral. However, the Trust did manage to continue the reduction in patients waiting at least 52 weeks for treatment, down from over 550 at the end of 2020/21 to less than 70 at the end of the year. Efforts to ensure the remaining very long waiters are treated are ongoing, with teams making every effort to provide more timely care for these patients.

18 Weeks													
% of Admitted patients Target >=90%	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**61.20%**	84.16%	79.90%	73.58%	50.19%	46.33%	49.43%	54.31%	61.51%	66.80%	69.40%	65.20%	62.50%
	71.50%	62.76%	64.29%	67.28%	66.93%	70.45%	65.25%	65.81%	64.62%	67.93%	64.77%	58.30%	58.40%
% of Non-Admitted patients Target >=95%	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**82.00%**	89.24%	86.42%	81.41%	76.24%	80.37%	84.77%	83.69%	85.03%	84.15%	79.80%	77.70%	78.80%
2021/22	**81.10%**	80.75%	85.83%	85.92%	86.51%	84.43%	80.77%	82.26%	82.95%	83.74%	75.92%	73.70%	72.70%

Number of patients waiting more than 52 weeks													
Target = 0	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**559**	2	1	8	46	113	207	307	445	610	721	765	559
2021/22	**62**	405	332	260	163	124	67	47	44	35	48	59	62

The A&E four hour waiting time standard/New Urgent and Emergency Care Standards

When the four-hour target was introduced in 2004 it helped to significantly reduce the lengthy waits faced by many patients in emergency departments. At that time the four-hour standard was the right measure, to drive and support improvement in patient flow within acute hospitals. Since the introduction of the A&E access standard 15 years ago, there has been major improvements embedded in the system, and changes in how urgent and emergency care is delivered meant that, increasingly, this single standard is no longer on its own driving the right improvement.

As a result, the NHS National Medical Director was asked by the Prime Minister in June 2018 to review the core set of NHS access standards which included the four hour standard, and recommend any required updates and improvements to ensure that NHS standards, promote safety and outcomes, drive improvements in patients' experience, are clinically meaningful, accurate and practically achievable, ensure the sickest and most urgent

patients are given priority, ensure patients get the right service in the right place, are simple and easy to understand for patients and the public and will not worsen inequalities.

A review of the NHS standards took place in March 2019. This was an opportunity to review access standards in urgent and emergency care and identify proposed standards that overcome the flaws in the current measure and are relevant in the context of the new ways of working outlined in the NHS Long Term Plan. The proposed new urgent and emergency care standards seek to drive the next step change in improving patient care and experience. The trial started in May 2019 with the cohort of hospitals involved in the pilot representing a "range of geographies and performance against the previous 4-hour A&E standard.

The Trust was one of the 14 Trusts involved with the pilot of the new urgent and emergency care standards set out in the NHS's review of clinical standards, which included identifying life-threatening conditions faster, reducing emergency time for critically ill patients, and the main waiting time for all patients, and the pilot continues.

The new urgent and emergency care standards focused on within the Trust are:

- Time to Initial Assessment in A&E
- Time to be seen by a Clinician
- Mean Total Wait in A&E

ED New Indicators - Time to Initial Assessment in A+E													
Target = 15	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**16**	14	12	12	13	15	16	18	16	20	20	17	20
2021/22	**24**	18	19	18	26	23	27	25	28	25	24	23	26

ED New Indicators- Time to be seen by a Clinician													
Target = 60	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**87**	38	42	56	65	93	102	95	87	115	92	89	116
2021/22	**161**	122	142	144	190	162	171	170	174	169	162	175	164

ED New Indicators - Mean Total Wait in A+E													
Target = 200	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**205**	159	128	147	157	194	208	231	240	259	259	229	243
2021/22	**306**	235	258	266	325	317	317	324	338	336	319	324	334

April 2021 saw the introduction of a new standard 'Clinically Ready to Proceed' to the pilot sites. The Clinically Ready to Proceed is when the Emergency Department (ED) Clinician has completed all necessary clinical patient treatment and all investigations have been initiated (not necessarily complete), the patient is therefore deemed to be clinically stable for Discharge/Admit/Transfer from the emergency department. Work has been ongoing with the UECC alongside a revision of ECDS V3 to ensure this is reported accurately in a timely manner and will be reported on from April 2022.

Cancer National Waiting Times

Trust performance against national waiting times for cancer services 2014/15, 2015/16, 2016/17, 2017/18, 2018/19, 2019/20 and 2020/21 and 2021/22:

Metric	Target	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	94.90%	95.12%	95.89%	95.1%	93.8%	93.2%	92.6%	93.6%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	94.70%	97.43%	94.98%	90.9%	85.7%	87.1%	74.7%	89%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%	99.21%	97.6%	97.6%	97.5%	95.4%	95.6%
Cancer 31 day wait for 2nd or subsequent treatment – surgery	94%	100%	98.67%	96.85%	98.8%	98.5%	95.5%	94.9%	98%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	92.70%	88.46%	86.93%	84%	81.3%	76.9%	64.8%	73.9%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	100%	98.20%	96.28%	90.8%	94.9%	92.5%	86.8%	88.3%
Consultant Upgrade	TBC	TBC	94.72%	91.95%	92.8%	88.5%	87.3%	89.2%	88.1%

(Source: InfoFlex/Open Exeter)

The criteria for this indicator are defined in the Cancer Waiting Times rules. These are used by the Trust and for ease of reference these are:

'Maximum two months (62 days) from Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment (62 days classic.'

Cancer Standards 62 Day 2021/22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	76%	74.8%	72.3%	79.7%	71.8%	67%	77%	69%	71.9%	74.2%	74.5%	77.6%
Numerator	49	53.5	53.5	49	44.5	29.5	43.5	53.5	52.5	46	41	57
Denominator	64.5	71.5	74	61.5	62	44	56.5	77.5	73	62	55	73.5

Cancer Standards 62 Day 2020/21	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	78.3%	58.5%	64.6%	63.7%	58.0%	59.5%	62.9%	63.3%	68.9%	64.0%	62.6%	71.8%
Numerator	27	15.5	25.5	32.5	23.5	33	36.5	38	36.5	32	43.5	51
Denominator	34.5	26.5	39.5	51	40.5	55.5	58	60	53	50	69.5	71

Cancer Standards 62 Day 2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	85%	74.2%	77.2%	78.5%	77.3%	74.8%	73.8%	66.2%	84.3%	79.7%	71.2%	80.3%
Numerator	45.5	34.5	44	53	49.5	41.5	55	43	53.5	49	37	49
Denominator	53.5	46.5	57	67.5	64	55.5	74.5	63	63.5	61.5	52	61

Performance Against Targets

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
62 day	No	No	No	No
Screening	No	No	Yes	No

Screening

Achieving screening targets can be challenging due to the small numbers of patients within the screening programme. We are striving to improve year on year, however due to low numbers this can be challenging, especially given in the last 12 months there have been more patients who have chosen to wait longer on occasion, or been unable to attend appointments due to being unwell. We have introduced working to 7 days for first seen appointment, to try and achieve this target, and additional clinics have been put on where required to reduce waiting times.

62 Day Cancer Waiting times:

Timely management of patients referred onto the cancer pathway is an important focus for the Trust. Following the significant reduction in some key cancer activity in 2020/21 based on national guidance, in 2021/22, our focus was on reducing the backlogs of patients waiting for care and returning to pre-pandemic levels of activity. The Trust was identified nationally as one of the top performers in responding to the increased number of cancer referrals in 2021/22, although the Trust remained non-compliant with the 62-day standard of patients being treated following urgent referral from their GP.

The Trust monitored performance against the new national 28-day cancer faster diagnosis standard, due for implementation in 2022, throughout the year. This new standard requires patients to be given a confirmed diagnosis within 28 days of referral, in order to ensure more patients with and without cancer receive this confirmed diagnosis much faster.

A number of improvements have been made in 2021/22, in order to try to manage the demand that we are now seeing in the most effective way. The Trust has returned to a straight-to-test pathway in Lower Gastrointestinal cancers, with the straight-to-test capacity within Breast increased to accommodate the extra demand. A number of Cancer Pathway Navigators have been employed to support patients on cancer pathways, and provide a critical link between the patient and their clinical team. In addition, investment has been made into new equipment in order to enable the Trust to implement the use of Transperineal biopsies in 2022/23 once the relevant staff are fully trained. Further pathway improvement work is planned for 2022/23, following confirmation of non-recurrent funding from the Cancer Alliance.

Incidence of C.Difficile

Number of reported cases of C.diff													
Target = <24	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2020/21	**22**	1	1	2	2	1	1	4	3	4	2	0	1
2021/22	**26**	2	1	3	2	0	1	2	2	6	3	2	2

(Source: Trust Winpath System)

Due to the changes in the National reporting system for C.difficile, the data is not comparable with the numbers pre 2019/20.

The definition for hospital acquired cases changed from 3 days after admission to 2 days and also includes any cases where the person was a hospital inpatient in the 4 weeks prior to the sample.

The trajectory for 2022/23 has been set at less than 19 cases.

National and local priorities and regulatory requirements

National and local priorities and regulatory requirements: -

The Trust is assessed through the submission of wide range of data.

