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The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Quality Account 2018/19

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Together

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NURSES' DAY
12 May
Join the UK's
BIGGEST
Nursing Party
I love being a student midwife because
I like to empower + Advocate
for women during
a time the may feel most vulnerable

Part One: Statement on Quality from the Chief Executive

In what has been another challenging year for NHS providers across the country, organisations like ours have continued to collaborate with partner organisations to transform services. As demand grows and the needs of patients change, it has never been more important to adapt to deliver and sustain high quality, sustainable services.

This Quality Account outlines the progress we continue to make, as well as the areas where we need to improve, as we strive to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital.

In 2018/19 we set nine Quality Priorities for the year which set out our biggest priorities of how we will improve the quality of care and services for our patients. These priorities are determined by stakeholder engagement and analysis of performance and data from the previous 12 months. This year's priorities include a continuation of work commenced on mortality, deteriorating patient and medicines management, alongside new priorities relating to transition of services to support children into adulthood and improving medical staff mandatory training compliance. We are committed to ensuring all of our patients have a positive experience with all of our hospital and community services and that they get the care they need, when and where they need it.

As part of our ongoing capital investment programme, a major scheme of reconfiguration and refurbishment works have taken place across the hospital site during the year. A lot of this work has focussed on our assessment and ambulatory facilities which support our urgent and emergency pathways. In February, one of the biggest aspects of the scheme, the Acute Surgical Unit, opened its doors to patients. These new and improved facilities are already making a really positive difference to the quality of our services and the overall experience of our patients.

It is important that we regularly seek the views of our patients, colleagues and members of the public so we can continue on our journey of improvement. There are a number of ways in which people can provide their feedback in both formal and informal ways.

The national Friends and Family Test continues to be one of the core ways in which we seek these views about the care our patients receive across all of our services. I am very pleased to be able to share that our results have continued to be extremely positive and above the national average, this is fantastic news.

This year our teams have also been working hard to maintain the progress we made in 2017/18 which saw almost 100% of complaints being responded to within 30 days. Whilst there have been some challenging periods during the year, we achieved 81.36% in 2018/19. (However, it should be noted that this does not include the complaints closed within agreed timescales of greater than 30 days in which we achieved 90.45%)

In September and October 2018, the Care Quality Commission (CQC) undertook a core service inspection at the Trust. This inspection covered five of the Trust's core services including:

- Urgent and Emergency Services
- Medical Care
- Maternity
- Acute services for Children and Young People
- Community services for Children and Young People

In the subsequent inspection report, published in January 2019, the overall rating for the Trust remained at 'requires improvement' with a 'good' rating for caring and responsive. However, the Trust was rated as 'inadequate' for Urgent and Emergency Services.

Since then, a significant amount of focussed work to drive quality improvements for our patients has been undertaken and progress continues to be made.

Throughout the year, our performance against our key target areas has overall been positive, however we recognise in a number of key areas, further progress is required. We are consistently among the best performing Trusts in the country for seeing and treating patients within 18-weeks and provide timely diagnostics. Despite a significant effort from our teams, we have continued to see sustained challenge in relation to the four-hour emergency access target. As outlined above, there is a significant amount of focused improvement work happening in our Urgent and Emergency Care Centre to ensure that we see improved performance and a better patient experience in 2019/20.

I would like to thank all of our colleagues, volunteers and governors for their continued hard work within the Trust. This is in addition to the ongoing support from our partner organisations, patients and members of the public as we all work together to implement sustained quality improvements for the population we serve. I declare that, to the best of my knowledge, the information in this document is accurate.

Louise Barnett
Chief Executive
22 May 2019

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

2.1 Priorities for improvement during 2019/20

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 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.

For 2019/20, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process including a public 'showcase' where colleagues, governors, patients and members of public were able to comment on the draft proposals and shape how these priorities were delivered, along with using the findings from the recent Care Quality Commission inspection.

Delivering continuous improvement is the responsibility of all colleagues. Clinical Trust services are delivered through our five 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 General Manager with support from a Divisional Director (a Senior Clinician), 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 improvement are needed and additional areas identified where improvements are required.

The quality priorities for 2019/20 are:

Patient Safety

- Increase Medication Safety
- Improve the treatment of the Deteriorating patient
- Improve mandatory training compliance for medical staff

Patient Experience

- Improve End of life recognition
- Improve patient discharge
- Enhance patient feedback and public engagement

Clinical Effectiveness

- Improving the experience of patients transitioning from children to adult services
- Improve Mortality Reviews
- Improve policy and National Institute for Health and Care Excellence (NICE) guidance compliance

Domain: Patient Experience

Increase Medication Safety

Executive Lead: Medical Director
Operational Lead: Chief Pharmacist

Current position and why is it important?
Medicines optimisation is a strategic issue fundamental to the way that hospitals work and to the quality of patient care provided. 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.

Several opportunities for improvement in governance and performance exist within the Trust with respect to medicines use. There have been some positive developments but further significant change and action is required to deliver the level of care that our patients need.

Medication Incidents	2017	2018
Medication	1,133	1,106

A fundamental requirement is to have a safe and effective system for managing medicines to ensure that all patients receive the medicines that they need, when the need them and irrespective of their location within the Trust. Medicines are complex so it should be as easy as possible for staff to do the right thing, each and every time.

The Trust wants patients to get the best out of their treatment, ensuring that they receive the information, help and support that they need and are given real input into the decisions made about the medicines they receive and the services used to provide them.

The aim and objective(s) (including the measures/metrics)
To increase the proportion of medication signed for and documented & increase the proportion of patients who receive medication in a timely & appropriate manner on discharge. This is a continued priority from 2018/19.

1) Reduce inappropriate medication omissions by 10% (9% in 2018/19)
2) Reduce critical medication omissions by 20% (11% in 2018/19)
3) Increase the appropriate prescribing and administration of antibiotics within the first hour by 10% (59.7% for the Emergency Department and 70.10% for Acute Inpatients in Quarter Four for the treatment of patients that have been identified as having sepsis)

The planned activity to achieve this

1) Roll out of Electronic Prescribing and Medicines Administration (EPMA) system
2) Undertake a review of medicines management training including Training Needs Analysis
3) Reduce the time the drug charts are off the ward
4) Undertake a pharmacy establishment review and the provision of pharmacy support to clinical areas.

How will progress be monitored and reported?

Ongoing progress reports through the Medication Safety Group which reports to the Patient Safety Group which ultimately reports to the Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve the treatment of the Deteriorating patient

Executive Lead: Medical Director
Operational Lead: Associate Medical Director for Patient Safety

Current position and why is it important?
Whilst significant improvements have been made in recognising and responding to the deteriorating patient, particularly around patients with sepsis, this remains an ongoing theme highlighted through Serious Incidents, Inquests and other quality matrices, such as complaints. It is therefore imperative that the Trust continues to give particular focus to this theme in order to improve clinical outcomes to patients and to reduce our mortality indicators.

This is a continued priority from 2018/19.

The aim and objective(s) (including the measures/metrics)
To improve the identification and treatment of deteriorating patients
1) Reduce the number of Serious Incidents relating to deteriorating patients (19 in 2018/19)
2) Reduce the Trusts Hospital Standardised Mortality Ratio (HSMR) to below 100

The planned activity to achieve this
1) Roll out of National Early Warning Score (NEWS) 2 throughout the Trust
2) Implement the Acute Response Team
3) Pilot the Clinical Sister Provision in wards

How will progress be monitored and reported?
Ongoing progress reports through the Deteriorating Patient Group which reports to Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

HSMR (Hospital Standardised Mortality Ratio) Target less than 100

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	123.4	129.2	116.2	105	91	87.4	101.5	122.5	101.2	102.1	114.7	115.2
2018/19	107.8	105.1	103.6	104.4	104.3	105.2	104.2	101.2	101.7	103.7	105.3	104.3

Data Source - Comparative Health Knowledge System (CHKS) Monthly values

Improve mandatory training compliance for medical staff

Executive Lead: Medical Director
Operational Lead: Head of Medical Workforce

Current position and why is it important?
Whilst overall mandatory training compliance across the Trust remains consistently above the national target, mandatory training compliance for medical and dental staff is not. In order to ensure that all of our staff groups are appropriately trained to do their respective roles, particular focus therefore needs to be given to improving the mandatory training compliance of medical and dental staff.

	31st March 2018	31st March 2019
	Compliance %	Compliance %
Core MaST	72.08%	70.84%
Information Governance	90.11%	79.88%

The aim and objective(s) (including the measures/metrics)
Improve clinical practice and maintain statutory requirements for completion of Mandatory and Statutory Training (MAST)

1) Increase mandatory training compliance for medical staff to 85% (with 95% for Information Governance)

This is a new priority for 2019/20.

The planned activity to achieve this
1) Review the mandatory training provision and learning culture
2) Respond to feedback from medical staff regarding access and operability of e-learning mandatory training

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Domain: Patient Experience

Improve End of life Recognition

Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse

Current position and why is it important?
The quality priority implemented in 2018/19 has been focused on a limited number of ward areas. It is important to continue to maintain a high focus on End of Life Care and use of the individualised care plans led by the Specialist Palliative Care Team. We need to sustain and improve leadership of areas across the Trust by providing additional support and training in relation to end of life care.

In 2017/18 there were 79 cardiac arrest calls and 4 had a DNACPR insitu and in 2018/19 there were also 79 cardiac arrest calls and 7 had a DNACPR insitu.

The aim and objective(s) (including the measures/metrics)
Improve the recognition of patients at the end of life. To increase the number of nurses trained in the use of end of life care plans and to increase the number of care plans in place for patients receiving end of life care.

This is a continued priority from 2018/19.

1) Increase positive feedback with regards to patient experience in end of life care
2) Reduce the number of cardiac arrest calls made for patients at the End of Life Care who have a Do Not Attempt Cardio-pulmonary resuscitation (DNACPR) in place.

The planned activity to achieve this
1) Improve training compliance in relation to End of Life Care (to achieve 85% across all wards)
2) Review the DNACPR policy and process
3) Reenergise and document ceilings of care
4) Implement the amber care bundle
5) Explore the identification of patients at end of life on the Meditech system
6) Introduce a combined end of life care and ceiling of care form.

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve Patient Discharge

Executive Lead: Chief Operating Officer
Operational Lead: Director of Operations

Current position and why is it important?
The NHS Improvement SAFER Patient Flow Bundle (NHS Improvement) is a practical tool to reduce delays for patients in adult inpatient wards. The SAFER Bundle blends five elements of best practice, an action is represented by each letter and when implemented together achieve cumulative benefits. SAFER also works particularly well when used in conjunction with 'Red and Green' bed days approach, which is a visual management system used to reduce internal and external delays. Implementing the principles of SAFER and Red and Green days across the Trust will see benefits of improved clinical outcomes, a reduction in length of stay, along with an improvement in patient flow and safety.

The percentage of patients discharged before noon in 2018/19 was 10.1%.

The aim and objective(s) (including the measures/metrics)
To improve the percentage of patients safely discharged from the Trust by midday on the day of discharge. This is a continued priority from 2018/19.

1) Reduce 0-1 day length of stays from 21% to 20% for 2019/20
2) Increase activity through ACC by 20% from 2382 in 2018/19 to 2858 (2019/20 increase activity by 50 patients per month, 10 patients per week)
3) Increase number of patients discharged before 12 noon, reported at 2018/19 – 10% (2019/20 - 20% and 2020/21 - 30%)

The planned activity to achieve this

1) Introduce post take ward round form
2) Review and refresh the admission clerking for medication booklet
3) Consistently monitor the admission predictor and day to day Predicted Discharge Dates (PDDs)

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Enhance Patient Feedback and Public Engagement

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Current position and why is it important?
Patient and Public Involvement and Engagement (PPIE) is a valuable tool to ensure our users are listened to and involved in decisions about the services we provide. Some good examples exist, particularly linked to specific clinical services, but a more consistent and co-ordinated Trust wide approach would be beneficial.

2017-18 In Patient Response Rate - Friends and Family

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Target 40%	56%	63%	60%	70%	60%	51%	58%	46%	43%	51%	49%	47%

2018-19 In Patient Response Rate - Friends and Family

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Target 40%	50%	50%	48%	54%	49%	54%	48%	47%	44%	43%	42%	48%

The aim and objective(s) (including the measures/metrics)
1) Achieve the Friends and Family Test Trust agreed response rate of 40% for all inpatient areas (48% in March 2019 but with 6 individual areas falling below the baseline)
2) Achieve the Friends and Family Test Trust agreed response rate of 10% for UECC (0.4% in March 2019)
3) To increase the number and range of opportunities for patients, carers and members of the public to be consulted with and have an opportunity to inform the decision making process within the Trust.
4) To liaise with local partners to ensure that Trust PPIE utilises existing best practice and can reach wider target audiences.