Measure	Department of Health	NHS Improvement	2019/20		2020/21		2021/22	
			*Year-end position	National Target	*Year-end position	National Target	*Year-end position	National Target
Number of cases - clostridium Difficile infection (C-difficile)	x	x	35	>26	22	>26	26	-
Number of cases - MRSA	x	x	1	0	0	0	1	0
Delayed transfers of care	x	x	4.16%	3.50%	not reported	3.50%	not reported	3.50%
Infant health & inequalities: breastfeeding initiation	x	x	67.90%	66%	66.90%	66%	67.60%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	80.63% up to end Feb-20	95%	91.00%	95%	95.40%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate, ADMITTED PATIENTS, NON ADMITTED PATIENTS and INCOMPLETE PATHWAYS.								
Admitted	x	x	72.70%	90%	61.20%	90%	71.50%	90%
Non - Admitted	x	x	93.60%	95%	82.00%	95%	81.10%	95%
Incomplete	x	x	91.60%	92%	65.23%	92%	81.10%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	0.67%	Less than 1%	46.50%	Less than 1%	18.20%	Less than 1%
Cancelled operations for non-medical reasons	x		1.11%	0.80%	0.83%	0.80%	1.79%	0.80%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		93.10%	90%	92.90%	90%	92.90%	90%
Patients who spend at least 90% of their time on a stroke unit	x		59.3%	80%	25.61% (end Oct)	80%	not reported	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		63.5%	60%	75% (end Oct)	60%	not reported	60%
Elective Adult patients 18years and over readmitted to hospital within 30 days of discharge from hospital	x	**Data in 19/20 was 28 days**	1.96%	6%	2.32%	6%	2.29%	6%
Non Elective Adult patients 18 years and over readmitted to hospital within 30 days of discharge from hospital	x	**Data in 19/20 was 28 days**	10.52%	12.50%	12.08%	12.50%	11.66%	12.50%

Elective patients 0-17 years readmitted to hospital within 30 days of discharge from hospital	x	**Data in 19/20 was 28 days**	1.34%	3%	1.22%	3%	0.96%	3%
Non-Elective 0-17 years patients readmitted to hospital within 30 days of discharge from hospital	x	**Data in 19/20 was 28 days**	6.04%	10.40%	11.99%	10.40%	9.93%	10.40%
Ensuring patients have a positive experience of care (Pt survey overall score)	x	x	Published 2 July 2020	-	2020 Survey results to be published November 2021	-	Awaited	-
Patients waiting no more than 31 days for second or subsequent cancer treatment								
Anti-Cancer Drug Treatments - Chemotherapy	x		100%	98%*	100%	98%	100%	98%
Surgery	x		95.50%	94%*	94.90%	94%	98%	94%
Radiotherapy	x		n/a	94%	n/a	94%	n/a	94%
62-Day Wait For First Treatment (All cancers)								
From Screening Service Referral	x		92.50%	90%*	86.80%	90%	88.3%	90%
Urgent GP Referral	x		76.90%	85%*	64.80%	85%	73.9%	85%
31-Day Wait For First Treatment (Diagnosis To Treatment)								
All cancers	x		97.50%	96%*	95.40%	96%	95.6%	96%
Two week wait from referral to date first seen								
All cancers (%)	x		93.20%	93%*	92.60%	93%	93.6%	93%
For symptomatic breast patients (cancer not initially suspected)	x		87.10%	93%*	74.70%	93%	89%	93%
SHMI	x			100				

(Source: Various Information Systems including InfoFlex/Open Exeter and Trust Information System)

Annex 1: Statements from Commissioners, the local Healthwatch organisation and the Overview and Scrutiny Committee

Statement on behalf of the Council of Governors

The comprehensive Quality Account Report which details the progress and delivery of quality improvement initiatives is welcomed by the Council of Governors.

We believe that the report is an accurate and true reflection in terms of actions taken by the Trust during the year 2021/22 and provides some clear objectives for quality improvement in the near term. The Governors recognise that their comments are in the context of the continuing challenge of dealing with the Covid pandemic.

During the year, the Trust once again welcomed the Care Quality Commission (CQC) who carried out inspections at the Trust. The Governors were concerned that enforcement action was taken against the Trust during the previous year.

The results were more mixed in 2021/2022. The Governors were very disappointed that another warning notification was issued within the UECC. We are assured that the checks and reviews that are in train will hopefully address this.

We were very pleased to note that the warning notification previously issued to the Acute Medical Unit, was closed with no further requirements. A testament to the hard work by Trust colleagues to meet the necessary standards.

The Council of Governors is also assured that a substantial amount of work has been and will continue to be carried out by the Trust to give assurance that the concerns were and are being addressed. We are also pleased with the appointment of a new Chief Nurse and Deputy Chief Nurse who have certainly given assurance both in their commitment to quality improvement and to engaging the Governors where appropriate.

The Governors have noted that the CQC inspections during 21/22, though offering some minor changes, have not changed the overall rating for the Trust from requires improvement. We were pleased to see that the CQC did rate the trust highly for Caring in all areas.

The Governors know that the most important asset of TRFT are our staff and so their health and wellbeing and morale are key to driving continual quality improvement. It is an area that the Governors continue to take an interest in and monitor.

The Governors were therefore concerned at some of the scores in the 2021 staff survey. In particular relating to staff being happy to recommend the Trust as a place to work, happiness with the standard of care provided by the organisation and not feeling that care of patients is the number 1 priority of the Trust.

The performance against some key indicators has also raised some concerns amongst the Governors. At TRFT, progress against recovery from earlier in the pandemic stalled. For example this reflected in a more than 50% increase in the number of patients waiting over 18 weeks for their treatment following a referral.

Performance against national indicators for cancer referrals did improve overall. However, there are still areas where the national targets are not met including 31 day wait for first treatment and 62 day wait for treatment from referral from NHS cancer screening service. These were historically indicators that TRFT performed well in prior to the pandemic.

The Governors are aware that a number of changes and initiatives have been implemented to address these issues, and the Governors are pleased to note that the Trust is in the top 10% of trusts who do not have any 52 week waiters.

One of the Quality Priorities for 21/22 was to reduce Hospital Standardised Mortality Ratios (HSMR) which has been a focus for the Trust and the Governors are delighted that our figures have reduced and we are no longer an outlier.

The Council of Governors want to take this opportunity to again thank the NHS staff within the trust and the community, for their dedication, hard work, compassion and diligence in continuing to help and support patients in general and especially with Covid 19. Hospital admissions due to Covid 19 were still higher than average in Rotherham during 21/22.

We salute all of the frontline staff and other key worker colleagues for their efforts once again this year as we slowly recover from the pandemic.

The Governors are assured that there is a clear focus on quality improvement across TRFT as we move into system working.

Gavin Rimmer
Lead Governor, The Rotherham Foundation Trust.

Statement from NHS Rotherham Clinical Commissioning Group

NHS
Rotherham
Clinical Commissioning Group

Oak House
Moorhead Way
Bramley
ROTHERHAM
S66 1YY

Direct Dial: 01709 302152
E-mail: sue.cassin@nhs.net
Date: 26 May 2022

TRFT Quality Account

2021/22 continued to be an unprecedented year for the NHS and, NHS Rotherham Clinical Commissioning Group (NHSR CCG) commend The Rotherham NHS Foundation Trust (TRFT) for the continuous commitment that they have shown in delivering safe and effective care to patients throughout the year.

As in previous years, NHSR CCG and TRFT have worked together to make improvements in the three domains of Patient Experience, Patient Safety and Clinical Effectiveness through engagement from TRFT clinicians and executives at contractual meetings and other key committees between the two organisations. The joint Contract Quality Meeting has continued throughout the pandemic with strong representation from both the Chief Nurse and Executive Medical Director. The level of assurance provided at this forum both verbally and through the detailed board reports in relation to actual and potential quality issues within the Trust has been robust and transparent. NHSR CCG also regularly attends the Trust's Clinical Governance Committee as an additional mechanism to gain assurance which is positive and welcomed.

NHSR CCG are particularly keen to highlight the achievements of TRFT in relation to a few areas: -

- TRFT's response to the most challenging of years due to the Covid 19 pandemic which saw staff continue to deliver healthcare. The ability to implement relevant changes and ways of working within a fast-paced changing environment.
- Critical care beds were increased by half, a non Covid 19 resuscitation unit within UECC and Covid specific wards created.
- A vaccination centre was established and over 10,000 staff and associated health and social care staff vaccinated in January and again in March/April 2021 and in December 2021 onwards the hospital vaccination centre supported the booster campaign enabling Rotherham residents to attend for vaccination
- The set-up of a Covid Oximetry Service supporting all the Rotherham community and the at pace set up of a Covid Medicine Delivery Unit

NHSR CCG via a plethora of meetings and with the trusts open and transparent attitude are fully sighted on the challenges of the Covid 19 pandemic and the impact on the Trust.

Referral to Treatment Times, Diagnostic wait times, the Cancer Patient Tracker List and the 62-day main cancer standard have not been met due to resources required for the emergency planning and services of the pandemic.
Likewise, NHS RCCG are assured that TRFT can drive forward the requirements of the recovery phase of the pandemic with the Trust making significant progress on reducing the number of patients waiting over 52 weeks and at the time of writing, the Trust has no patients waiting over 78 weeks. The improvement to the diagnostic waiting times has also been significant with the Trust currently at lower than 5% of patients breaching as at April 2022.

NHSR CCG have continued to see an improvement to services since the easing of lock down and are pleased that TRFT have been able to recommence a number of services with restrictions in place thus ensuring patients are risk assessed, seen and treated as quickly possible.

The 12-hour trolley breaches of 2019/20 were not repeated this year. A reduction of wait times in A&E were evident as were ambulance waiting times recorded, whilst still challenging they are significantly better than across SY.