This is a continued priority from 2018/19.

The planned activity to achieve this
1) Employ an Engagement and Inclusion Officer.
2) To develop a Patient and Public Involvement and Engagement Strategy (PPIE).
3) To undertake a scoping exercise to identify the baseline PPIE position.
4) For Divisional leads to identify and promote PPIE opportunities within their services.
5) To develop a Trust wide process for PPIE events.
6) Implement 'I Want Great Care' to provide more qualitative feedback for medical staff.
7) Introduce online feedback for consultants

How will progress be monitored and reported?
Patient and Public Involvement and Engagement is a standing agenda item on the monthly Patient Experience Group agenda. The Patient Experience Group reports to Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Domain: Clinical Effectiveness

Improving The Effectiveness of the Transition Process from Child to Adult Services

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Current position and why is it important?
The experience of transitioning young people into adult services is variable, depending upon the service. Within paediatrics, there are certain agreed principles such as an accompanying adult during appointments, the opportunity for a carer to be resident during admissions and additional support to help navigate healthcare services. This ends once the young person reaches 16 years of age in most cases.

The Trust do not currently collect data showing the number of children transitioning from paediatric to adult services except in Diabetes where there has been an average of 72 transition clinic slots per year for the last two years. Diabetes data covers the 15-19 age group. During Quarter 1, a review will be undertaken to identify the number of children during 19/20 for each of the identified services that are in the 14-19 age range. This will enable these children to have their journey into adult services to be mapped. This data will be reviewed on a quarterly basis to demonstrate impact of interventions.

There are three main areas to consider:

a) Long Term Conditions - Predominantly this relates to Diabetes, Epilepsy and Asthma. As an example, the Diabetes team have made some progress with this but this is not yet meeting national recommendations. Approximately 48% of the diabetes caseload is aged 14-17 years (14-16 year olds account for 22.4% of the caseload and 17-19 year olds account for 26.2%). There is a monthly transition clinic for the over 17's which is a joint consultation with both paediatric and adult Consultants and specialist nurses from both areas. However, the adult specialist nurses have no designated time for this work and its development. The dietician for adult services also attends. There is not the capacity within this service to facilitate transitional clinics for all young people over 14, which is the age that transition should ideally commence. There also needs to be capacity within the paediatric diabetes team to facilitate this.

b) Complex Needs - Work has commenced on establishing links for transitioning young adults with complex needs however there is a significant challenge as there is no reciprocal adult service to transition into. There is also a lack of clarity regarding signposting into services.

c) Other Services - Many young adults have their first or an ad hoc encounter with healthcare, during the 14-19 age range. They may present for a variety of medical/surgical/mental health reasons with variable levels of physical and emotional maturity and vastly differing personal circumstances. There are limited opportunities for care to be delivered in a bespoke, age appropriate environment.

The aim and objective(s) (including the measures/metrics)
The aim is to ensure that as many children as possible can be seamlessly transitioned from child to adult services. The proposed activity to achieve this and anticipated success measurements will vary depending upon the pathway.

a) Where national recommendations are available, a baseline position should be established and The Rotherham NHS Foundation Trust (TRFT) should aim to meet the national recommendations. It is recognised that this may not be possible within one year but a measure of progress made against available recommendations should be recorded.

b) TRFT to develop a similar model to the 'Ready Steady Go' transition programme used in other organisations, which routinely commences for all children with long term conditions at 14 years.

c) The Trust should plan to offer a staged approach to transition at different ages, dependent on wishes and feelings of the young person, appropriate to the underlying healthcare requirement.

d) Metrics/Audit to be developed to monitor the progress for all services that transition into the adult service.

This is a new priority for 2019/20.

The planned activity to achieve this

a) To participate in the NHS Improvement Transition Programme during 2019/20 to access advice and support for the introduction of initiatives to improve transition.

b) To create and embed an action plan covering any initiatives resulting from participation in the national NHSI programme.

c) To include Transition as a key priority on the Children's Trustwide Steering Group Work Plan to ensure Trust wide engagement and support and provide a forum for cross divisional action to be monitored.

d) To look at capacity within both paediatrics and adults to facilitate progressing with this initiative. This may require consideration of a business case for recruitment of a Transition Nurse to work within this important and specific area of work – joint funding from both Paediatric and Adult services.

How will progress be monitored and reported?

a) Baseline data to be obtained, where available to provide a starting metric.

b) National guidance, including any provided through participation in the NHSI Transition programme, to be monitored and measured against.

c) Compliance rates and re-admission rates to be recorded to provide evidence of the impact of interventions.

d) Progress with this improvement priority will be reported through the Children's Trust-wide Steering Group, Divisional Governance Meetings, Clinical Governance Committee and Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve Mortality Reviews

Executive Lead: Medical Director
Operational Lead: Medical Examiner

Current position and why is it important?
It is imperative that all deaths are reviewed and in a timely manner in order to ensure that appropriate learning and opportunities for improvement are identified and actioned. Whilst the Trust has made significant improvements in its Learning from Deaths and its mortality review process, significant challenges remain in ensuring all deaths are reviewed, particularly within the Division of Integrated Medicine. Improvements are also required in how such reviews are captured, with the aim of capturing them all electronically via the Trust's Meditech system.

There were 81 mortality reviews in 2017/18

The aim and objective(s) (including the measures/metrics)
Improve the mortality review process undertaken within the Trust.
1) Increase the mortality reviews undertaken by the Medicine Division by 50% (10 in 2018/19)
2) Increase mortality reviews undertaken within two months of death by 50% (3 (30%) in 2018/19)

This is a new priority for 2019/20.

The planned activity to achieve this
1) Review the mortality policy
2) Improve the mortality review process including introducing the two stage reviews to the mortality review process.
3) Introduce medical examiners
4) Increase compliance using Meditech for reviews.

How will progress be monitored and reported?
Ongoing progress reports through the Mortality Group which reports to Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve Policy and NICE Guidance Compliance

Executive Lead: Chief Nurse and Medical Director
Operational Lead: Quality Governance, Compliance and Risk Manager and Research, Innovation & Clinical Effectiveness Manager

Current position and why is it important?
The 2017 Care Quality Commission (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 CQC Inspection. Whilst improvements have been made with the use of a new intranet site where documents can be located easier, there are still 46% of policies which are out of date. There is therefore a risk that staff could be following out of date processes.

Policies	
2017/18	51.1%
2018/19	54%

NICE guidelines are evidence-based recommendations for health and care in England. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. NICE guidance helps TRFT staff to standardise and clarify care and improve efficiency, productivity, and safety.

NICE Guidance			
Time period	# requests to review	# returned ≤ 28 days	%
2017/18	**497**	**276**	**56%**
Q1	151	86	57%
Q2	118	77	65%
Q3	145	63	43%
Q4	82	49	60%
2018/19	**351**	**176**	**50%**
Q1	112	56	50%
Q2	84	52	62%
Q3	79	38	48%
Q4	79	30	38%

Confirmation that NICE guidance has been reviewed is important as the first step in a process to confirm quality of care and services. Without this confirmation the Trust does not have assurance that current practice is compliant or non-compliant with the current evidence base and unable to make a decision on whether changes in practice are required.

The current standard is that the Clinical Effectiveness Department receives a response to a request for review within 28 days.

The aim and objective(s) (including the measures/metrics)
Improve clinical practice and effectiveness through using up to date polices and complying with relevant NICE Guidance.
1) Increase the number of in date policies by 30% (baseline is 54% of policies in date at 31 March 2019)
2) Increase the number of NICE guidance compliance reviews undertaken in line with agreed timescales by 20% (baseline is 38% responses received in 28 days).

This is a new priority for 2019/20.

The planned activity to achieve this
1) Review the policy management process
2) Review the NICE guidance management process

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Keeping our stakeholders Informed
The Trust will continue to share information on progress throughout the year with NHS Rotherham Clinical Commissioning Group and provide a mid-year update to Rotherham Health Select Commission. A quarterly report on progress against the indicators will be provided to the Council of Governors.

2.2: Statements of Assurance from the Board of Directors

Subcontracted services

During 2018/19 The Rotherham NHS Foundation Trust provided and/or subcontracted 65 relevant health services, both community and acute services. The Rotherham NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 65 of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represented 83% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2018/19.

Clinical Audit

During 2018/19, 53 national clinical audits and 11 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation provides. During that period The Rotherham NHS Foundation Trust participated in 50 (94%) of national clinical audits and 11 (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 2018/19, 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
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	No	N/A	Data not collected as use of mesh procedure is on hold.
BAUS Urology Audits - Nephrectomy audit	Yes	100%	Not Applicable.
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	100%	Not Applicable.
Case Mix Programme (CMP)	Yes	100%	Not Applicable.
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)	Yes	98% (as at 31 Dec 2018 – patient completed questionnaire facilitated by external body).	Not Applicable.
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	100%	Not applicable
Falls and Fragility Fractures Audit programme (FFFAP) National Audit Inpatient Falls	Yes	Figure unavailable at time of report as audit started in January 2019.	Not Applicable.
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	Yes	100%	NA
Feverish Children (care in emergency departments)	Yes	100%	Not Applicable.
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	No	N/A	Subscription required for participation.
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%	Not Applicable.
Major Trauma Audit	Yes	45-57% (January - July 2018) – This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.	Not Applicable.
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%	Not Applicable.
National Adult Community Acquired Pneumonia (CAP) Audit	Yes	N/A	Not Applicable.
National Adult Non-Invasive Ventilation (NIV) Audit	Yes	N/A	Not Applicable.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Adult Asthma Secondary Care	Yes	N/A – data collection in progress.	Not Applicable.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Figures not available.	Not Applicable.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation	Yes	Figure unavailable at time of report as data collection started in March 2019.	Not Applicable.
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%	Not Applicable.
National Audit of Cardiac Rehabilitation	Yes	100%	Not Applicable.
National Audit of Care at the End of Life (NACEL)	Yes	60% – This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.	Not Applicable.
National Audit of Dementia (care in general hospitals)	Yes	100%	Not Applicable.
National Audit of Intermediate Care (NAIC)	Yes	Organisational questionnaire.	Not Applicable.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Figure unavailable at time of report as audit started in December 2018.	Not Applicable.
National Cardiac Arrest Audit (NCAA)	Yes	100%	Not Applicable.
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)	Yes	100%*	Not Applicable.
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%*	Not Applicable.
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Yes	100%*	Not Applicable.
National Comparative Audit of Blood Transfusion programme Management of massive haemorrhage	Yes	No eligible cases.	Not Applicable.
National Diabetes Audit - Adults National Diabetes Foot Care Audit	Yes	Figure unavailable at time of report as data being collected.	Not Applicable.
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDIA)	Yes	Organisational Questionnaire.	Not Applicable.
National Diabetes Audit - Adults NaDIA-Harms	Yes	100%	Not Applicable.
National Diabetes Audit - Adults National Diabetes Transition	Yes	100%*	Not Applicable.
National Diabetes Audit - Adults National Pregnancy in Diabetes Audit	Yes	100%	Not Applicable.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Organisational Questionnaire only – data not collected.	This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.
National Emergency Laparotomy Audit (NELA)	Yes	68% – This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.	Not Applicable.
National GastroIntestinal Cancer Programme National Oesophago-gastric Cancer (NOGCA)	Yes	100%	Not Applicable.
National GastroIntestinal Cancer Programme National Bowel Cancer Audit (NBOCA)	Yes	100%	Not Applicable.
National Joint Registry (NJR)	Yes	99% (number of patients who consent for data to be used).	Not Applicable.
National Lung Cancer Audit (NLCA)	Yes	100%	Not Applicable.
National Maternity and Perinatal Audit (NMPA)	Yes	100%*	Not Applicable.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%*	Not Applicable.
National Ophthalmology Audit (NOD)	Yes	44% (100 case collected for each main surgeon over a set time period).	Not Applicable.
National Paediatric Diabetes Audit (NPDA)	Yes	100%	Not Applicable.
National Prostate Cancer Audit	Yes	100%	Not Applicable.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) *Antibiotic Consumption*	Yes	100%*	Not Applicable.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) *Antimicrobial Stewardship*	Yes	100%*	Not Applicable.
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%*	Not Applicable.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%	Not Applicable.
Seven Day Hospital Services Self-Assessment Survey	Yes	100%	Not Applicable.
Surgical Site Infection Surveillance Service	Yes	100%	Not Applicable.
Vital Signs in Adults (care in emergency departments)	Yes	100%	Not Applicable.
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%	Not Applicable.