TRFT's current registration with the Care Quality Commission (CQC) is 'registered with conditions' following the October 2018 inspection. Section 31 of the Health and Social Care Act 2008 was notified to the Urgent and Emergency Care Centre Paediatric Emergency Department, with a focus on medical and nurse staffing levels. NHSR CCG are delighted that following the trusts hard work they are in the process of applying to have the condition removed.

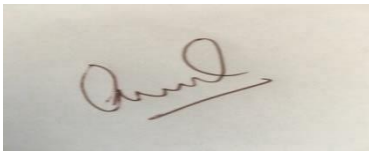
Additionally, NHSR CCG were pleased when the Section 29 a Warning Notice issued to the Acute Medical Unit in November 2020 was closed by CQC following on from their routine core services inspection in May/June 2021. This visit, which included a Well Lead Assessment demonstrated significant improvements had been made and embedded into practice.

The overall rating to the Trust remains as 'Requires Improvement' however NHSR CCG recognise the significant work and improvements that have been demonstrated by all across the trust.

NHSR CCG are fully sighted on the increased efforts and internal scrutiny of the HSMR and SHMI mortality scores which have over recent months, started to decline demonstrating a picture which is not above national average. This has been a concern for NHSR CCG and the CQC during 2021/22 and NHSRCCG continues to utilise the Contract Quality Meetings to gain assurance on the actions that the Trust are taking to reduce these levels. There is a clear focus on mortality within the Trust to understand and drive improvement.

NHSR CCG is supportive of how the Trust's key quality priorities of Patient Safety, Patient Experince and Clinical Effectievness for 2022/23 have been developed via a consultation process involving colleagues, governors, patient and members of the public. A trianugulation method of selection has ensured that the priorities are borne from recent findings of the CQC inspecton and other incidents and risk of the Trust.

Yours sincerely



S. K. Cassin.

Dr Anand Barmade
GP Executive Lead – TRFT Contract
NHS Rotherham CCG

Sue Cassin
Chief Nurse
NHS Rotherham CCG

Statement from Healthwatch Rotherham

The Rotherham Foundation Trust (TRFT) Quality Report 2021/22

These comments are provided on behalf of Healthwatch Rotherham.

Healthwatch Rotherham again welcomes the opportunity to be involved in the Rotherham Foundation Trust Quality Report this year. We recognise there are still improvements to be made which are delayed due to the national COVID-19 pandemic and the pressures on services even now we are slowly returning to some normality.

Healthwatch Rotherham would like to express congratulations to the Trust for all the hard work and dedication to the parts of the report where actions have been achieved and rated green despite all the pressures of the national pandemic and its lasting effects. We recognise the work continued to be carried out to ensure quality and safety of services delivered by the Trust and congratulate the Trust for the openness and transparency in the responses to the continued work required and the commitment to a culture of quality improvement which listens to and learns from the views of patients, families, carers, and colleagues.

Healthwatch Rotherham is particularly interested and pleased with the 2022-2023 Quality priorities around patient experiences and are keen to see the developments of a robust process to measure and improve following patient feedback, alongside this the positive changes informed by patient feedback regarding the accessibility of information materials is an example of The Rotherham Foundation Trust listening to what patients want and taking actions to provide this ensuring patients are able to make informed choices around their care and treatment.

We are thankful for the continued opportunity to attend the Patient Experience Group and Patient Information Group where we are able to see improvements made to services and welcome future collaboration with The Rotherham Foundation Trust to ensure patient voices are heard and no community feels unheard.

Natalie Palmer
Service Manager
Healthwatch Rotherham

Health Select Commission Stakeholder Statement

TRFT Quality Account 2021-22:

Members appreciate being invited to review the draft Quality Account and were impressed by its honest reflections and self-appraisals, as well as consistent emphasis on patient experience. This tone gives Members confidence that the leadership focus reflected in the draft will result in successful turnaround of services.

Acknowledging the persistent challenges to service delivery caused by the pandemic, the draft identifies several areas for continued growth and development which Members wish to emphasise. Foremost, enhancing patient safety and reducing mortality ratios by improving leadership and shop-floor practice in the Emergency Department. Concerned by the CQC rating of Urgent Care leadership as inadequate, Members urge further streamlining of handovers to ensure patients are seen as quickly as possible and sent to the right place in the first instance. Members note the Trust's continued efforts in respect of timely identification and treatment of sepsis and are interested to see how the new sepsis quality improvement group will revise pathways for non-elective and elective patients. Members are also interested in how the Trust plans to expedite the complaints process to maximise timely learning.

Members share the Trust's resolve to tackle health inequalities, which is noteworthy in the draft. Members observe that improving life expectancy in Rotherham will involve expanding preventative work in the community. Members hope to see prevention efforts address the wider determinants of health that have been shown to affect Rotherham residents, for example, smoking and respiratory conditions, physical inactivity, and alcohol and substance misuse (Rotherham Data Hub). Focusing on the prevention needs of Rotherham residents can help add more healthy years onto many lives.

Members note positive progress in respect of inclusion and diversity work, including the creation of a diverse public panel, and, in respect of making the Trust a better place to work, achieving the highest ever staff survey response rate. Members are keen to observe the trajectory of staff comfort with having a friend or relative receive care at the Trust. Reduction in waiting times between referral and treatment is also very important progress that we need to see continue. Members once again express thanks for the dedication of hospital staff under the continued pressures of the COVID-19 environment and for all the hard work and long hours that have gone into this year.

Sincerely,
Taiba K. Yasseen
Chair of Health Select Commission

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 to prepare Quality Accounts for each financial year.

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

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

- the content of the Quality Account meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20.*
- the content of the Quality Account is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2021 to 31 March 2022.
    - papers relating to quality reported to the Board over the period April 2021 to 31 March 2022.
    - feedback from governors dated 16 May 2022.
    - feedback from NHS Rotherham Clinical Commissioning Group received 26 May 2022.
    - feedback from local Healthwatch organisation dated 9 May 2022.
    - feedback from Health Select Commission received 12 May 2022.
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2022.
    - the national patient survey, published September 2021.
    - the National Staff Survey 2021, published 30 March 2022.
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2022 (approved at Audit Committee on 13 June 2022).
    - CQC inspection report dated 29 September 2021.

- the Quality Account presents a balanced picture of The Rotherham 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 Account, 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.

- the Quality Account 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 Account.

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

By order of the Board

Chairman
June 2022

Interim Chief Executive
June 2022

Appendix 1: Review of Local Clinical Audits

The reports of 130 clinical audits were reviewed by the provider in 2021-2022 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

CSU	Title	Actions to improve care	Project No
A&E	Emergency Nurse Practitioner (ENP)	Good medical practice in relation to reviewing results and prescribing of oxygen to be highlighted to the team.	R1227
A&E	Re-audit of the management of paediatric burns patients presenting to the Emergency Department (ED)	A Standard Operating Procedure (SOP) for the management of paediatric burns has been circulated to all clinicians. A teaching session on burns management should be considered and offered to all levels of clinician.	R1257
A&E	Vital signs in Adults re-audit	Education required to the nursing team regarding observations, repeat and abnormal.	R1280
A&E	Feverish Children	Mortality education, including sepsis, to be carried out to staff. Poster to be created and displayed in the department.	R1168
A&E	Emergency Nurse Practitioner (ENP) Documentation	Good medical practice in relation to reviewing results and prescribing of oxygen to be highlighted to the team.	S1942
A&E	Advanced Clinical Practitioner (ACP) Documentation Audit 20-21	Medical practice regarding reviewing results and the prescribing of oxygen to be reiterated to the team.	S1977
A&E	UECC Paediatric Documentation Audit	Body mapping Standard Operating Procedure (SOP) in place and to be followed for all patients that present with safeguarding concerns. Reiterated to staff that pain score should be repeated 1 hour post pain relief being given and documented in the notes.	S2004
A&E	UECC Paediatrics Priority 2 audit	Reminder to staff to escalate to Clinician and Nurse in Charge if there is a delay in patient receiving assessment within the 15 minutes suggested and to document this clearly in patient notes. Discuss with IT regarding an option on meditech at triage that prompts a	S2005

		warning that a patient is a priority 2 and should have 1 hourly observations.	
A&E	UECC Paediatrics POPS/ NEWS 2 Audit	Frequency of observations for patients highlighted to paediatric staff, along with the importance of recording a PEWs score prior to transfer and to escalate score above 5 to the paediatric registrar prior to transfer.	S2006
A&E	Nursing Electronic Documentation audit	Continued recruitment in progress to improve the staffing levels. Ensure all Registered Nursing staff are able to undertake Patient Group Directives to enable timely administration at triage/completion of Emergency Department (ED) patient safety checklist. Ensure all Registered Nursing staff are able to administer IV additives/IV Morphine. To arrange Breakfast teaching sessions.	S2007
A&E	Is Urgent & Emergency Care Centre (UECC) meeting the standard of having a recorded 12-lead Electrocardiogram (ECG) within 10 minutes of any patients presenting with chest pain?	Poster to be created highlighting that all patients presenting to ED with chest pain should have a 12-lead ECG within 10 minutes of arrival.	S2025
A&E	Incidence and type of injuries in trauma	The trauma call criteria has been updated and uploaded onto the Hub. Radiology department have provided an onsite radiographer.	S2084
A&E, CYP, Safeguarding	Urgent & Emergency Care Centre (UECC) identification of vulnerable adults with dependent children safeguarding referrals (Care Quality Commission (CQC) 4H2)	The process is being reviewed for identification of vulnerable adults with dependent children and cases discussed at the safeguarding huddle. The Power BI Module data is being utilised for UECC and Safeguarding staff to review and bring to the safeguarding huddle rather than rely on the floor report being complete. Safeguarding Think Families training programme level 3 for UECC staff – full day course - rolling programme for UECC staff to be rostered in to attend. A focused Safeguarding 7 minute briefing will be sent out and communications in UECC to	S2043

		reinforce professional curiosity, embedding in practice routine enquiry over adults presenting or partner having dependent children and standards for documentation.	
A&E, Safeguarding	Audit of children 0-18 years repeat attendances to UECC has been appropriately been actioned and escalated	To review the regular attendances on a quarterly basis for the previous 12-month period to highlight those that meet the frequent attender flow chart. Recirculate the flowchart for information. Use the Frequent Attenders template to document any outcomes from the meetings regarding frequent attendances, ensuring this is embedded in Meditech. Use Emergency Department (ED) Management Plans template on Meditech to record Multi-disciplinary Team (MDT)/Actions as appropriate	R1249
A&E, Safeguarding	UECC Think Families approach - Documentation Audit	Recirculate information from safeguarding team regarding think families/ Learning Board. Recirculate 7-minute briefing (Nov 2020) record keeping. Reinforce key messages at the daily safety and safeguarding huddle. Work with departmental safeguarding champions to educate importance as role models for the department	R1250
A&E, Safeguarding	Audit of Beta-human chorionic gonadotrophin (BHCG) in Female patients aged 10 to <18 years in UECC	To liaise with IT and the Paediatric Lead to build into meditech a section asking if the patient has been informed of their BHCG result and when requesting urinanalysis a prompt that will remind staff to verbally advise the patient of the reason and rationale for taking a urine sample.	S2042
AMU	Review of case of Diabetic foot ulcers in Acute Medical Unit (AMU) (TRFT)	Standardise that all patients with diabetes foot gets referred to Diabetes/Endocrine team within 24 hours of admission. To make some posters and post it in AMU doctor's office.	S2029
Anaesthetics	Re-audit of Investigating the Documentation of Nasogastric tube placement in the Critical Care Department	Introduce trust wide nasogastric (NG) form on electronic patient record (EPR). Chest x-rays to be reported by Radiology prior to NG tube use and this documented on EPR form.	S1935

Anaesthetics	Perioperative Management of Diabetes in patients undergoing emergency surgery	Develop clear policies for ward/Theatre Admissions Unit (TAU) staff regarding fasting times and agreement needed over where to document fasting time. Introduce a system to flag diabetes at morning emergency theatres meeting and factor this into deciding list order/allow teams to appropriately treat diabetic patient preoperatively.	S1965
Anaesthetics	Time from decision to admit to patient arrival on Intensive Care Unit (ITU)	Email critical care doctors advising about use of referral response (RR) form. Ensure that time of acceptance is documented on admission document, if it has not already been documented on RR form. Change admission document to say admission within 4 hours instead of 'timely admission'.	R1205
Anaesthetics	Perioperative management of diabetic patients undergoing elective surgery in Rotherham foundation Trust	Ophthalmology to review their pre-operative assessment policy to bring it into line with National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations (i.e. HbA1C < 69 within 3 months of referral). Ophthalmology to review possibility of use of online Pre-operative assessment (POA). Glucometer training to be organised. Consider trial of automatic glucometers to theatres with all diabetic patients. Appoint a perioperative diabetes lead for the Trust.	S1932
Community Adult Services	Management of missed paediatric appointments, audit of adherence to the Neglect and Did Not Attend (DNA) policy	Rotherham NHS Foundation Trust Paediatric Dental Neglect Guideline will be updated, incorporating "Was Not Brought Pathway".	R1176
Community Adult Services	Quality of Radiographs in Barnsley, Doncaster and Rotherham Community Dental Service 2020	Construction of new custom screen for Radiograph Quality to reflect the changes in the quality scoring. Liaise with Software of Excellence (SOE) and request writing of reports to enable analysis of data.	R1279

Community Adult Services	Audit of the quality of paediatric new patient referrals to Barnsley Community Dental Service	A letter summarising the findings of the audit and standards for what should be included in referrals will be sent to all referring General Dental Practitioners in the area. Audit to be completed in the other community dental areas.	R1316
Community Adult Services	Audit compliance with National Institute for Health and Care Excellence (NICE) guidelines for referral for cochlear implant	Clinical meeting to be used to remind staff of professional clinical responsibility to meet the requirements of the NICE guidance regarding eligibility criteria for cochlear implantation and that continued poor compliance may develop into capability discussion. Clinical meeting to be used to discuss and collaborate practice with respect to severe-profound hearing impaired patients. New departmental cochlear implant (CI) Champion will present a teaching and training session to audiology clinical staff outlining the role of the CI champion and provide information regarding local services. Implement a severe/profound CI review waiting list in SystmOne with a view to improved identification and management of any service users whom are in process with regards CI referral process.	R1324
Community Adult Services	Audit of patient outcomes for those who attend the TB clinic	To reduce the time between referral and first seen by the respiratory doctor by upskilling of TB nursing service to support nurse led clinic for those diagnosed with latent TB infection. Continue to meet needs of the underserved by looking at delivering care in different venues as applicable.	S2034
CYP Community	Record Keeping Audit 0-19s (2020/21)	Feedback at staff meetings regarding the outcomes of initial and subsequent audits quarterly and at Clinical Governance annually. Where issues have been identified in relation to a particular member of staff, this is to be discussed at a one to one, quarterly. Audit tool to be	R1210

		reviewed and updated. Responsibility for completing the record keeping audit to be passed to practitioners in order for them to identify areas for improvement.	
CYP Community	Complex Care Team Record Keeping Audit 2021	Specifically audit the records of those children directly working with, to avoid records with minimal to no record entries, making it difficult to audit. To develop an audit specific to the Special Educational Needs (SEN) team and their workload. Educate staff within the team further to encourage, ask/document whom has attended with a child including names.	R1286
CYP Community	Children's Community Nursing Team - Record Keeping Audit	Reiterate to the team the importance of ensuring groups and family relationships are completed on the first visit. Discuss how the team will ensure consent is gained when completing repeat treatments.	S2032
CYP, Safeguarding	Audit of the effectiveness of discharge planning meetings (by reviewing Huddle documentation) – Children & Young People (CYP)	Update and circulate the discharge planning policy once ratified Work directly with staff during 'Stop the shift' to raise the awareness of the Discharge Planning Meeting for any new emerging concerns when subject to Child Protection Plan or Looked After Children. Raise the awareness of importance of the 0-19 service undertaking any concerns from admission and ensuring contribution to the discharge plan. Ward manager to be notified to ensure consistent process for Safeguarding Case. Specific Huddle sheets to be scanned into Meditech patient record.	R1191
CYP, Safeguarding	Re-audit of Safeguarding Documentation on the Children's Ward (Voice of the child and Think families approach)	Work with the champions to continue to embed the Think families approach and reinforce the key messages. A training programme is being developed. Review e-safeguarding template for prompts regarding assessment of vulnerable adults with dependent, to include teenage	S2040

		parents and asylum seekers where English is not their first language. Review Meditech template regarding domestic abuse to add questions for routine enquiry. Communication to be circulated and development of training sessions for Paediatric staff to be competent and confident with routine enquiry for domestic abuse and responding to any safeguarding concerns. Circulate the voice of the child guidance document and reinforce at Daily huddles, supervision sessions with signs of safety tool focus and importance of capturing voice of the child. Recirculate genogram reference guide and tools and reinforce at safeguarding supervision and training with medical colleagues.	
CYP, Safeguarding	Missing Children Standard Operating Procedure (SOP): audit of completion of template and adherence to the SOP	Review of the Missing Children SOP to ensure changes to the local/national alert letter is included. Review processes on contacts for services mentioned, and consider whether an alert box can be utilised in systmone as a reminder.	R1223
CYP, Safeguarding	Audit of the use of the Ante Natal SOP in 0-19 service	Monthly exception reporting to include review of multiparous reports not completed	R1251
CYP, Safeguarding	Audit of Paediatric Child Protection Medicals done in Clinics/ Wards	Introduce a checklist on the proforma so the clinician completing it can ensure they have completed all necessary sections, to ensure better description of developmental and social history, more clear conclusion and opinion, Voice of child, Management Plan and signing Body Map.	S2027
CYP, Safeguarding	Safe Sleep assessment re-audit 0-19s - 2021	Complete dip sample audit of safe sleep assessments when looking at ICON audit. Share Audit outcome with the service and remind staff to follow the safe sleep SOP. Email audit outcome to staff Team Leaders to remind staff to ensure the safe sleep questionnaire is completed, but not to finalise the safe sleep	R1273