(Source Respective audit provider website)

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 - June 2019 and therefore final figures may change.

National Confidential Enquires	Participation yes/no?	Reason for non-participation	% Cases submitted
Young People's Mental Health	Yes	100%	Not Applicable.
Long-term ventilation in children, young people and young adults	Yes	Figure unavailable at time of report as project currently in progress.	Not Applicable.
Perinatal Mortality Surveillance (reports annually)	Yes	100%	Not Applicable.
Perinatal morbidity and mortality confidential enquiries (reports alternate years)	Yes	100%	Not Applicable.
Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Yes	100%	Not Applicable.
Maternal morbidity confidential enquiries (reports annually)	Yes	100%	Not Applicable.
Acute Heart Failure	Yes	100%	Not Applicable.
Cancer in Children, Teens and Young Adults	Yes	100%	Not Applicable.
Perioperative diabetes	Yes	70% - 3 anaesthetic clinical question-naires not completed.	Not Applicable.
Pulmonary embolism	Yes	100%	Not Applicable.
Acute Bowel Obstruction	Yes	Project currently in progress.	Not Applicable.

(Source: National Confidential Enquiry into Patient Outcome and Death (NCEPOD))

The reports of 27 national audits were reviewed by the provider in 2018/19 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title	Published	Report Reviewed	Action(s) to improve quality of care
BAUS Urology Audits - Nephrectomy audit	Yes	Yes	Currently no actions identified however they are being developed.
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	No actions required.
Case Mix Programme (CMP)	Yes	Yes	No actions required.
Elective Surgery (National PROMs Programme)	Yes	Yes national level.	No actions required from national report review, waiting for local results.
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	The Fracture Liaison Nurse is responsible for ensuring the following actions are completed during 2019/20. Improve the identification of patients for inclusion in the audit, particularly patients with spinal fractures. This will be achieved by accessing Accident and Emergency (A&E) attendance data to identify patients with eligible fractures. A Standard Operating Procedure (SOP) is also being developed with Radiology to improve on identification of patients over the age of 50 with fractures and any incidental findings of vertebral fractures on all imaging. Patients with vertebral fractures will be identified via the Trust re-portal every quarter. A new system to improve on follow up monitoring of patients at 16 weeks post fracture will be implemented. A letter will be sent to the patient to enquire about progress/medication if no telephone contact has been made following 3 attempts. A Growth Assessment Protocol (gap) analysis of the Fracture Liaison Service (FLS) has been undertaken with the National Osteoporosis Society (NOS).
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	Yes	Yes	Ensure physiotherapists are prioritising the hip fractures to improve day 1 mobilisation of hip fractures.
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	Actions being developed.
Major Trauma Audit	Yes	Yes	No specific actions identified. Overall, continue to provide care in line with Operational Delivery network guidance.
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	No actions required.
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Actions being developed.
National Audit of Cardiac Rehabilitation	Yes	Yes	A business case proposal is pending for completion in 2019 by the Specialist Nurse and Operational & Performance Manager within Medicine, for the delivery of a cardiac rehabilitation exercise programme for heart failure patients as this is currently not commissioned by the Clinical Commissioning Group (CCG).
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Actions being developed.
National Audit of Dementia (care in general hospitals)	Yes	Yes	Actions being developed.
National Audit of Intermediate Care (NAIC)	Yes	Yes	No actions required.

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Actions being developed.
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Yes	Yes	Actions under review.
National Diabetes Audit - Adults National Diabetes Transition	Yes	Yes	To focus on improving HbA1c[1] levels in patients on insulin pumps, to lower the number of patients with HbA1c between 58 - 86. In order to achieve this, increased insulin pump follow up clinics have been introduced. A Diasend transmitter is also being used, which is software that links with data from the insulin pumps to provide up to date information about the patient. This is reviewed and discussed with the patient at each contact.
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Increase the number of locked cases on a regular basis with regular feedback at Clinical Effectiveness meetings relative to Monthly NELA progress reports. Improve the percentage of cases for patients >70 having input from Health care of the Older Person by a formal service arrangement. Improve mortality rates via discussion at regular Mortality Group meetings. Improve the documentation of discussions with Critical Intensivists at the time of Emergency Laparotomy via discussion at Clinical Governance.
National GastroIntestinal Cancer Programme National Oesophago-gastric Cancer (NOGCA)	Yes	Yes	All High Grade Dysplasia (HGD) to be discussed at the local Multi-Disciplinary Team (MDT) meetings. The selection process of patients for palliative oncology requires review to investigate the reasons why patients who may have been sufficiently fit to be candidates for chemotherapy received best supportive care. To improve accurate reporting of performance status at the Multi Disciplinary Team Meeting (MDTM) as this is the single most important predictor of fitness for palliative oncology interventions.
National GastroIntestinal Cancer Programme National Bowel Cancer Audit (NBOCA)	Yes	Yes	No actions required.
National Joint Registry (NJR)	Yes	Yes	No actions required.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Actions being developed.
National Ophthalmology Audit (NOD)	Yes	Yes	No actions required.

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	To Improve Transitional care and flow. To address issues with adult services capacity. To ensure updated clinical guidelines are on Trust website. Establish teaching for each batch of trainee doctors. Insulin e-learning package added to Mandatory training for nursing staff. All paediatric Medical & nursing staff to be offered e-Learning for health Diabetic Ketoacidosis (DKA) module. To improve structured patient education. To improve Diabetes clinical outcomes aiming for a clinic target HbA1c of <48mmol/mol (some patients will need different, individualised target). Establish Monthly 'Patient in difficulty' meetings. Standing agendas added to our quarterly operational meetings: to discuss age-banded median HbA1c and 'Was Not Brought' (WNB) rates. Introduce Virtual clinics and continually encourage patient's uptake. To reduce waiting times by changing clinic format. To provide alternative Psychology input to make up for 8 week gap. To introduce use of British Society for Paediatric Endocrinology & Diabetes (BSPED) DKA guidelines for all young people up to age of 18 years. Involve regular management input for operational planning.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	A number of actions are in progress for completion in 2019 by the Trust Transfusion Practitioner and Blood Bank Manager, which include the inclusion of basic ABO and RhD blood group principles into Module 5 paperwork of the nursing staff education. A business case is also to be formulated for the introduction of electronic bedside management systems in all clinical settings where transfusion takes place.
Seven Day Hospital Services Self-Assessment Survey	Yes	Yes	It was agreed to review the middle grade rota in medicine re additional middle grade cover weekends Review Consultant rota in regard to Acute Medical Unit cover Appoint to vacant Acute physician posts Review and increase Hospital out of hours cover and support Develop a dedicated weekend discharge team Review of estimated dates of discharge And development of internal professional standards
Surgical Site Infection Surveillance Service	Yes	Yes	No actions required

(Source: Trust Audit Database)

During the year, the Trust's internal auditor undertook an assurance review of clinical audit to assess the adequacy of governance arrangements, including in-year assurance reporting against an annual plan. The auditor found a lack of a Clinical Effectiveness Strategy, and noted that the clinical audit plan was predominantly pulled together with input from the Trust's Clinical Service Units. The outcomes of audits were shared locally, but not across the Trust, and a communication strategy is now being developed in order to have optimal impact on the quality improvement agenda.

Review of Local Clinical Audits

The reports of 93 local clinical audits were reviewed by the provider in 2018-19 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table at Appendix 1).

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2018/19 that were recruited to participate in research was 1255 compared to 988 in 2017/18. A significant number of recruits (434) are the result of participation in the Yorkshire Health Study, which is a questionnaire study available to staff, patients and members of the public which closed in September 2018 [figures taken from the Local Performance Management System, final numbers may change as updates are made].

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 actively recruiting during 2018/19

Study Type	Number of studies
NIHR Portfolio Commercially sponsored	2
NIHR Portfolio Non-commercial	27
Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	7
Non-portfolio The Rotherham NHSFT Sponsored	7
Other Non-portfolio (supporting academic qualifications)	3

(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)

A proportion of The Rotherham NHS Foundation Trust income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between The Rotherham NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2018/19 £3.88 million of Trust income for all applicable Commissioners was conditional upon achieving the quality improvement and innovation goals compared with £3.77 million in 2017/18.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically from the Trust Website at: http://www.therotherhamft.nhs.uk/CQUINqualityindicatorframework/

CQUIN goals are being reviewed nationally but will continue to form part of the National NHS Standard contract for 2019-20 once finalised. All schemes agreed are national indicators. A high level summary of the indicators applicable in 2018/19 is provided on the next page:

National (N) Local (L)	Goal Name	Contract Year for delivery	Rationale for Inclusion
N	NHS Staff Health and Wellbeing	2018/19	To support and maintain a healthy and happy work-force, evidence of which is known to enhance quality and reduce sickness absence rates
N	Reducing the Impact of Serious Infections (Sepsis)	2018/19	To reduce the number of deaths from Sepsis through early identification and treatment
N	Improving Services for People with Mental Health needs who present to A&E	2018/19	To develop integrated pathways across organisations to support timely and appropriate access to services for patient with Mental Health needs
N	Advice and Guidance	2018/19	To provide specialist advice to General Practitioners (GPs) to support clinical decision making
N	Preventing Ill Heath by Risky Behaviours – alcohol and tobacco	2018/19	To improve the health of the local population through prevention

(Source: NHS England)

CQC Registration and Periodic Reviews/Specialist Reviews

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Registered with Conditions'. The Rotherham NHS Foundation Trust has the following conditions on registration.

In October 2018, the Care Quality Commission served a condition on the Trust registration relating to mitigating the risks within paediatric Urgent and Emergency Care Centre with a focus on medical and nursing staffing levels.

The Care Quality Commission has not taken enforcement action against the Rotherham NHS Foundation Trust during 2018/19.

The Trust was fully inspected by the Care Quality Commission in February 2015 with a follow-up re-inspection occurring between 27-30 September 2016 (and a further unannounced inspection on 12 October 2016) and then further unannounced inspections in September and October 2018.

At the 2018 inspection, the Trust was given an overall rating of Requires Improvement, with the rating broken down as follows;

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

The tables opposite show the detailed ratings by key question and by core service for the re-inspection conducted in 2018.

CQC ratings for Trust Hospital services after 2018 re-inspection:

	Safe	Effective	Caring	Responsive	Well led
Urgent & Emergency Services	Inadequate	Requires Improvement	Requires Improvement	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	Requires Improvement	Requires Improvement
Children and young people	Good	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 services after 2018 re-inspection:

	Safe	Effective	Caring	Responsive	Well led
Adults	Good	Requires Improvement	Good	Good	Requires Improvement
Children & young people	Requires Improvement	Requires Improvement	Good	Requires Improvement	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 re-inspection report

A comprehensive action plan was created as a result of the inspection findings for the regulation breaches which was approved by the Board of Directors on 26th February 2019. The plan aims for all actions to be in place by 31 October 2019, with the audits to confirm this completed by 31 March 2020.

Throughout the course of the year the Trust has maintained contact with the CQC through regular conversations and correspondence with the Trust's lead CQC Inspector and quarterly engagement meetings.

The Chief Nurse is the nominated individual. Amendments were made to the Trust's CQC registration during 2018/19 which included changing the name of the individual undertaking the Chief Nurse role.

A copy of the Trust's registration certificate can be viewed at http://www.cqc.org.uk/provider/RFR/registration-info or by requesting a copy from the Company Secretary at the address below:
Ms Anna Milanec
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 culminating in the Clinical Governance Committee and Quality Assurance Committee.

The Trust is also required to report any breaches of the **Ionising Radiation Regulation**s to the CQC. Below is a summary of the radiation incidents which have been reported to the CQC from 1 April 2018 to 31 March 2019.

	Reportable to				
Date	**MHRA**	**CQC**	**HSE**	**Dose (mSv)**	**Description**
18-Apr-18	No	Yes	No	8.7	Patient had an unnecessary Thorax CT examination due to an incorrect request. The Trust understands that the referrer accidentally requested a scan on the wrong patient. The intended patient had the same name and a very similar date of birth to the person that received the scan.
01-May-18	No	Yes	No	2.3	An incorrect patient was scanned for an unnecessary CT head due to the referrer requesting the wrong patent.
09-May-18	No	Yes	No	19.2	Patient received Chest Abdo Pelvis CT scans, intended for another patient, due to referrer error. Patient has been notified and told that the doctor had referred the wrong patient.
18-May-18	No	Yes	No	0.3	A patient recently underwent the initial portion of a CT examination unnecessarily due to an incorrect referral. After the CT Topogram was performed, it was noted the clinical details did not match the request. The remainder of the exam was then cancelled.
31-July-18	No	Yes	Yes	5.2	An incorrect patient was scanned for an unnecessary CT chest as the referrer had selected the wrong patient when requesting imaging. The referrer realised their mistake and tried to cancel the examination but did not follow proper procedure and the cancellation request did not come through to the Radiological Information System (RIS) SCBU system from the Electronic Patient Record (EPR) system.
07-Aug-18	No	Yes	No	5.2	A patient received a chest CT scan, intended for another patient, due to referrer error. The referrer recognised the error and cancelled the scan on the Electronic Patient Record (EPR) system (Meditech). However, the referrer failed to follow the instructions of the EPR system to also telephone Clinical Radiology to cancel the request. The Meditech EPR system does not currently update cancelled orders in the AGFA RIS. Hence there is an additional requirement for the referrer to telephone Clinical Radiology to cancel the request.
14-Nov-18	Yes	Yes	No	55	Equipment error in X-ray room 5 (AGFA DR 600) caused a patient to receive 25 times the expected dose when undergoing a chest radiograph. The incident was initially thought to be operator error; however on inspection by the RPS and Modality Lead the fault was not re-creatable and the use of the equipment suspended.
30-dec 2018	No	Yes	No	0.05	The incorrect patient was x-rayed for a chest x-ray, this occurred due to a misinterpretation of patient information passed from one radiographer to another. Since this incident we have made sure that one radiographer is responsible for the identification of the patient, therefore reducing the chances of error. We have passed this information on to all staff via the communication book and morning staff meetings.
8-Jan- 2019	No	Yes	No	0.3	This incident occurred when a patient had a pelvis x-ray instead of a chest x-ray due to a miscommunication regarding patient information between radiographers. Since this incident we have made sure that one radiographer is responsible for the identification of the patient and justification of the referral, therefore reducing the chances of error. We have passed this information on to all staff via the communication book and morning staff meetings.
15-Jan 19	No	Yes	No	0.025	Paediatric chest and neck x-ray was incorrectly requested from the clinicians on the wards. Reflective statement acquired from the clinician. Accurate ID checks made by the radiographer.
7-Feb-19	No	Yes	No	2	CT head scan requested on incorrect patient referrer error.
12-Feb-19	No	Yes	No	0.03	Incorrect identification of a patient for a chest x-ray by the ED department.

(Source: Datix and Radiation Protection Advisors Report)

Each of the incidents have been investigated and all have been escalated through to the Clinical Support Services Divisional Governance meeting and onto the Trust's Clinical Governance Committee to provide assurance as to the quality of the investigation and the robustness of the remedial actions taken. The incidents caused no harm to the patients concerned.

Special Reviews and Investigations

The Rotherham NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data April 2018 – January 2019.

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

99.9% (99.9% for 2017/18) for admitted patient care
100.0% (100.00% for 2017/18) for outpatient care
99.5% (99.2% for 2017/18) 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 2017/18) for admitted patient care
100% (100% for 2017/18) for outpatient care
100% (100% for 2017/18) for accident and emergency care

Please note: 2018/19 data in this section is based on a refreshed data position from NHS Digital submissions. The 2017/18 data is based on the published data April 2017 – January 2018 from the same source.

Information Governance Toolkit attainment levels

The replacement of the Information Governance Toolkit, with the Data Security and Protection Toolkit (DSPT) during 2018/19, means that The Rotherham NHS Foundation 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. The format of the new toolkit has removed the former 'attainment levels', and instead, works on an a 'standards met' (requiring 100% compliance), or 'standards not met' (anything less than 100%), basis.

Organisations are expected to achieve the 'standards met' assessment on the DSPT by 31 March each year. However, with this being the first year of the DSPT, organisations have been able to publish a DSPT assessment if they are approaching a level of 'standards met' in all but a few areas. In this case, the submission of an action plan to achieve full compliance would need to be submitted by the organisation and agreed by NHS Digital.

The Rotherham NHS Foundation Trust's DSPT assessment as at 28 March 2019, was "standards not fully met (plan agreed)".

Payment by Results

The Rotherham NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. (Note: NHS Improvement (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 NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'costing audit'.)

The Rotherham NHS Foundation Trust will be taking the following actions to improve data quality and clinical coding.

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 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. This is now evidenced in the NHS Digital Data Quality Dashboards where it is clearly shown that the Trust now has an NHS Number completeness rating well above the national average.

The Rotherham NHS Foundation Trust was subject to the mandatory clinical coding Information Governance (IG) audit in November 2018 during the reporting period as required by NHS Digital. The Trust again achieved an IG rating of level three which is the highest possible rating that can be achieved.

In addition, TRFT have also had external audits of the following specialities; Obstetrics and Gynaecology. Feedback was very good for both diagnosis / procedure coding and the depth of coding.

Data Quality Index (HRG4+ based)

CHKS continues to be the source of information for the Data Quality Index and at the time of reporting data for the period April 2018 to December 2018 is available. There has again been an increase from the previous year; the Trust continues to outperform peer averages with an index of 97.69% compared to a peer average of 96.21.

The Rotherham NHS Foundation Trust will be taking the following actions to improve data quality;

As a team the Data Quality Indicators are reviewed monthly both from a CHKS perspective and from the NHS Digital Data Quality Dashboard perspective. Any fluctuations in performance are identified and actions plans are put in place to resolve. If aide memoires 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.

Blank, invalid or unacceptable primary diagnosis rates (HRG 4 based)

The Trust position for unaccepted diagnosis codes in the period up to December 2018 has improved, achieving 0.02% against a previous measurement of 1.17% for 2017/18. The action plans put in place

following the migration of our Emergency Department onto a primary Acute System Meditech, have improved this position. The Trust continues to take steps to reduce the impact of this change on data. The depth of coding (average number of diagnoses per coded episode) continues to increase from 6.8 in December 2017 to 7.2 in December 2018, this is an improvement of 5.6% in year.

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	95.5	97.1	100	97.1

(Source: The Rotherham NHS FT Information Governance Audit Report 2018/2019)

These scores helped achieve assurance Level 3 of the Information Governance Toolkit for coding accuracy, this is the second time that the Trust has managed to achieve the highest grade Level 3 for the Information Governance Audit.

In 2017/18 the Trust took the following actions to improve clinical coding data quality and these continued throughout 2018/19:

- Using data analysis to flag up potential coding and data quality errors and generate regular reports to monitor coding and data quality, using the ever expanding locally designed clinical coding indicators
- Engaged clinicians across specialties, creating coder/clinician two way communications through coding/documentation review sessions
- Provided in-house coding training sessions for consultants.
- Annual coding training sessions included on the F1 junior doctor's induction.
- A service level agreement has been put in place for professional coding support from Barnsley Hospital Trust 0.2 whole time equivalent. Plans have been put in place to implement regular internal individual and departmental audits.

Improvements and actions to further improve clinical coding during 2018/19 included:

- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable.
- Implement and review coding performance indicators.
- The Trust is now 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 the auditors are of the opinion that we are also rated in the top quartile nationally from that perspective too. Combined these indicators demonstrate an improvement in the quality of the clinical coding.

An Operational Manager was appointed in April 2017 to lead the team and two Supervisors appointed within the team to handle day to day support of the team. Additional steps were taken to integrate the Data Quality Teams into the Clinical Coding department which has improved the engagement between the two teams and the Trust staff, enabling them to react more quickly to issues being identified at source of coding.

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2017-18	Qtr 2 2017-18	Qtr 3 2017-18	Qtr 4 2017-18	YTD	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	96.12%	95.38%	96.82%	97.53%	96.43%	
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	1.23%	1.39%	0.86%	0.27%	0.96%	
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)	2015 -16	8.84%	Decrease	12.07%	12.15%	9.96%	9.64%	11.43%	
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)	2015 -16	11.99%	Decrease	16.99%	17.59%	15.12%	12.53%	16.64%	
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 -16	99.80%	Increase	99.90%	99.90%	99.80%	99.90%	99.90%	
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 -16	100.00%	Maintain	100.00%	100.00%	100.00%	100.00%	100.00%	
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	99.90%	99.90%	100.00%	100.00%	
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Maintain	100.00%	100.00%	100.00%	100.00%	100.00%	
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	99.20%	98.40%	98.80%	99.20%	99.20%	
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	100.00%	100.00%	100.00%	100.00%	100.00%	

(Source: NHS Digital and CHKS Live)

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2018-19	Qtr 2 2018-19	Qtr 3 2018-19	Qtr 4 2018-19	YTD	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	97.86%	97.88%	97.34%	Data not yet available	97.69%	
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	0.28%	0.20%	0.48%	Data not yet available	0.32%	
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)**	2015 -16	8.84%	Decrease	9.53%	9.98%	10.68%	Data not yet available	10.07%	
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)**	2015 -16	11.99%	Decrease	11.51%	12.41%	15.50%	Data not yet available	13.21%	
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 -16	99.80%	Increase	99.90%	99.90%	99.90%	Data not yet available	99.90%	
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 -16	100.00%	Maintain	100.00%	100.00%	100.00%	Data not yet available	100.00%	
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	100.00%	100.00%	Data not yet available	100.00%	
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Maintain	100.00%	100.00%	100.00%	Data not yet available	100.00%	
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	99.40%	99.50%	99.50%	Data not yet available	99.50%	
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	100.00%	100.00%	100.00%	Data not yet available	100.00%	

(Source: NHS Digital and CHKS Live)

** Due to clinical coding team coding from Electronic Medical Record (EMR) and not notes due to lack of access to notes there is always a tendency to have signs and symptoms as this is usually only the data that the patient had recorded on admission

The baseline was established in 2015-16 and the Trust uses that baseline to compare against. The data for Q4 was not available at the time of production of the report.

Learning from Deaths

During 2018/19, 1,016 of TRFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 234 in the first quarter
- 236 in the second quarter
- 235 in the third quarter
- 311 in the fourth quarter

By 15 April 2019, 260 case record reviews and 18 investigations have been carried out in relation to the 1,016 deaths included in the above. In 18 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 40 in the first quarter
- 81 in the second quarter
- 63 in the third quarter
- 85 in the fourth quarter

From the case record reviews, 6 representing 0.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the Preventable Incidents Survival and Mortality (PRISM) methodology.

The Trust has just introduced a 2-stage mortality review process, whereby every death will undergo a review moving forward; this involves every death having an initial stage 1 review, followed by a more detailed Structured Judgement Review (SJR) where indicated by the stage 1 review, in line with national guidance. The Trust is also working towards capturing all case record reviews electronically, such that it can monitor compliance with mortality reviews and the learning from deaths more efficiently and effectively.

What the provider has learnt from case record reviews

The Trust has been conducting case record reviews on selected patients within the Trust at random and following specific diagnosis codes that have been identified through the data. The specific diagnosis codes reviewed were septicaemia, intestinal hernia without obstruction, and 30-day mortality following both emergency and elective surgery.

There were specific themes that arose from these case note reviews, such as poor communication and failure to recognise a deteriorating patient; however, the Trust is making good progress with improving the recognition of and timely response to the deteriorating patient, which is reflected in a sustained improvement in our Hospital Standardised Mortality Ratio (HSMR).

Description and assessment (including actions)

The mortality data provider for the Trust, CHKS, highlighted issues with septicaemia, but the Trust is making good progress with improving the recognition of the deteriorating patient and sepsis; this is triangulated with the CQUIN target.

The restructuring of the deteriorating patient pathway with earlier intervention by senior medical staff and highlighting the Modified Early Warning System (MEWS) scores undertaken in 2018/19 has continued to reduce the number of unexpected admissions to critical care and the number of cardiac arrests within the ward based areas, both of which are monitored at the Trust's weekly Harm Free meeting chaired by the Medical Director and the Chief Nurse.

The Trust successfully rolled out the new National Early Warning Score (NEWS2) towards the end of quarter 4, which is the replacement to MEWS. As a result, the Trust is currently developing plans to replace the current Hospital at Night Service with a 24/7 Acute Response Team, in order to further improve patient safety by supporting the medical workforce and by improving the timely response to deteriorating patients.

There has also been a significant amount of work around the acute kidney injury care pathway, including the sustained use of the acute kidney injury bundle, which has helped lead to a decrease in the number of serious incidents and inquests relating to the deteriorating patient.

The palliative care team have worked extremely hard with advance care planning, which has shown a marked improvement in the mortality data related to the length of stay of palliative patients. This has also reduced the number of patients who have been inappropriately admitted to hospital, with this year's data shows that there has been a decreasing trend in the number of patients dying within 0-1 day length of stay.

There has been an in-depth review of 30-day mortality following emergency surgery and 30-day mortality following elective surgery. Most of these patients have died expectedly from medical causes not relating to the surgical procedure, and some have been placed under surgeons as the responsible consultant, when in fact they were a medical patient. Ongoing work is underway to ensure that there is always an appropriate level of care from all necessary specialist teams throughout the stay of all patients, in line with the standards for 7-day services.