		questionnaire if a reassessment is required, but once reassessment is completed, the questionnaire should be finalised. Staff to be reminded to ensure effective and robust liaison with midwifery services especially where safe sleep issues have been identified.	
CYP, Safeguarding	Re-audit of the use of the Ante Natal SOP in 0-19 service	To continue to review monthly exception reporting to include review of Multiparous reviews not completed. Remind staff of ensuring effective caseload management in order that they can identify any Mothers to be who require a visit if a colleague is on sick leave.	R1303
CYP, Safeguarding	Audit of the use of the Young Persons Service (YPS) SOP in 0-19 service	To review the current staffing against the caseload numbers to ensure that the appropriate amounts of staff are within the service. Feedback at team meetings and Clinical Effectiveness meeting the theme of the findings to all Young Persons Team practitioners.	R1308
CYP, Safeguarding	Audit of the use of the YPS SOP in 0-19 service	To ensure that the Young Persons Team is staffed appropriately, by reviewing the current staffing against the caseload numbers to ensure that the appropriate amounts of staff are within the service.	R1308
CYP, Safeguarding	Audit of Paediatric Child Protection Medicals done in Clinics/ Wards	Arrange a teaching session on child protection for all new paediatric registrars. Introduce a checklist on the proforma so the clinician completing it can ensure they have completed all necessary sections. Add a tick box on the front of the document for 'Nothing to declare' so that absence of lesion or mark is documented.	S2027
CYP Service	UNICEF Baby Friendly Initiative Audit of Staff Education	Accurate training records of staff to be maintained. Recruit at least 1 champion for each 0-19 Team. Establish regular team meetings to disseminate information and discuss infant feeding initiatives. Champions to have access to further training. 0-19 Team Managers to support Champions	R1253

		role development. 0-19 infant feeding newsletter to be collated and distributed to all staff every 2-3 months. All new staff to complete 2 day Infant Feeding Training within 6 months of employment.	
CYP Service	UNICEF Baby Friendly Initiative Audit of Breastfeeding Mothers	Health Visitors to be informed of importance of obtaining consent. Lead auditors to access UNICEF baby friendly initiative audit workshop for training in use of tool. Conduct audit of breastfeeding mothers using UNICEF Baby Friendly Initiative Audit Tool.	R1254
CYP Service	UNICEF Baby Friendly initiative Audit of Staff Education	Introduction of a new updated training programme from January 2022 for all staff to attend. Staff resource packs made available as well as a quarterly infant feeding newsletter.	R1299
CYP Service	Looked after children's clinic: Audit of Action Plan	All health recommendations should be completed in a Specific, Measurable, Achievable, Relevant, Time-based (SMART) way and by a specific date, email and discussions with all doctors who do Look After Children medicals to inform them of this.	R1306
CYP Service	Audit of quality of records on Children's Assessment Unit (CAU) and Children's ward	Educate staff around how to correctly address errors, deletions and alterations in hand written care records and to ensure that the use of date, time and signatures are in the correct place, using posters, newsletters and the stop the shift method. Consultants to discuss in training in Dr teaching sessions.	S2008
CYP Service	Audit of quality of records on Special Care Baby Unit (SCBU)	Amend nursing records to facilitate documentation of patient name and ID on every page (header) Educate all staff how to correctly address any errors, deletions or alternations in hand written records using posters, newsletters and stop the shift sessions. Teaching session on Mandatory and Statutory Training (MAST) on record keeping. Develop a small working group to develop core	S2009

		care plans. Meet with Health Informatics to discuss move to digital format of documenting.	
CYP Service	Service Evaluation of Paediatric Acute Rapid Response Outreach Team referrals (Parrot) team referrals	To incorporate the PARROT team in the paediatric medical induction. Set up regular education days in UECC for both medical and nursing staff. To revisit and update the referral criteria for PARROT to include other conditions such as upper respiratory tract infection and feeding support.	S1962
CYP Service	Are the correct blood sampling and labelling processes being undertaken when obtaining blood specimens?	To ensure new Doctors have training, ensure they are competent when ordering bloods from the system. That the doctors are aware how to print blood labels from the printers and how to reprint if printer not linked; The Doctor checks the stickers printed correlates to the bloods taken.	R1211
CYP Service	Audit of the Management of Asthma in Paediatric Outpatients	Ensure asthma proforma is visible in ALL consulting rooms. Add all information to the Asthma drawer. Asthma Nurse referral criteria in place to ensure every child with Asthma should be referred. All registrar clinics are supervised by a consultant. To include the topic of Asthma in the junior doctor induction programme.	S1930
CYP Service	Re-audit of Antimicrobial Stewardship in Paediatrics	Update the guideline to clarify which antibiotic to use in sepsis in <1 month old. Email to all the prescribers to improve documentation regarding any deviations from the guideline.	R1237
CYP Service	Child Death audit	Audit shared with Lead Nurse Child Death Review, and at Clinical Effectiveness forum.	R1271
CYP Service	Pain assessment in children during their admission into the department	Share the pain management SOP with the team.	S2037
Dermatology	Cutaneous Allergy Investigations as measured against standards derived from the British Association of	Audits have been disseminated to the clinical team and a re-audit will be undertaken when the national audit is launched.	R1192

	Dermatology (BAD'S) 2019 published guidelines		
Dermatology	Dermoscopy: an essential part of lesion assessment	Formal teaching presentations to be undertaken. Dermatoscopes to be stored at the front desk for ease of access.	S1973
Endoscopy	Audit of patient comfort scores	Mandate all endoscopists to consent 100% outside of the procedure room. Discuss all options for sedation / comfort at pre-procedure check by nurses and communicate to staff in room.	S2020
Endoscopy	Audit of Key Performance Indicators (KPIs) (July 2020 - December 2020)	To Review individual performance with endoscopists at appraisal.	S2013
Endoscopy	Audit of consent for Endoscopy (July to December 2020)	Mandate all endoscopists to consent prior to entering room.	S2015
Endoscopy	Audit of sedation (July 2020 - December 2020)	Remind all nurses during meetings to discuss all options for comfort, including sedation at pre procedure check by nurses and communicate to staff in room.	S2017
Endoscopy	Audit of Key Performance Indicators (KPIs) Quarter 3 & Quarter 4 2020-21	Underperformers identified in Caecal Intubation Rate, Comfort scores, Polyp detection and retrieval rates, D2 intubation and Rectal retroversion rates. Address underperformance through upscaling workshop.	S2062
Endoscopy	Audit of Consent for Endoscopic retrograde cholangiopancreatography **(**ERCP) - January 2021 to June 2021	Local training sessions for consent taking for junior doctors to be arranged. Accessible leaflets about ERCP to be readily available.	R1352
Endoscopy	Audit of Outcomes of ERCP (January 2021 – June 2021)	Review of ERCP service in view of unexpected numbers of complications and deaths reported to the Joint Advisory Group (JAG) has been completed.	S2021
Endoscopy	Audit of Repeat endoscopy within 12 weeks for gastric ulcer – Sept 2020 to March 2021	Ensure that all endoscopists are aware of gastric ulcer guidelines. Complete amborder for rescope on the day of first scope so cannot be missed or forgotten.	S2061
ENT	Thyroid Fine-needle aspiration (FNA) Re-Audit	Conduct 2nd cycle of audit to look at Royal Hallamshire Hospital Multi-Disciplinary Team pathologist grading of Rotherham Fine Needle Aspiration cytology,	S2038

		as a comparison from histopathology. Identify costs of repeat Fine Needle Aspirations at Rotherham Hospital compared to sending patients' cytology directly to Sheffield.	
ENT	Prospective audit of thyroid cytology	Re-audit to be undertaken.	R1049
General Surgery	Audit of Complex decision making in whether to perform Laparotomy	Repeat audit to include further data.	S1910
General Surgery	Extended Pharmacological Venous Thromboembolism (VTE) Prophylaxis (28 days) for Patients Who Had Major Cancer Surgery in Abdomen	To have a check box on Meditech (discharge letter) to document if the discussion if extended prophylaxis required on discharge completed.	S1926
General Surgery	Evaluation of the use of the Multidisciplinary Emergency Laparotomy Pathway (MELP) booklet and the assessment of the time of the first dose of the antibiotics given on the MELP pathway patients	Implement Electronic MELP pathway.	S1946
General Surgery	Ileostomy reversal post Low Anterior Resection Audit	To develop a pathway dividing the patients into chemotherapy and non-chemotherapy pathway, and ensure booking gastrograffin on discharge for 4 weeks after surgery for non-chemo patients.	S2011
General Surgery	The use of vital signs on ward rounds	Draft a 'Perfect Ward' guide to ensure appropriate documentation of every ward round.	R1294
GU Med	Child Safeguarding Documentation Audit	To set up task lists within the Electronic Patient Record to co-ordinate the follow up and return of samples by the administration team. To review the Standard Operating Procedure and communicate issues at team meetings to improve standards of record keeping. Make changes to the post operation leaflet and advise patients to contact Integrated Sexual Health Service if problems occur in the first 4 weeks to improve the accuracy of data in relation to post operation problems.	S1948