The Trust alerted with intestinal obstruction without hernia; however, following an in-depth review of all of these cases, whilst various improvements were identified, none were of significant concern. The main issue was one of coding in view of the fact that most did not have intestinal obstruction. There has been a significant amount of work around educating clinicians and coding on documentation and data capture.

A significant amount of work and improvements have been made following reviews of fractured neck of femur. Indeed, whilst it was previously highlighted that there were issues with this cohort of patients, following quality improvement projects that have been very successful, the Trust has moved from one of the worst performing to one of the best performing nationally, with sustained performance.

With the help of the bereavement and Patient Experience team, the Trust can now capture the views of the patient's families if they wish to comment on the patient's admission before death. This is captured on a comment card, rather than through a formal complaint, and will add valuable information to the review process and the learning that should be gained from every death within the hospital. It will also help capture positive experiences which have previously not been recorded.

The Trust will also be introducing its first Medical Examiner role in quarter one of 2019/20, in line with national guidance and best practice. This will be a pivotal role in improving the Trust's Learning from Deaths by ensuring that all deaths are independently reviewed, in addition to the standard mortality review process. They will liaise directly with HM Coroner and the Medical Director, and will seek the input of each patient's next-of-kin.

44 case record reviews and 0 investigations completed after 1 April 2018 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Preventable Incidents Survival and Mortality (PRISM) methodology.

0 representing 0% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Since the publication of the quality report, this information has re-validated, and the outcome of the validation has been detailed above.

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 level Hospital Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline. The banding for TRFT is "as expected".

Indicator name	Latest & previous reporting periods	TRFT value Oct 17 - Sept 18	TRFT previous value July 17 - June 18	Acute Trust average Oct 17 - Sept 18	Acute Trust previous average July 17 -June 18	Acute Trust highest value Oct 17 - Sept 18	Acute Trust previous highest value July 17 -June 18	Acute Trust lowest value Oct 17 - Sept 18	Acute Trust previous lowest value July 17 - June 18
Summary Hospital Mortality Indicator – Value	July 17 - June18 Oct 17 - Sept 18	105.72	103.13	100.34	100.35	126.81	125.72	69.17	69.82
Summary Hospital Mortality Indicator – Banding	July 17 - June18 Oct 17 - Sept 18	2	2	2	2	1	1	3	3
SHMI: Percentage of patient deaths with palliative care coding at diagnosis level	July 17 - June18 Oct 17 - Sept 18	32.4	32.4	33.6	33.1	38.9	58.7	26.3	13.4

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 2017 - 28th March 2018	79	0.17	0.75	0.577	72 (91.1%)	1 (1.3%)	6 (7.6%)
	1st April 2018 - September 2018	15	0.29	0.75	0.46	14 (93.3%)	0 (0%)	1 (6.6%)
	Groin hernia surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	*	*	*	*	*	*	*
	1st April 2018 - September 2018	*	*	*	*	*	*	*
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	92	0.37	0.77	0.4	82 (89.1%)	5 (5.4%)	5 (5.4%)
	1st April 2018 - September 2018	11	0.57	0.8	0.22	8 (72.72%)	1 (9.09%)	1 (9.09%)
	Varicose vein surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	*	*	*	*	*	*	*
	1st April 2018 - September 2018	*	*	*	*	*	*	*

* No Data - 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 18 - September 18 and subject to change until the publication of finalised data, which is expected to be on 09 August 2019 (after production of the report). (Source: NHS Digital)

Re admissions within 28 days of discharge from Hospital: Please note that this indicator was last updated in December 2013 and future releases have been suspended pending a methodology review. Further information is located at Appendix 2.

DOMAIN	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain4: Ensuring that people have a positive experience of care.	*CQUIN: Responsiveness to patients personal needs	2016/17	65.1	68.1	85.2	60
		2017/18	68.6	68.6	85	60.5
	Staff who would recommend the Trust to their family or friends (Acute Trusts for comparison)	July 17 - Sept 17	45%	62%	96%	25%
		July 18 - Sept 18	68%	64%	94%	31%

*Please note data for 18/19 is not published until 22nd August 2019 which is after the deadline date of the report and so is not included. (Source: NHS Digital)

DOMAIN	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain5: Treating and Carng for people in a safe place.	*Percentage of patients admitted to hospital and risk assessed for Venous Thromboembolism (VTE)	Jul18 - Sept 18	95.89%	95.44%	100%	68.67%
		Oct 18 - Dec 18	95.65%	95.37%	100%	54.86%
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over	Apr 16 - Mar 17	1.7	3.0	11.9	0
		Apr 17 - Mar 18	1.5	3.1	13.8	0
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison)	Apr 17 - Sept 17	48.14	42.84	111.7	0
		Oct 17 - March 18	37.3	21.8	101.4	0
	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	April 17 - Sept 17	30%	15.12%	64%	0%
		Oct 17 - March 18	14%	17.10%	55%	0%

* C Diff figures 18/19 published July 2019 (which is after the deadline date of the report and so is not included)
* Patient safety incidents: next publication 23rd May 2019 (which is after the deadline date of the report and so is not included)
(Source: NHS Digital)

The Rotherham NHS Foundation 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 opposite.

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT 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. See page 32 The Trust has experienced a fall in mortality indicators after the number of deaths decreased between July 2017 and June 2018. There has been a subsequent fall in deaths and the review process continues. The SHMI reported rose until the most recent result in June 2018 when it has started to come down as the reporting period no longer includes the rise in deaths in 2016.	The Trust holds regular meetings of the Mortality Review Group which reports to the Clinical Governance Committee. 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. Deaths are reviewed and reported quarterly in the 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 patients receiving care from the team are included in the data. See page 32	To improve the percentage score the Trust's Consultant-led Specialist Palliative care Team continue to identify and assess all patients receiving 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 post-operatively 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) groin hernia surgery; (ii) varicose vein surgery; (iii) primary hip replacement surgery (iv) primary knee replacement surgery during the reporting period.	The latest reporting periods vary between the type of surgery performed. Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement. See page 33	(i) No longer collected. (ii) No longer collected. (iii) 93% 14/15 patients stated they noticed an improvement post surgery. (iv) 72.72% 8/11 patients stated they noticed an improvement post surgery.
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 28 days of discharge from the Trust	This indicator is not presently being updated by NHS Digital; as yet there is no date available for the next data release. 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 See page 33	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.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's position is drawn from 5 key questions asked in the national in-patient survey (administered by the CQC). The most recent data is from the survey conducted between August 2017 and January 2018. Full results are available later in this report.	CQC will publish 2018 patient survey results in August 2019.

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to improve this score and so the quality of its services by:
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. See page 67	Complete
21.1 Friends and Family Test – " How likely are you to recommend our hospital to friends and family if they need similar care or treatment" Services covered: - Inpatients - Day Cases - Accident and Emergency - Outpatients - Maternity - Community	The data is considered to be accurate based on the number of forms inputted into the system received for each area. The data is submitted to NHS Digital monthly for publication. The published data relates to the positive and negative scores for each area derived from the number of patients who would or would not recommend our services. Since March 2017 the Trust has run the Friends and Family test in house, previously it was out sourced to an external contractor. Due to the large number of outpatient clinics there is a rota system in operation which ensures all clinics are captured at certain months throughout the year. See page 52	Complete
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 See page 84	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.	Data is validated and published by NHS DIGITAL See page 83	The Trust will continue to monitor rates through root cause analysis and audits and report through local clinical governance structures to the Clinical Governance Committee; for further actions to reduce rate of c-diff see Part 3.
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 Oct 2017 - March 2018. This was the latest reporting period where TRFT has submitted its data. The next publication is due 23rd May 2019 which will cover the period April18 - Sept 18 (after the report deadline and so not included). Number of incidents occurring in this period – 2, 877.	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 2018/19

From 1 April 2018 responsibility for the co-ordination and management of Coronial Inquests transferred from the Patient Safety team to the Legal Affairs team. This alignment facilitates effective triangulation and analysis of data in relation to any incidents or experiences that result in an investigation, whether through the complaints, claims, inquest or incident process. By continuing to work collaboratively with the divisions, the identification and embedding of learning as a result of an investigation via these routes will assist in improving the safety, care and experiences of our patients and their families.

The number of Inquests held involving the Trust has risen sharply over the last 12 months, with 63 inquests held during 2018/19 in comparison to 38 in total for 2017/18.

Learning from Inquests continues to be a priority for our organisation. During 2018/19 the Trust did not receive any "Reports to Prevent Future Deaths"; the power that comes from regulation 28 of the Coroners (Inquests) Regulations 2013. Learning has however been identified in a number of Inquest cases, and this has been widely shared within the organisation through the Patient Safety Group, Clinical Governance Committee and Divisional Governance Meetings in order to avoid repeat of harm events and improve the quality of patient care.

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2018/19

A summary of the Trust's quality priorities for 2018/19 is provided below with an indication as to whether the priority was achieved or not by the year end.

For all RAG ratings throughout this document the colours mean:
Green: Met; Amber: Partially Met; Red: Not met.

Reference	Metric	RAG Rating
Patient Safety		
Missed or Delayed Diagnosis	Improve the percentage of positive electronic acknowledgement of radiology examinations requested by TRFT clinicians from 30% to 100% by 31 March 2019.	
Deteriorating Patient (including Sepsis)	To improve the percentage of patients who met the criteria for screening for sepsis and were screened for sepsis using the appropriate tool within one hour of having identified that the patient needed screening from 71.5% to 90% by 31 March 2019.	
	To improve the percentage of patients receiving Intravenous Antibiotics within one hour of having identified that the patient has sepsis from 60.5% to 90% by 31 March 2019.	
Medication Safety	Improve the percentage of medication administrations signed for or, a reason for non-administration recorded on the medication chart, from 96% to 100% by 31 March 2019.	
	Improve the percentage of patients leaving the organisation with a discharge letter, their medication and having received information about their medication from the discharging ward/nurse from 80% to 100% by 31 March 2019.	
Patient Experience		
End of Life Care	Improve the percentage of registered nursing staff and relevant Multi-Disciplinary Team Members trained in the use of end of life care plans from 0% to 80% on two wards (Ward A1 and Ward A4) by 30 June 2018 and repeat this each quarter for 2 new wards.	
	Improve the use of end of life care plans for patients receiving end of life care on the two wards from (A1 0% and A4 6%) to 100% by 30 June 2018 and repeat this each quarter for the wards identified.	
Patient Discharge from Hospital	Improve the percentage of patients discharged across the site by 12 midday from 10% to 20% by 31 March 2019. Increasing by 2.5% each quarter, sharing information across divisions and teams on how this metric is progressing each quarter.	

Reference	Metric	RAG Rating
Learning from the Views of Inpatients	To improve the percentage of patients reporting that they were not bothered by noise at night from other patients from 49.5% to 62.5% by 31 March 2019.	
	To improve the percentage of patients reporting that they were given the right amount of information about their condition or treatment from 72% to 81% by 31 March 2019.	
	To improve the percentage of patients reporting that they were given enough privacy when discussing their condition or treatment from 78.6% to 85.6% by 31 March 2019.	
	To improve the percentage of patients reporting that before leaving hospital they were given written information on what they should or should not do after leaving from 48.5% to 63.5% by 31 March 2019.	
	To improve the percentage of patients reporting that hospital staff discussed whether any additional equipment or adaptations were required at the patient's home from 66.8% to 81.8% by 31 March 2019.	
	To improve the percentage of patients reporting that they were asked to give their views on the quality of care during their stay in hospital from 20.5% to 35.5% by 31 March 2019.	
	To increase the percentage of patients reporting that they received information on how to complain to the hospital about the care they received from 19.5% to 34.5% by 31 March 2019.	
Clinical Effectiveness		
Preparing for the CQC Inspection	Reflecting on individual services highlighted in the 2016 inspection and gaining assurance on where improvements have been made and where further improvements can be implemented.	
	Review the actions allocated by the CQC and identify the current position and any improvements needed, thereby ensuring the standards of quality care are met.	
Improved Compliance with the Mental Capacity Act	The percentage compliance with the Mental Capacity Act based on three assessment criteria being: Compliance with the Adult Safeguarding training (that includes Mental Capacity Act) from 84.27% (October 2017) to 95% by 31 March 2019.	
Effective Outcomes for Women and Baby	Improve the percentage of Small for Gestational Age (SGA) babies detected from 43.9% to 58% by 31 March 2019.	

3.1.2 Performance against the 2018/19 Priorities

There were nine quality priorities for 2018/19, as follows;

- Patient Safety
  - Missed or delayed diagnosis
  - Deteriorating patient (including sepsis)
  - Medication safety
- Patient Experience
  - End of life care
  - Patient discharge from hospital
  - Learning from the views of inpatients
- Clinical Effectiveness
  - Preparing for the CQC inspection
  - Improved compliance with the Mental Capacity Act
  - Effective outcomes for women and baby

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

Domain: Patient Safety

Missed or delayed diagnosis

Executive Lead: Medical Director
Operational Lead: Associate Medical Director (AMD) Health Informatics

Rationale
The systems of acknowledging the results of radiology investigations was a hybrid of electronic and paper based systems. By introducing a single electronic system, the Trust can reduce the risk of a result being either missed or there being a delay in it being reviewed.

This was one of the 17 priorities in the Trust Quality Improvement Plan in 2017/18.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to improve the current rate of electronic acknowledgement of radiology results by reducing to one system of reporting radiology results and ceasing the production of paper results.

The objective for 2018/19 was to improve the percentage of positive electronic acknowledgement of radiology examinations requested by TRFT clinicians from 30% to 100% by 31 March 2019.

What did we achieve?
Paper Reports were turned off in August 2018, for the main Hospital site for Inpatients and Outpatients, with all radiology reports now being delivered through Meditech. Additional paper copies are still being sent out for Urgent and Critical Reports. The Policies around Results Acknowledgement have been updated, and are out for consultation.

By March 2019 the electronic acknowledgement of radiology notices was at 30%.

How was progress monitored and reported?
Progress is being monitored by Associate Medical Director for Health Informatics through a PowerBI Dashboard. Progress of the Project was reported at Clinical Health Informatics Development Group (CHID), Clinical Governance Committee (CGC), and Quality Assurance Committee (QAC).

What further actions need to be undertaken?
To expand the system into out of scope areas (e.g. UECC, and community areas). To disseminate the updated policy, and get each Division to update their own Policies for Result Acknowledgement, and to delegate responsibility for monitoring the process to each area.

Work is also required to re-engage with clinicians. Results Acknowledgement is frequently discussed at the Patient Safety Group and work is ongoing between the Medical Director and Chief Clinical Information Officer.

Deteriorating patient (including sepsis)

Executive Lead: Medical Director
Operational Lead: AMD Patient Safety & Acute Medical Unit (AMU) Consultant

Rationale
In 2016 there was a noted rise in crude mortality across The Rotherham NHS Foundation Trust associated with an increase in Serious Incident (SI) reports about late identification of clinical deterioration. Steps were taken to change the processes used to identify, quantify and respond to clinical deterioration and subsequently there has been an improvement in mortality metrics for subsequent time periods and a reduction in SIs being reported in relation to failure to recognise clinical deterioration.

However, TRFT's quarter 1 performance on the Sepsis CQUIN was poor on the parameter looking at the timely delivery of antibiotics. Whilst sepsis is recognised promptly, there was also a lack of evidence to demonstrate that an appropriate antibiotic was then administered within 60 minutes (the CQUIN standard).

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to improve the time between the identification of the need to screen a patient to identify if they have sepsis and the administration of the first dose of intravenous antibiotics for those patients that require treatment for sepsis.

The objectives for 2018/19 were:

To improve the percentage of patients who met the criteria for screening for sepsis and were screened for sepsis using the appropriate tool within one hour of having identified that the patient needed screening from 71.5% to 90% by 31 March 2019. (Note: Baseline using Quarter 3 data 2017/18, taken as an average of Emergency Department and Inpatient figures, 69% and 74% respectively.)

To improve the percentage of patients receiving Intravenous Antibiotics within one hour of having identified that the patient has sepsis from 60.5% to 90% by 31 March 2019. (Note: Baseline using Quarter 3 data 2017/18, taken as an average of Emergency Department and Inpatient figures, 39% and 82% respectively.)

What did we achieve?
NEWS2 (National Early Warning Score)
The use of NEWS2 was mandated for use in all acute NHS trusts by March 31st 2019. The Critical Care Outreach Team wrote a guide to introduce the management of the deteriorating ward patient (age 16 and above) using the NEWS2 document for roll out during March 2019. This guide includes stop the shift information, demonstrates how to use the document, details what the changes are compared to the previous early warning MEWS (modified early warning score), and includes "Think Sepsis". NEWS2 doesn't include a calculation for urine output; this is also included within the guide, and the Fluid balance charts have been reviewed and updated. Paediatrics and Obstetrics have separate tools specific to those patient groups. The Trust successfully rolled out NEWS2 across the Trust before the end of March 2019 and will continue to roll-out electronic observations (e.Obs) throughout the Trust during Financial Year 19/20.

Sepsis screening tool

A sepsis early warning detection system has been built into Meditech which links to the electronic observations (e.Obs). The initial trial was rolled out within UECC during January 2019, followed by a pilot within the Surgical Assessment Unit (SAU), with training support from the Electronic Patient Record (EPR) and Practice Development Team. All other areas continue with the paper form of the tool pending the full roll-out of e.Obs.

CQUIN

The National CQUIN for sepsis is focussed on the timely identification and treatment of sepsis in emergency departments (ED) and in the acute in-patient setting, including appropriate antibiotic review and an overall reduction in antibiotic consumption per 1000 admissions.

For the percentage of patients who met the criteria for screening for sepsis and who were subsequently screened for sepsis using the appropriate tool within one hour (of having identified that the patient needed screening). The table below shows the improvements made over the space of this financial year:

	ED	Acute Inpatients
Qtr 1 17/18	83%	39%
Qtr 1 18/19	74.80%	*
Qtr 2 17/18	71.40%	76.20%
Qtr 2 18/19	88.60%	98.10%
Qtr 3 17/18	69.20%	73.80%
Qtr 3 18/19	99.40%	100%
Qtr 4 17/18	78.10%	74.50%
Qtr 4 18/19	100%	100%

For the percentage of patients receiving intravenous antibiotics within one hour (of having identified that the patient has sepsis). The table below shows the improvements made over the space of this financial year:

	ED	Acute Inpatients
Qtr 1 17/18	36%	39%
Qtr 1 18/19	54.20%	*
Qtr 2 17/18	40.20%	83.90%
Qtr 2 18/19	54.30%	78%
Qtr 3 17/18	42.20%	95.50%
Qtr 3 18/19	75.20%	75%
Qtr 4 17/18	73.70%	81.30%
Qtr 4 18/19	59.70%	70.10%

* There was no submission for Quarter 1 for the Inpatients.

How was progress monitored and reported?

Reports were provided to the Deteriorating Patient/Sepsis Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

Regular meetings are being held to identify how this can be improved and support is being obtained from other divisions. In addition, the divisions (in particular medicine) have been asked to identify what, if any, additional resource may be required to improve our achievement of the CQUIN moving forward. The launch of the Trust's new Safe & Sound Quality Framework will help drive improvements in the recognition and treatment of the deteriorating patient, including those with sepsis. A full Training Needs Analysis of current training and education provision to clinical staff in recognising the deteriorating patient and sepsis will be undertaken during Financial Year 19/20.

Medication Safety

Executive Lead – Medical Director
Operational Lead - Chief Pharmacist

Rationale
Medicines optimisation is a strategic issue fundamental to the way that hospitals work and to the quality of patient care provided. 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.

Several opportunities for improvement in governance and performance exist within the Trust with respect to medicines use. There have been some positive developments but further significant change and action is required to deliver the level of care that our patients need.

A fundamental requirement is to have a safe and effective system for managing medicines to ensure that all patients receive the medicines that they need, when they need them and irrespective of their location within the Trust. Medicines are complex so it should be as easy as possible for staff to do the right thing, each and every time. The Trust wants patients to get the best out of their treatment, ensuring that they receive the information, help and support that they need and are given real input into the decisions made about the medicines they receive and the services used to provide them.

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to increase the proportion of medication administration signed for or, a reason for non-administration to be recorded on the drugs kardex and to increase the proportion of patients who are discharged, and receive their medication and information in a timely and appropriate manner.

The objectives for 2018/19 were to:

- Improve the percentage of medication administrations signed for or, a reason for non-administration recorded on the medication chart, from 96% to 100 % by 31 March 2019.
- Improve the percentage of patients leaving the organisation with a discharge letter, their medication and having received information about their medication from the discharging ward/nurse from 80% to 100% by 31 March 2019.

(Note – Medication Safety is also covered in metrics in other priorities, including Discharge and Learning from the Views of Inpatients)

What did we achieve?
The latest audit of omitted medications took place in March 2019.

For 2018/19 the aim was to improve the percentage of medication administrations signed for, or, a reason for non-administration recorded on the medication chart, from 96% to 100% by 31 March 2019. Following the latest omissions audit in March 2019, this remains at 96%.

An audit of medication omissions occurs quarterly (June, September, December and March). The audit report/results are shared and discussed with Ward Managers, Matrons, Heads of Nursing and Pharmacy colleagues, and presented at Medication Safety Group, Patient Safety Group, Clinical Governance Committee and Quality Assurance Committee.

There has been a strong drive to share the omissions information with nurses at ward level in order to improve practices. This is done at the time of the audit. Pharmacy staff at ward level also raise omissions and blanks with ward staff when reviewing prescription charts; if blanks are present they follow up with nursing colleagues with a view to getting the administration signed or an appropriate omission reason code applied.

Over the course of 2017/18 and 2018/19 it has proved very challenging to reduce the number of blanks on the administration record where a signature or a reason-for-omission code should have been used.

The March 2018 omissions audit reviewed the medication charts of 5 patients from each inpatient area.

A total of 89 patient medication charts were reviewed and included in the audit on this occasion.

A total of 6,602 doses were possible to administer with 972 doses omitted. This gives a crude omission rate of 14.7% (similar to previous audit results).

The adjusted (validated) omissions, i.e. the rate when valid omissions are removed, was 686 omissions, giving an adjusted (validated) omission rate of 7.1%.

For reference, valid omissions are:
- Code 3: Patient refused dose
- Code 5: Withheld at nurse's discretion and reasons documented
- Code 6: Withheld at doctor's request and reasons documented

Of the 686 (7.1%) invalid omissions:
- 458 (66.8%) were blanks (no signature nor omission code used)
- 0 (0%) were Code 1 (patient away from ward)
- 51 (7.4%) were Code 2 (patient could not take dose)
- 177 (25.8%) were Code 4 (dose not available)

The March 2019 omissions audit reviewed the medication charts of 5 patients from each inpatient area.

A total of 85 patient medication charts were reviewed and included in the audit on this occasion.

A total of 6,733 doses were possible to administer with 1082 doses omitted. This gives a crude omission rate of 16.1% (similar to previous audit results).

The adjusted (validated) omissions, i.e. the rate when valid omissions are removed, was 616 omissions, giving an adjusted (validated) omission rate of 9.1%, an increase from audit in December 2018. For reference, valid omissions are:

- Code 3: Patient refused dose
- Code 5: Withheld at nurse's discretion and reasons documented
- Code 6: Withheld at doctor's request and reasons documented

Of the 616 (9.1%) invalid omissions:

- 269 (43.6%) were blanks (no signature nor omission code used)
- 8 (1.3%) were Code 1 (patient away from ward)
- 134 (21.8%) were Code 2 (patient could not take dose)
- 205 (33.3%) were Code 4 (dose not available)

The proportion of omissions due to "blanks" is same as the audit in December 2018.

A total of 119 (11.0%) key critical medicines were omitted: anticoagulants (45), antimicrobials (38) and insulins (16), Parkinson medicines (9) and chemotherapy (2). These five will be monitored over the next 12 months.

How was progress monitored and reported?

Reports were provided to the Patient Safety Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

Work needs to continue in terms of sharing audit data with ward managers and nurses at ward level in order to change and improve practice. Matrons forums and Ward Managers forums will be utilised to share omissions data with a view to improving practice at ward level.

Next steps: the following work will be carried out with wards:

- Ward staff to escalate if patient unable to take doses via the route prescribed
- Display ward stock lists prominently for reference in medicines storage areas
- Educate ward staff regarding pharmacy annotations when a supply is made
- Emphasise the importance of transferring medicines with patients on transfer to another ward
- Reinforce the message that patient's own supplies when available need to be used
- Inform ward staff of common approved names and brand names e.g. macrogol = Movicol
- Review and update stock lists to expand the range of medicines available at ward level

Domain: Patient Experience

End of life care

Executive Lead – Chief Nurse
Operational Lead – Assistant Chief Nurse (Vulnerabilities)

Rationale

The Care Quality Commission (CQC) Trust re-inspection in 2016 identified a number of excellent examples of systems and processes of care provision. However, the re-inspection also identified the following areas that require improvement and a Regulatory Action was issued to the Trust by the CQC:

Acute – End of Life Care

Ensure all "do not attempt cardio-pulmonary resuscitation" (DNACPR) decisions are always documented in line with national guidance and legislation.
Ensure there is evidence that patients' capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

Community - End of Life Care

Ensure that all DNACPR forms are completed appropriately and accurately ensuring that mental capacity assessments are completed for patients where it has been assessed they lack capacity.