GU Med	Implant audit	Modifications to be made to the implant template within the Electronic Patient Record (EPR) (Inform) added to both implant insertion and removal templates, and clear documentation of the advice given to patient regarding return to our service in the event of problems with the implant. Department to agree recommended practice in relation to cleaning agent used.	R1181
Haematology	Gold Standards Framework (GSF) prophylaxis for lymphoma patients undergoing chemotherapy	GCSF added to chemo care protocols. Prescribers made aware of need to risk assess individual patients.	S1934
Lab Medicine	Audit for the use of Tranexamic (TXA) acid in a major haemorrhage event	Transfusion Team to continue to engage and promote adherence to national policy and guideline as per current practice. Continue to reiterate to clinical areas the need to record when TXA is given, and ensure it is documented on EPR, physical notes, anaesthetic chart or obstetric proforma. Transfusion Practitioner to continue to review all major haemorrhage protocol (MHP) activation.	R1240
Medicine	Management of Acute Upper GI bleeding	Explore the possibility of including the UK Acute Upper GI bleeding bundle onto Meditech.	S1909
Medicine	Assessment of COVID-19 patients and management standards	Clinical Frailty score training to be included in FY1/medical doctor induction programme.	S1966
Medicine	Clinician compliance with screening for delirium on acute admission to medicine/Clinician compliance with Dementia screening and completion of clinical frailty score.	To continue monitoring delirium and dementia screening to achieve the target >90%. To continue monitoring referral to memory service for people positively identified on screening for dementia to achieve the target of 100%.	S2002
Medicine	Stroke Unit compliance with anticoagulation policy of the Trust	Tabs on Meditech to become mandatory to complete ie height and weight, creatinine clearance, baseline blood tests, indications and contraindications. Introduce a tab on Meditech labelled Anaemia which should be mandatory in case of how Hb. CHA_2DS_2-VASc will become mandatory only in	S2045

		case of atrial fibrillation or flutter. A generic comment for blood monitoring for patients started on anticoagulants will be proposed which should populate automatically in the discharge summary.	
O&G	Audit of Termination of Pregnancy (TOP) before and during COVID-19 pandemic	Train more unit nurses and Advanced Care Practitioners (ACPs) in implant insertions to increase provision of Long Acting Reversible Contraception (LARC) as part of one stop care. To increase provision of manual vacuum aspiration (MVA) as part of one stop care when appropriate, and reduce number of general anaesthetic (GA) Surgical Terminations of Pregnancy.	S1970
O&G	Evaluating Diagnosis of Small for Gestational Age Antenatally and Appropriate Documentation (CNST)	Introduce foetal growth restriction risk assessment sticker. Update ultrasound guideline. Assess at booking and prescribe Aspirin accordingly.	S1981
O&G	Steroids in preterm birth	Laminate and place toolkit on Labour Ward (LW) to ensure that all patients in Pre-term labour are given appropriate treatment. Add 'Pre-incision Antibiotics to checklist on Meditech.	R1263
O&G	Audit on Assessment and Diagnosis of Ectopic Pregnancy (PUL)	Scan criteria for intrauterine pregnancy to be reviewed by including the double decidual sign. To give clear impression/diagnosis on the Ultrasound Scan (USS) report to reduce need for subsequent scans. Colour Doppler to be used in evaluation of the endometrium and retained products of conception. Ensure new trainees are familiar with the guidelines on induction in August 2021.	R1264
O&G	Audit to evidence compliance of National Institute for Health and Care Excellence (NICE) quality standards in abortion care	To circulate the Termination of Pregnancy self-referral poster to GP practices to ensure easy access to Patient Administration System (PAS) by self-referral options for patients. Patient to have option of both Medical and Surgical options for Termination of Pregnancy. Laminate copies of	R1305

		Patient decision aids. Ensure all contraception options available post abortion.	
O&G	Audit of Reduced Fetal Movements 2020	Educate midwives though leaning points and newsletter. To communicate the need to ensure that foetal heart is auscultated using pinnard / Doppler to ensure viability and maternal pulse is recorded on all foetal monitor/cardiotocograph (CTG'S), and ensure that fundal height is measured and plotted on CGC if not plotted within the last 2 weeks.	R1230
O&G	Audit of Birth choices for mums (for Ockenden Assurance)	Mandatory link on Meditech to Vaginal Birth after Caesarean check list and patient information.	R1284
O&G	Re-audit of heavy menstrual bleeding management	Develop simplified form for each visit of heavy menstrual bleeding referrals, to include impact of quality of life (QOL) by adding a mandatory form on new patient Gynaecology outpatient (OP) visit summary form, or a new heavy menstrual bleeding (HMB) OP visit summary form, on Meditech and / or paper form. To raise at next GP forum to include on the annual GP training schedule. Register prospective re-audit of all quality standard criteria when QOL history form implemented.	S2053
O&G	Audit of Vitamin K Administration	Education of midwives regarding prescribing of vitamin K through Learning Points and Stop the Shift.	R1231
O&G	Management of glandular abnormalities over 5 years in a DGH	Patients should be referred to the appropriate 'see and treat' clinics.	S2090
O&G - Maternity	Postnatal Ward Audit of Care Quality Commission (CQC) Quality Improvement Project (QIP) Safe Domain	Provide senior management in maternity with evidence to support compliance with CQC Safe Domain Safety standard 3. Add to Wharncliffe Ward and Labour Ward Learning Points that providing women with the red book should be mandatory. Safeguarding documentation process to be made available electronically to avoid risking mis-	S1987

		communication or near misses regarding safeguarding issues.	
O&G - Maternity	Audit of correct classification of Cardiotocography (CTG) both Antenatally and Intrapartum and appropriate management	A risk assessment tool should be used prior to start of fetal monitoring. The risk assessment tool is to be uploaded to Meditech. New fresh eyes tool to also be uploaded onto Meditech and an audit to check compliance of the use of this carried out. There should be appropriate escalation where CTG is abnormal. An audit will be undertaken to review if this is taking place.	S2076
O&G – O&G Maternity, Safeguarding	Maternity safeguarding children record keeping audit to ensure vulnerabilities identified and Think Family approach used within records.	Audit results to be presented during Maternity Clinical Effectiveness and Safeguarding Operational meetings and Training day to be developed and shared across the Trust regarding Think Family approach, to give targeted awareness raising to improve standards of record keeping in relation to safeguarding. Develop a proforma for use during the audit process.	R1216
O&G – O&G Maternity, Safeguarding	Re-Audit of Perinatal Domestic Abuse Screening 2021	Recirculate revised Domestic Abuse Policy to all areas to highlight changes and how this may affect practice. 7 Minute briefing to be circulated to maternity clinical leads for all areas to cascade reminder that women must be seen alone to ask routine enquiry questions if safe to do so.	R1260
O&G – O&G, Maternity, Safeguarding	Re-audit of Documentation of who accompanies women during labour 2021	To work with Digital Midwife to ensure relevant documentation for labour and birth have mandatory fields to reflect the need to capture accompanying person's details.	R1285
O&G – Gynaecology	Biopsy to Treatment interval in Colposcopy	To create a business case for extra clinics to accommodate increase in referrals since pandemic.	R1270
O&G – O&G Maternity	Audit of World Health Organisation (WHO) checklist in Labour ward theatre	Reminder to all staff re: importance of completion of WHO checklist in Labour ward theatre via learning points and newsletter.	R1232

O&G – O&G Maternity	Audit on Management of Multiple Pregnancy	Allocate named Consultant to manage antenatal care of multiple pregnancy. Incorporate twin checklist within Meditech. Create twin delivery document within Meditech (to correlate with scribe sheet).	S2044
O&G – O&G Maternity	Audit to review body mapping of neonates following birth (April - Sept 2021)	Ensure all staff are documenting in Meditech by ensuring there are no copies of the paper body maps still available. For staff members who are not compliant: 1st time – Formal discussion by labour ward lead midwife 2nd time – Formal discussion by Line manager 3rd time – consider a formal action plan for learning	S2087
OMFS	A second cycle audit of the quality of General Dental Practitioner (GDP) referrals received by Rotherham General Hospital Oral and Maxillo Facial Surgery (OMFS) Department	Encourage use of the referral proforma by targeting practices that are not using it yet. If GDP practices continue to avoid using proforma, ask Local Dental Committee (LDC) to contact them to request that they use it.	R1289
OMFS	Electronic Venous Thromboembolism (VTE) Assessment and prescribing. Are we doing it correctly?	The On-call Max Fax Dental Core Trainee (DCT) should produce a Post Take Ward Round document for each patient the morning after their admission, to ensure all admitted patients have a VTE assessment done at 24 hours or Post Take ward round. If prescribing TED (anti-embolism) stockings, prescribe them from the admission time (not 1800 or 2200 that day or the following day). If prescribing Tinzaparin, the Max Fax DCT makes sure the patients weight and eGFR has been noted, and allow 12 hours pre-op, 6 hours post-op, or ask the Operating Consultant for guidance. The Max Fax DCT withholding Tinzaparin should document any reasons why Tinzaparin is being withheld.	R1215
OMFS	Consent in third molar extractions	Ensure the provision of patient information leaflets for initial outpatient visits. Consent form	S2077

		stickers will hopefully be introduced as a memory aid.	
Ophthalmology	Emergency eye clinic audit	Advise to all clinician by email that source of referral to be written in most cases at first visit. Patients seeking self-referrals must be instructed to get professional advice through available services unless justified. Receptionists and secretaries must not book general clinic patients to Emergency Eye Clinic (EEC) and must keep 1 or 2 consultant clinic slots available for EEC patient follow ups. Discharge guidelines to be reviewed and updated. EEC telephone triage to be taken over by staff nurses and orthoptists follow with appropriate triage training.	R1220
Ophthalmology	Diabetic Macular Oedema (DMO) Re-audit	Move patients to a one stop clinic for treatment. Longer acting treatment Beovu regime introduced.	R1243
Ophthalmology	Cataract surgery outcome for all surgeons at RDGH 2019	Re-audit in 12 months time.	S1893
Ophthalmology	Retinopathy of Prematurity (ROP) Screening Re-Audit	Discuss with special care baby unit (SCBU) that referral to ROP screening should be made in advance, to allow the infant to receive 1st screening appointment before discharge, even if the baby is younger than 4 weeks postnatal age. Discuss with SCBU that Parents' information leaflet provision must be clearly documented in the referral letter in all cases. For transferred babies, to include in the SCBU referral letter, the date of the screening.	S2033
Orthopaedics	Management Audit of Paediatric Anterior Cruciate Ligament (ACL) and Meniscal injuries	Every paediatric knee injury must be reviewed by the Consultant – the Registrar should present the case as soon as possible in the clinic. Skyline radiographic view should be taken in all patients with soft tissue knee injury alongside Anterior Posterior (AP) and Lateral views. Develop a system whereby	R1258