In addition to the above, the following areas were also identified for improvement:

All areas in the community adopt and embed the individualised end of life care plan and ensure that advanced care planning is discussed to prevent any inappropriate admissions to hospital.
Arrangements reviewed to monitor the patient's preferred place of care and death.

The Trust has had an opportunity as one of 15 Trusts to take part in an NHS Improvement, End of Life Care Collaborative. The first 2 areas identified are wards A2 and Fitzwilliam (a surgical and medical ward and both have a purple butterfly room, which is a dedicated facility for patients and their families at the end of their life).

This priority continued from 2017/18.

In 2018/19 the Trust aimed to continue to ensure that patients requiring palliative or end of life care receive care consistent with the best practice standards of One Chance to Get It Right. (Leadership Alliance for the Care of Dying People 2014)

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

The aim for 2018/19 was to embed improvements in the care of patients on the End of Life Care Pathway through progressing the improvements achieved on wards A2 and Fitzwilliam following their participation in the NHS Improvement End of Life Care Collaborative.

The objectives for 2018/19 were to:

- Improve the percentage of registered nursing staff and relevant Multi-Disciplinary Team Members trained in the use of end of life care plans from 0% to 80% on two wards (Ward A1 and Ward A4) by 30 June 2018 and repeat this each quarter for 2 new wards as outlined in the roll out.

- Improve the use of end of life care plans for patients receiving end of life care on the two wards from (A1 0% and A4 6%) to 100% by 30 June 2018 and repeat this each quarter for the wards identified in the roll out plan.

What did we achieve?

Outcome as per finding at the end of each quarter and area focus of support

Ward	Staff Trained	End of Life Care Plan
A2	100%	100%
Fitzwilliam	100%	72%
A1	81%	88%
A4	70%- ward manager to cascade training to night staff	40%
Medical Assessment Unit	86%	55%
Stroke	81%	50%
A5	86%	26%
A7	92%	44%
B4	83%	To be collected April-June 2019
B5	83%	To be collected April-June 2019

How was progress monitored and reported?

Reports were provided to the Patient Experience Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

- To continue to maintain a high focus on End of Life Care and use of the individualised care plan led by the Specialist Palliative Care Team.
- To continue to undertake quarterly audits and reviews to provide assurance of use of the end of life care plan or to identify areas where additional support or action is required.
- To sustain and improve leadership of areas as required by providing additional support and training in relation to end of life care – support provided from Specialist Palliative Care Team.
- Monitoring and oversight of priority actions and improvement trajectory via the Clinical Governance Committee and Quality Assurance Committee.
- Executive support

Patient discharge from hospital

Executive Lead: Chief Operating Officer
Operational Lead: Director of Operations

Rationale
The NHS Improvement SAFER patient flow care bundle (NHS Improvement) is a practical tool to reduce delays for patients in adult inpatient wards. Each letter of SAFER stands for an action and the E is for Early discharge. NHS Improvement recommend that 33% of patients will be discharged from base inpatient wards before midday. This then allows emergency admissions from the Emergency Department to be accommodated without delay.

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)
In 2018/19 the Trust aimed to continue to improve the management of hospital discharge ensuring people leave hospital in a safe, timely way.

The aim for 2018/19 was to increase the proportion of discharges that take place in the morning as part of implementing the SAFER patient flow care bundle.

The objective for 2018/19 was to improve the percentage of patients discharged across the site by 12 midday from 10% to 20% by 31 March 2019. Increasing by 2.5% each quarter, sharing information across divisions and teams on how this metric is progressing each quarter. This was achieved on the two wards where measurement was undertaken.

(Note – discharge is also covered in metrics in other priorities, including Medication Safety and Learning from the Views of Inpatients)

What did we achieve?
Pre-Noon Discharge
The Trust identified that not all discharges were entered on to Meditech at the time patients were discharged and those patients transferred to the Discharge Lounge prior to discharge were not discharged off the system until later in the day, by the discharge lounge team. To reflect the true position of Pre-noon discharges a pilot of manual data collection was undertaken on Wards A1 and A5 (Medical Wards).

The month of March 2019 showed that 25% of patients on A1 were discharged before midday and 31% of patients were discharged before midday on A5, above the 20% Trust target. In the short term, the plan is to roll out manual data collection to the rest of the wards so the Trust has a clear understanding of when patients are being discharged throughout the day.

The month of March 2018 showed that 20% of patients on A1 were discharged before midday and 14.29% of patients were discharged before midday on A5, above the 20% Trust target.

Criteria Led Discharge
Some elements of criteria led discharge were being adopted at ward level but not fully embedded across the Trust. A5 is one of the exemplar wards for SAFER and were following the principles of Criteria Led Discharge although it is not fully embedded into practice 7 days.

Criteria Led Discharge is one of the principles of SAFER patient flow bundle. The plan is to incorporate criteria led discharges in to the ward rounds, initially on the exemplar wards A5 and A1 and then roll out across the rest of the Trust.

Long Length of Stay (LLOS) Reviews
Initial work with Emergency Care Intensive Support Team (ECIST) commenced in October 2018, with a review of current processes and at that point the Trust was introduced to NHS Improvement methodology for Long Stay Reviews.

#LongStayWednesday was implemented across the Trust in November 2018, there is an MDT approach with representation from nursing, medical, therapy and Integrated Discharge Team (IDT). The long stay review team visit ward areas weekly to understand why patients are still in hospital, they identify themes, areas of good practice and areas requiring focus where there is an opportunity for improvement. Themes are emerging and the information will be available for dissemination in 2019/20.

Initially patients with a Length of Stay (LOS) over 21 days were identified for review, this reduced to 14 days. #LongStayWednesday has been greatly received by the ward areas and the Trust has seen a reduction in long stay/stranded patients since implementation in November 2018.

ECIST reviewed the #LongStayWednesday process in February 2019 and commended the team on the investment in time and commitment to the reviews. Very positive feedback with further opportunities identified for improvement. Work continues internally to evolve the membership of the MDT review Team, improve the process and work towards reviewing patients with a length of stay over 7 days.

SAFER/Red2Green
The Trust initiated conversations with NHS Improvement to participate in the 3rd Cohort of the SAFER/Red2Green/LLoS Collaborative and the SAFER team attended back in November 2018 and in March 2018 to share and learn from experiences. The Trust is paired with Mid Cheshire Hospitals NHS Foundation Trust and a peer visit took place in April 2019.

There is a SAFER working group with a membership that is evolving, again using an MDT approach. The group meets weekly to discuss plans and progress is made using the Plan, Do, Study, Act (PDSA) methodology.

An Operational Improvement Lead has been secured and will remain in the Trust for 6 months to support wards in SAFER/Red2Green/LLoS.

Progress has been made on the wards with Estimated Date of Discharge (EDD) the 'Golden Patient' with board and ward rounds ongoing. The SAFER team are currently working with the ward team on A5 around the quality of board rounds, criteria led discharges and a push for early discharges and this will start on A1 early April.

How was progress monitored and reported?
Reports were provided to the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?
Continue work with SAFER Collaborative and peer to peer learning. The next Collaborative meeting the Trust will be attending is 14 May 2019 and Mid Cheshire NHS Foundation Trust visit in April 2019.

Continue the process of gathering SAFER data to monitor progress, a SAFER/Red2Green dashboard is in draft ready to be reviewed. A SAFER Baseline Ward Assessment is to be undertaken initially on A1 and A5 and rolled out over 3 months across the rest of the Trust, this includes asking patients the 4 key questions: What is the matter with me? What is going to happen today? What is needed to get me home? When am I going home? To be completed throughout April 2019.

Work with the Chief Nurse and Medical Director to re-launch the SAFER/Red2Green as part of the 'Safe as Sound' Trust Quality Agenda and send communication out to all staff to raise awareness.

Educating staff at ward level for SAFER principles and Red2Green with support from NHS Improvement, this will start April 2019.

Implementation of SAFER/Red2Green will be a phased approach with a plan to work with A1 and A5 and identify another ward in medicine and surgery for the month of April.

Learning from the views of inpatients

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Rationale
The annual national inpatient survey (2016) showed 5 areas where The Rotherham NHS Foundation Trust (TRFT) was performing worse than the majority of Trusts in the country. Subsequently 'Learning from the views of inpatients' was identified as a Quality Priority for 2018/19 and an action plan was devised to address the key concerns identified. Monthly surveys take place on in-patient wards to establish if responses to poorer performing questions are improving.

The 2017 adult inpatient survey was completed before the action plan was fully embedded and therefore the objectives were set linked to the outcomes of the 2018 survey. The 2017 results do however give a useful indication in changes in perceptions of our patients. Data collection for the 2018 survey is now complete so any further actions taken will not impact upon results this year.

Quarterly surveys provide a useful barometer showing how we are performing but as the year has progressed, it has become evident that the methodology is too different from the national postal survey to provide an accurate assessment of likely outcomes within the national survey.

This was a new priority for 2018/19

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to improve our patient's experience, which will then be reflected in our scores reported in the annual national inpatient survey. The comparison of current performance and planned improvement is shown below based on benchmarking the Care Quality Commission scores against other Trusts (Table 1) and comparing the Trust data with data from the previous year (Table 2).

Table 1 – Performance against other Trusts

	Number of responses in 2016 survey in each category	Planned improvement for 2018 survey
Below national average	5	Decrease by 2
About the same	60	
Above national average	0	Increase by 8

(Source: Care Quality Commission)

Table 2 – Internal performance against previous years

	2016 (compared to 2015)	2018 (compared to 2016)
Lower score	45	Decrease by 20
About the same	18	
Improved score	2	Increase by 20

(Source: Care Quality Commission)

Specific objectives were:
1. To improve the percentage of patients reporting that they were not bothered by noise at night from other patients from 49.5% to 62.5% by 31 March 2019.
2. To improve the percentage of patients reporting that they were given the right amount of information about their condition or treatment from 72% to 81% by 31 March 2019.
3. To improve the percentage of patients reporting that they were given enough privacy when discussing their condition or treatment from 78.6% to 85.6% by 31 March 2019.
4. To improve the percentage of patients reporting that before leaving hospital they were given written information on what they should or should not do after leaving from 48.5% to 63.5% by 31 March 2019.
5. To improve the percentage of patients reporting that hospital staff discussed whether any additional equipment or adaptations were required at the patient's home from 66.8% to 81.8% by 31 March 2019.
6. To improve the percentage of patients reporting that they were asked to give their views on the quality of care during their stay in hospital from 20.5% to 35.5% by 31 March 2019.
7. To increase the percentage of patients reporting that they received information on how to complain to the hospital about the care they received from 19.5% to 34.5% by 31 March 2019.

The percentage increases shown for objectives 1-5 are to increase the Trust to the level of the national average performance for 2016. The performance for objectives 6-7 is already above national average and therefore a target of 15% increase is proposed.

In order to establish that the level of progress required to achieve these improvements in the National Inpatient Survey is achieved. A Trust baseline score for these 7 questions was established during Quarter 4 2017/18 using a local survey methodology and this baseline then had the appropriate percentage increases applied to provide the target score for 2018/19.

What did we achieve?

The results show an improved picture with improvement aims being met in 5 of the 7 categories within locally conducted surveys. All inpatient divisions were included.

Objective	2016	2017	Quarter 4 2018/19	2018 (aim) – Data not yet available
To increase the percentage of patients reporting that they were not bothered by noise at night from other patients by 13%	49.5%	56.1%	53%	62.5%
To increase the percentage of patients reporting that they were given the right amount of information about their condition or treatment by 9%	72%	76%	94%	81%
To increase the percentage of patients reporting that they were given enough privacy when discussing their condition or treatment by 7%	78.6%	76%	97%	85.6%
To increase the percentage of patients reporting that before leaving hospital they were given written information on what they should or should not do after leaving by 15%	48.5%	59%	63%	63.5%
To increase the percentage of patients reporting that hospital staff discussed whether any additional equipment or adaptations were required at the patient's home by 15%	66.8%	77.9%	88%	81.8%
To increase the percentage of patients reporting that they were asked to give their views on the quality of care during their stay in hospital by 15%	20.5%	20.1%	22%	35.5%
To increase the percentage of patients reporting that they received information on how to complain to the hospital about the care they received by 15%	19.5%	28.9%	69%	34.5%

Quarter 4 results showed that targets had been achieved in 5 of the 7 domains. The greatest change within the quarter was in relation to the number of patients knowing how to make a complaint. Comments from patients included knowing there was a Patient Experience Team, awareness of the dedicated telephone number, knowledge of signs about making a complaint and an understanding of the role of the nurse in charge to assist.