		the locked knee case is discussed in the trauma meeting the very next day and the patient is called in the next available acute knee clinic/other clinic for review by the consultant, followed by urgent MRI and surgery	
Orthopaedics	Immediate Trauma Care Audit	Results to be discussed with Emergency Department colleagues.	S2046
Orthopaedics	Evaluation of emergency MRI availability for patients with suspected Cauda Equina Syndrome - Society of British Neurological Surgeons and British Association of Spine Surgeons Guidelines	Discussion with team members for adequate documentation of cause of delay in MRI scans.	R1246
Orthopaedics	Audit of the use of VTE prophylaxis post knee Arthroplasty	Re-audit in 6 months time as a prospective audit. To additionally expand to include all lower limb (hip and knee) arthroplasty.	R1283
Orthopaedics	Appropriate documentation of consent form 4, and of Mental Capacity Assessment (MCA) form for new suspected cognitive decline	Senior House Officer (SHO)/registrar assessing patient to fill in section D of the consent form. Must include if next of kin (NOK)/relative is not available via phone. Proactive involvement of junior doctors to check signed consent form and inform Consultant if needed whilst on post take ward round (PTWR). To include label / sticker box on page 3 of consent form 4.	R1297
Orthopaedics	Audit looking into prescription and administration of peri-operative antibiotics on EMR elective Orthopaedic cases	Surgeons to prescribe post-op antibiotics after discussing the World Health Organisation (WHO) checklist and before leaving theatre.	R1342
Orthopaedics	Early Management of the Paediatric Forearm Fracture	Teaching sessions to be arranged for SHO/Advanced Nurse Practitioners (ANPs) on manipulation techniques. A clear protocol for both manipulation and analgesia to be produced.	R1357
Orthopaedics	Retrospective review of medical records to check assessment of joint above and below the fracture	Make sure that examination of the joint above and below the injury is documented in the patient notes.	S1999

Palliative Care	Documentation of patient's preferred place of death	Advance care planning should become a routine part of patient care. As a part of this, patients should be asked where their preferred place of death is.	R1295
Patient Safety	Adherence to Trust Duty of Candour Policy	Patient safety team to deliver training on Duty of Candour policy adherence and requirements. Datix to be reformatted to encompass all requirements of regulation 20 for Duty of Candour. A patient focussed information leaflet to be created to provide direction and focus for the patient on the elements of Duty of Candour. The Trust Duty of Candour policy will be updated and issued to all staff via the intranet.	S1967
Patient Safety	Naso-Gastric (NG) tube insertion audit	To introduce an electronic NG tube confirmation record. Meditech Proforma to be developed and introduced. NG feeding policy to be rewritten. Standardisation of all NG feeding and drainage tubes Trust wide. Introduction of mandatory standardised training for all Nursing staff/ NG tube placers.	S1964
Patient Safety	Compliance with Trust Falls Risk Assessment	Policy for slips, trips and falls involving patients to be updated and circulated to all appropriate teams. Revise the falls care plan trigger to ensure the risk assessment process falls in line with evidence based practice. Falls Learning and Competency Package created and rolled out across the trust.	R1236
Patient Safety	An audit to ensure the correct monitoring of vital signs. National Early Warning Score (NEWS2) audit (previously MEWS)	Nursing staff need additional training on the rationale for completing observations as per policy. Changes required in Meditech to ensure scheduling observations is a more efficient process. Creation of a proforma for reviewing deteriorating patients. Escalation planning education and improved compliance.	R1174
Patient Safety, Trust wide	Harm Grading Audit	Training to be provided to medical and nursing staff on Harm risk	S2041

		grading, to help staff understand what the level of harm is assigned to. Regular audits to be undertaken to review if training is productive and practice is improving.	
Pharmacy	Antimicrobial policy: prescribing on the drug card	Discuss IV antimicrobials and review dates with Electronic Prescribing and Administration (EPMA) team. Develop ward round proforma document. Feedback to directorate Governance meetings.	R989
Pharmacy	Antimicrobial Stewardship audit of IV Broad Spectrum antibiotic Prescribing 48-72 hour review	Create an algorithm that mandates completion of 'Review Date' field or restricts validity of prescription to a maximum period of 72 hours. Create an e-proforma for 48-72 hour review documentation. Flag Public Health Agency (PHA) clinical advice & guidance documents as actionable tasks on Meditech (EPMA team to assess). Encourage pharmacy staff to raise prescribing issues directly with medical teams on the wards. Deliver teaching on ‘Start Smart then Focus’ and COMS criteria principles during the Clinical Effectiveness for Microbiology meeting. Increase awareness of antimicrobial policy and how to utilise guidance effectively to make more informed choices on treatment.	S1947
Radiology	Optimise Computed Tomography (CT) Kidneys, Ureters and Bladder (KUB) imaging to stop over radiation	Teach the Radiographers about over radiation and make them aware of results. To change the CT KUB guidance for patients with renal colic undergoing the scan with T10 suggested as an anatomical landmark to start the scan from.	R1224
Rheumatology	An Audit for Sjogren's Syndrome Treatment	Raise awareness of guidelines for Sjogren's Syndrome in Clinical Effectiveness meeting.	R1307
Safeguarding	Safeguarding 16 & 17 year olds pathway when presenting to Rotherham Hospital	Meeting with IT and practice development to review the 16 & 17 admissions template, to review the process for all safeguarding checks to be completed within 4 hours of admission.	R1265

		Children's ward manager to send communications to staff regarding preoperative care patients to ensure that the information is documented for safeguarding checks on admissions template. Maternity staff to ensure all safeguarding information checks are documented in the safeguarding admissions maternity template. Safeguarding Advisors to attend areas Acute Medical Unit (AMU) / Acute Surgical Unit (ASU) / Ward A6 / Ward B11 to complete stop the shift daily to educate staff on adult wards regarding safeguarding 16-17 year old policy. Develop guidance standard for documentation of parental vulnerabilities and circulate practice guidance for staff. Review ward B11 process for recording safeguarding checks and plan for implementation for staff documentation on trust standard Meditech 16 & 17 admission template.	
Safeguarding	Clinical compliance with Making Safeguarding Personal (MSP) for The Rotherham Foundation Trust	Incorporate the safeguarding Form 1 onto Meditech with a prompt to appear before submission to remind the referrer to ensure that they are making safeguarding personal. To work with the children's safeguarding team to develop a training and support programme for Trust staff. Weekly dip tests of safeguarding referral forms received and feedback will be provided to ward managers.	R1238
Safeguarding	Safeguarding Survey Monkey - acute and community maternity areas	To provide a 'pulse point' check on maternity staff's understanding of children's safeguarding processes. Share results of survey in Summary On A Page format at Maternity Governance and Safeguarding Operational meeting for wider learning.	R1317
Safeguarding	Medication Management Audit	To review the MCA Policy to ensure there is clarity over missed medications and consideration of the use of Covert medication. Develop a flow-chart to support	R1272

		staff in their decision making related to medication refusal and the use of covert medication.	
Safeguarding	Re-audit Safeguarding 16 & 17 year olds pathway when presenting to Rotherham Hospital	Meet with IT and practice development to review the process for all safeguarding, to make any additions and amendments to support staff with documenting safeguarding checks and any emerging concerns identified. Communications to staff from ward manager to compliment previous safeguarding communications relating to discharge planning where there are emotional wellbeing concerns. Safeguarding Advisors to attend areas Same Day Emergency Care (SDEC) / Acute Surgical Unit (ASU) / Surgical Day care, to complete stop the shift daily.	R1332
Safeguarding, Trust wide	Electronic Multi-Agency Request For service (EMARF) Audit (Worried About A Child form) on a weekly basis	Resend 7- minute briefing threshold descriptors with communications email to TRFT staff, safeguarding champions for cascade out to raise the awareness that referrals need to evidence level of concern and map threshold for referral. 1:1 Safeguarding supervision. Feedback to staff for any learning over poor quality referrals and encourage attendance at the bespoke training.	R1198
Safeguarding, Trust wide	Re-Audit of The Effectiveness of Safeguarding Huddles - Consideration Given to Discharge Planning on children's ward	Reinforce criteria of referral for discharge planning via communications summary on a page briefing. Add into the current monthly audit dip sample additional questions to monitor use of the safeguarding templates. Practice Resolution process with support of the Safeguarding team to resolve differences at the earliest opportunity to be part of the huddle discussion daily. Ward Staff to ensure 0-19 staff are invited to all Discharge Planning Meeting: inform duty team for the specific child of the meeting date and time. If 0-19 worker declines to attend, ask them to escalate to	R1293

		their 0-19 team leader. Email to be sent to social care manager to reinforce with social care managers the need for the formal discharge planning and strategy minutes to be sent within 5 working days. Embed e-safeguarding care plans and discharge planning meeting templates on children's ward.	
Trust wide	Management of suspected sepsis adhering to the Trust Sepsis Screening Tool	Promote Sepsis Mandatory and Statutory Training (MAST). Face to face discussion with junior doctors twice a year.	S2028
Trust wide	Audit of Barcode Scanning when Administering Medication on Electronic Prescribing and Medicine Administration (EPMA)	Purchase more scanners to permit barcode scanning of wrist labels	R1245
Trust wide	Trust wide Do Not Attempt cardiopulmonary resuscitation (DNACPR) audit (2020/21)	Trust DNACPR policy to be updated. All staff (especially senior clinicians) should have training on how to complete DNACPR form correctly and could be part of MAST training. Consider having a DNACPR champion on each ward to ensure compliance with policy. Mental capacity training for all grades of staff.	S1982

Appendix 2: Readmissions within 28 days

Emergency Re admissions within 30 days of discharge from Hospital		
Age Bands	**1st April 2020 - 31st March 2020**	**1st April 2021 - 31st December 2021**
Age 0- 15 years	9.73%	7.91%
Age 16 years and above	8.69%	7.81%

Data source: TRFT Data Warehouse SQL Server Reporting Services - Re admissions

The latest update available from NHS Digital is for the period 2011/12. Therefore, the internal TRFT data Warehouse is used for all reporting of re admissions for the performance reports for the Board, the Divisions, the clinical support units (CSU) and for the Service Line Monitoring (SLMs) reports.

The internal TRFT data has been aligned to the National Benchmarking reports - in this case Model Hospital. Model Hospital is an NHSI tool that uses HES (Hospital Episode Statistics) Data and contains some additional methodology on how they report readmissions. From 2020, we have now rewritten our reports to align to National data, the NHSI methodology is very similar to the old methodology, with some slight variances, we are now including INO, same day readmissions and reporting within 30 days. We are also picking up if a patient has had multiple readmissions in the reporting period if within the time frame. This is all as per the National Methodology. - The report does however report readmissions - Same Treatment Function code back to Same Treatment Function Code.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2021/22

Detail of Visits	Date of Visit
Radiopharmacy - Insp GMP 12994/29314-0032 - Postponed	Postponed
CQC Inspection	11 May to 13 May 2021
CQC Well-Led Inspection	22 June to 24 June 2021
Urology GIRFT	12 November 2021
Yorkshire and Humber ODN ITU Peer Review	7 October 2021
Critical Care Paediatric Service Evaluation Review Update	October 2021
Ofsted and the Care Quality Commission (CQC) Joint area SEND inspection	5 to 9 July 2021
Health & Safety Executive	December 2021
UKAS Full assessment visit	08 February & 03 March 2022
Counter Terrorism Safety Advisor (CTSA)	March 2022
CQC Unannounced Inspection (UECC)	2 March 2022

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Acronyms

A&E	Accident & Emergency Department
AMD	Associate Medical Director
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
APC	Admitted Patient Care
ART	Acute Response Team
ASU	Acute Surgical Unit
BAME	Black, Asian and Minority Ethnic
BMA	British Medical Association
BSI	British Standard Institute
BSL	British Sign Language
CAP	Community Acquired Pneumonia
CCG	Clinical Commissioning Group
C-DIFF	Clostridium Difficile
CEO	Chief Executive Officer
CHKS	Comparative Health Knowledge System
CMP	Case Mix Programme
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CPE	Carbapenemase Producing Enterobacterales
CRM	National Audit of Cardiac Rhythm Management
CSDS	Community Services Data Set
CSE	Child Sexual Exploitation
CSU	Clinical Support Unit
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computed Tomography
CYP	Children and Young People
DCT	Dental Core Trainee
DFI	Dr Foster Intelligence
DIPC	Director of Infection Prevention and Control
DNACPR	Do not attempt cardio-pulmonary resuscitation
DoLS	Deprivation of Liberty Safeguards
DP	Dental Practice
DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
ECDS	Emergency Care Data Set
ED	Emergency Department
EEC	Emergency Eye Clinic
EPIQ	Enhanced Patient Care through Improvement in Quality
EPMA	Electronic Prescribing and Medicine Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GAfREC	Governance Arrangements for Research Ethics Committee
GDP	General Dental Practice

GI	Gastro Intestinal
GIRFT	Getting it Right First Time
GP	General Practitioner
GSF	Gold Standard Framework
HDU	High Dependency Unit
HES	Hospital Episode Statistics
HOPE	Helping People to Overcome Problems Effectively
HSE	Health and Safety Executive
HSMR	Hospital Standardised Mortality Ratio
ICS	Integrated Care System
IDQ	Improving Data Quality
IG	Information Governance
IPC	Infection Prevention and Control
ITU	Intensive Treatment Unit
KPI	Key Performance Indicator
KUB	Kidneys, Ureters and Bladder
LeDeR	Learning Disabilities Mortality Review
LGBT+	Lesbian, Gay, Bisexual, Transgender and related identities
LPS	Liberty Protection Safeguards
MAG	Mortality Analytical Group
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MaST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MCISS	Macmillan Cancer Information Support Base
MDT	Multi-Disciplinary Team
ME	Medical Examiner
MELP	Multidisciplinary Emergency Laparotomy Pathway
MEO	Medical Examiner Office
MHRA	Medicine and Healthcare Products Regulatory Agency
MIG	Mortality Improvement Group
MINAP	Myocardial Ischaemia National audit Project
MQEM	Macmillan Cancer Support Quality Environment Mark
MQUISS	Macmillan Quality in Information and Support Services Standard
MQVS	Macmillan Quality Volunteer Standard
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSDS	Maternity Services Data Set
mSv	Millisievert
NABCOP	National Audit of Breast Cancer in Older People
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme
NaDIA	National Diabetes Inpatient Audit
NBOCA	National Bowel Cancer Audit
NCAP	National Cardiac Audit Programme
NCAA	National Cardiac Arrest Audit
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NGO	National Guardian Office
NHS	National Health Service
NHSD	National Health Service Digital
NHSE	NHS England

NHSFT	National Health Service Foundation Trust
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMPA	National Maternity and Perinatal Audit
NOGCA	National Osophago-Gastro Cancer Audit
NOK	Next of Kin
NPDA	National Paediatric Diabetes Audit
NQOPS	National Quarterly Pulse Survey
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OLAF	Organisation Learning Action Forum
OMFS	Oral and Maxillofacial Surgery
OP	Out Patient
PARROT	Paediatric Acute Rapid Response Outreach Team
PAS	Patient Administration System
PDSA	Plan, Do, Study, Act
PEG	Percutaneous Endoscopic Gastrostomy
PEIL	Patient Engagement and Inclusion Lead
PHA	Public Health Agency
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient-led Assessment of the Care Environment
POC	Point of Care
PPE	Personal Protective Equipment
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
PSSRU	Personal Social Services Research Unit
PTL	Patient Tracking List
PTWR	Post Take Ward Round
QI	Quality Improvement
QIP	Quality Improvement Programme
QOL	Quality of Life
QR	Quick Response
R&D	Research and Development
RCA	Root Cause Analysis
RCCG	NHS Rotherham Care Commissioning Group
RCHC	Rotherham Community Health Centre
RDaSH	Rotherham, Doncaster and South Humber NHS Foundation Trust
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIS	Radiology Information System
RMBC	Rotherham Metropolitan Borough Council
RPA	Radiation Protection Advisor
RSAB	Rotherham Safeguarding Adult Board
RSCP	Rotherham Safeguarding Children Partnership
RTT	Referral to Treatment
S1	SystmOne
SCBU	Special Care Baby Unit
SHMI	Summary level Hospital Mortality Indicator
SHO	Senior House Officer

SHOT	Serious Hazards of Transfusion
SJR	Structured Judgement Review
SLM	Service Line Monitoring
SOP	Standard Operating Procedure
SQL	Structured Query Language
SSNAP	Sentinel Stroke National Audit Programme
StEIS	Strategic Executive Information System
SUI	Serious Untoward Incident
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TB	Tuberculosis
TIA	Transient Ischaemic Attack
TOP	Termination of Pregnancy
TRFT	The Rotherham NHS Foundation Trust
TWC	Together We Can
UECC	Urgent and Emergency Care Centre
VTE	Venous Thromboembolism
WHO	World Health Organisation
YTD	Year To Date

Glossary

Acute Services	Include treatment for a severe injury, period of illness, urgent medical condition, or to recover from surgery. In the NHS, it often includes services such as accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery.
Care Quality Commission	The independent regulator of all health and social care services in England
Clinical Coding	The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.
Clinical Commissioning Group	Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Commissioning for Quality and Innovation (CQUIN)	A payment framework where commissioners reward excellence, by linking a proportion of income to the achievement of agreed quality improvement goals.
Data Quality Maturity Index	A monthly publication about data quality in the NHS
Datix	incident reporting and risk management software
Data Security and Protection Toolkit	An online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards
Duty of Candour	A statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.
Friends and Family Test	A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
Healthcare Associated Infection	Infections people get while they're receiving health care for another condition.
Hospital Episode Statistics	A database containing details of all admissions, A and E attendances and outpatient appointments at NHS hospitals in England.
Hospital Standardised Mortality Ratio	Broad system-level measure comparing observed to expected deaths
Human Factors Approach	Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings
Never Event	Defined by the Department of Health as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place.
Patient Reported Outcome Measures	Questionnaires measuring the patients' views of their health status

Power BI	Power BI is an interactive data visualization software product developed by Microsoft with a primary focus on business intelligence. It is part of the Microsoft Power Platform.
Quality Account	A report about the quality of services offered by an NHS healthcare provider.
Secondary Uses Service	A collection of health care data required by hospitals and used for planning health care, supporting payments, commissioning policy development and research.
Structured Judgement Review	Usually undertaken by an individual reviewing a patient's death and mainly comprises two specific aspects: explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received.
Summary level Hospital Mortality Indicator	The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there
SystmOne	Clinical Software System