During the year, there has been very little improvement in the number of patients being disturbed at night by other patients with snoring being the most commonly named disturbance. It is proposed to trial an offer of earplugs on a medical ward and evaluate the uptake and effectiveness. Although the Quality Improvement Priority does not include noise from staff (as this did not show as an outlier on the national survey), it is recorded each quarter on the internal surveys. This has shown a significant improvement in quarter 4 with only 15% of respondents identifying noise at night from staff being problematic compared to 53% last quarter. Bins were identified as being noisy at night in some areas and this has been fed back for action by Ward Managers. It is hoped that this improvement reflects a growing awareness of the night noise issue amongst staff and will continue to be monitored to ensure sustained change.

The second area to not show any improvement during the year is the percentage of patients being asked about the quality of their experience. Although this quarter's results are the best results achieved during the year, this still falls short of the desired improvement. Whilst this is disappointing, it is expected that the percentage would increase within the postal survey due to the Friends and Family Test only being offered at the point of discharge. This metric will continue to be monitored to identify if additional interventions prior to discharge would be beneficial. Matrons will be asked to talk to patients about

their perceptions of quality as part of their ward assurance processes. It is hoped that planned developments for next year, linked to the Safe and Sound strategy will also help to improve this domain.

The results of local surveys do not always reflect expected findings from the national data survey due to the differences in data collection methodology. Key differences include the timing of the survey and the point the patient is upon their journey. As an example, the timing of the surveys means that many patients do not think it is yet appropriate to be receiving written discharge information or do not require adaptations (50% and 71% respectively). The positive responses above therefore only relate to the patients who felt these questions were applicable. The results however, were encouraging and were supported by a range of positive comments from patients, particularly in relation to therapy adaptations.

Quarter 4 has shown an improved picture when compared to the 2016 and 2017 surveys and previous quarters. The improvement aims have been met in 5 of the 7 categories. Data collection for the 2018 survey is now complete so any further actions taken will not impact upon results this year. It is acknowledged that the findings may vary from the national inpatient survey due to the different method of data collection and timing of the collation of information. The 2018 National Inpatient Survey findings will be published in early summer 2019.

How was progress monitored and reported?
Reports were provided to the Patient Experience Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?
The Patient Experience Group will consider the results of the 2018 Inpatient Survey once published. An action plan will be developed to support continuous improvement and will be monitored quarterly through the group with escalations to Clinical Governance Committee as required.

Domain: Clinical Effectiveness

Preparing for the CQC inspection

Executive Lead – Chief Nurse
Operational Lead – Quality Governance, Compliance and Risk Manager

Rationale
The Care Quality Commission is the independent regulator of all health and social care services in England. They monitor, inspect and regulate hospitals and other care providers.

The Trust was inspected in September 2016 and whilst there was a lot of good practice identified, there were also areas for improvement, which led to 3 requirement notices (compared to 12 in 2015) and a total of 65 actions – a combination of Must Do (29) and Should Do (36) actions (compared to 15 Must Do and 12 Should Do actions in 2015). Most actions fall within the effective and well-led domains. At this inspection, the overall key question of well-led was reviewed and based upon the findings in the inspection this was rated as Requires Improvement which remains at the same level as at the previous inspection in 2015.

The CQC have revised their inspection process and confirmed that all Trusts will be inspected again by June 2019.

This is an opportunity to revisit where the Trust is at and through ensuring that the CQC standards are met, further improve the quality of services.

This was a new priority for 2018/19.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to use the opportunity of the CQC inspection cycle to promote better quality of care. This includes:

1. Reflecting on individual services highlighted in the 2016 inspection and gaining assurance on where improvements have been made and where further improvements can be implemented.
2. Review the actions allocated by the CQC and identify the current position and any improvements needed, thereby ensuring the standards of quality care are met.

What did we achieve?
In order to prepare staff for the inspections the following has been undertaken:

- The processes for the CQC inspections have been developed (including for the Factual Accuracy process) and have been circulated to all relevant individuals to ensure that they are aware of their role in an inspection.
- 13 staff awareness sessions have been held (a mixture of in the hospital and community). A leaflet has been developed to support staff with the inspection.
- NHS Improvement supported the Trust on 29 August 2018 with some peer reviews and mock interviews. The feedback has been positive, and each team were welcomed to the area, colleagues were open and honest about the care they provide and patients were complimentary about those caring for them and the service they received. A series of key areas for improvements were identified and include and actions put in place. The Trust then replicated these peer reviews with Executive Directors leading the reviews.
- A bi-weekly CQC Steering Group meeting was held to prepare staff and share the work that is being undertaken.

The Trust received a focused inspection on 17 July 2018 looking at Non Invasive Ventilation and treatment of paediatric patients in the Urgent and Emergency Care Centre (UECC). Acton plans were submitted to the CQC and these were being reviewed and resubmitted on a fortnightly basis. The CQC have now agreed that these no longer need to be submitted to the CQC.

The Trust received the following inspections;
- core service unannounced inspection on 25-27 October 2018 of four core services;
  - Acute - Maternity
  - Acute – Children and Young People
  - Acute – Medicine
  - Acute – Urgent and Emergency Services.
- Use of resources inspection on 28 September 2018
- Community unannounced inspection on 16-18 October 2018 - Community Children and Young People core service only
- Well led inspection on 22-24 October 2018

The final reports were published on 31 January 2019. A communication plan had been developed and various presentations were delivered towards the end of that week and the beginning of the next to ensure that staff were aware of the findings in the report.

Four requirement notices have been given to the Trust. These are the legal requirements that the Trust were not meeting, they are as follows;

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan was required to be produced for each of the above, using the CQC template. These were submitted to the CQC in February 2019.

The CQC have also issued the Trust with 74 actions (a combination of Must Do (47) and Should Do (27) actions). They are split as follows:

	Service	Must Do	Should do
	Trust Level	7	3
Hospital	Urgent and Emergency Care	12	10
Hospital	Medical Care	11	9
Hospital	Surgery	Not Inspected	
Hospital	Critical Care	Not Inspected	
Hospital	Maternity	9	2
Hospital	Children and Young People	4	3
Hospital	End of Life Care	Not Inspected	
Hospital	Outpatients and diagnostic imaging	Not Inspected	
Community	Community adults	Not Inspected	
Community	Community end of life care	Not Inspected	
Community	Community inpatients	Not Inspected	
Community	Community Children and Young People	7	8
Community	Community Dental	Not Inspected	
	TOTAL OVERALL	47	27

How was progress monitored and reported?

Reports were provided to the CQC Steering Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

Continue to address the findings from the CQC inspection and prepare staff for the next inspection.

Improved compliance with the Mental Capacity Act

Executive Lead:Chief Nurse
Operational Lead: Assistant Chief Nurse (Vulnerabilities)

Rationale

The CQC Trust inspection in 2015 and more recently at the CQC Trust re-inspection in September 2016 identified compliance with the Mental Capacity Act (MCA) as an area that required improvement and was identified as a 'Must Do' and regulatory action. Although a significant amount of work to improve has been undertaken, this remains an important area of focus. The Trust aims to safeguard vulnerable adults and achieve full compliance with the Mental Capacity Act and statutory regulations relating to vulnerable people, including those assessed as lacking capacity to make decisions for themselves.

This priority continued from 2017/18.

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

The aim for 2018/19 was to ensure compliance with the Mental Capacity Act, through learning from the CQC and other Trusts who are demonstrating outstanding compliance in relation to the Mental Capacity Act (MCA).

The objectives for 2018/19 were to improve:

- The percentage compliance with the Mental Capacity Act based on three assessment criteria being:

(A) Is there evidence of a capacity assessment in the patient's record
(B) Is there evidence of a best interest decision in the patient's records
(C) Has a Deprivation of Liberty (DoL) request been completed (where appropriate) (Acute Adult Services only)

Benchmark data obtained during March 2018
(A) 17% to 80% by 31 March 2019
(B) 14% to 80% by 31 March 2019
(C) 34% to 80% by 31 March 2019

- Compliance with the Adult Safeguarding training (that includes Mental Capacity Act) from 84.27% (October 2017) to 95% by 31 March 2019.

What did we achieve?

Audit	Benchmark Data Q3/Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) - Acute - Community	Audit undertaken 12 - 15 March 2018				
(A) Is there evidence of a capacity assessment in the patient's record	23.5%	Target 30% Actual 53%	Target 45% Actual 61%	Target 60% Actual 70%	Target 80% Actual 68%
(B) Is there evidence of a best interest decision in the patient's records	21%	Target 30% Actual 56%	Target 45% Actual 57%	Target 60% Actual 70%	Target 80% Actual 64%
(C) Has a DoLS request been completed (where appropriate) Acute Adult Services only	35%	Target 50% Actual 57%	Target 60% Actual 53%	Target 70% Actual 63%	Target 80% Actual 50%
Safeguarding Training	End of Feb 2018 85.01%	Target 87% Actual 84.35%	Target 89% Actual 87.2%	Target 93% Actual 86.48	Target 95% Actual 76.2%

As per the agreed actions for the end of Quarter 4, an audit was completed and led by the Safeguarding Adults Team. The audit is to assess compliance of assessment of capacity against the agreed trajectory as described above and below.

Overall the findings of the audit for Q4 were not as expected as per trajectory however have demonstrated a significant overall increase from the initial commencement of the priority actions.

Quarter 4 2018/2019 Adult Safeguarding Training Compliance was:

- January 84%
- February 79.3%
- March 76.2 %

The trajectory for training was to achieve 95% so not achieved. All Actions have been taken as per the agreed plan above and support is provided for the Divisions to achieve compliance in relation to options for training. Further support is required from the Heads of Service in the Divisions and for individuals to take ownership to achieve compliance as per MAST requirements. The Learning and Development Team have also put in place a number of processes to try to improve MAST compliance such as reminders 3 months in advance of expiry and Managers Dashboard are sent out on a monthly basis to ensure visibility of colleagues' compliance with MAST are some examples.

Overall in relation to DoLS requests this has increased overall by 25%.

How was progress monitored and reported?

Reports were provided to the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

- To continue maintain a high focus and priority of MCA compliance as a Trust – sustained commitment at all levels
- To continue to undertake bespoke audits as required including targeted support as appropriate and reviews to provide assurance of compliance and understanding of the MCA
- For all colleagues to be fully aware of expectations in relation to training, standards and adherence to the Mental Capacity Act – achieved via compliance of level 2 safeguarding training, review of competency and confidence, compliance of MAST requirements and Personal Development Review (PDR) and accountability
- To identify 'MCA champions' and provide an enhanced level of training to enable them to cascade and embed training in their work area
- Review of workload of the Safeguarding Team and prioritisation of specific actions
- Review of how MAST training is provided
- Monitoring and oversight of Priority actions and improvement trajectory via the Clinical Governance Committee and Quality Assurance Committee
- Executive support

Effective outcomes for women and baby

Executive Lead – Chief Nurse
Operational Lead – Head of Midwifery

Rationale

The improved detection of small for gestational age (SGA) babies is a clinical priority for the Rotherham Maternity Service. Across the community there are notable public health challenges affecting optimum foetal growth and therefore the detection of pregnancies affected in this way is vital to improving foetal wellbeing and neonatal outcomes, in particular the reduction of stillbirths and long term morbidity.

The position at the start of this piece of work was a detection rate of 35% for SGA babies (Quarter 1 2016/17). Rotherham has a high level of babies born that are SGA (approximately 13.5% v 10% in the national population) and is currently at 43.4% (Quarter 3 2017/18).

This was a new priority for 2018/19.

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

The aim for 2018/19 was to continue to increase the detection rate and to continue to improve detection by more than 1% per quarter, beginning with a 44.5% detection rate for Q 1 of next year. This would represent a significant improvement in the first year of the programme, with a clear trajectory for year 2.

The objective for 2018/19 was to improve the percentage of small for gestational age babies detected from 43.4% to 50% by 31 March 2019.**What did we achieve?**

Audit	Benchmark Data Q3 2017/2018	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Trajectory - Small for Gestational Age – Detection Rate	End of December 2017 43.4% End of March 2018 40.4%	45.5%	47%	48.5%	50%
Actual – as per data information below		40.4%	37.8%	35.6%	38.6%

The data in the chart shows that Rotherham SGA detection for the Quarter 3 (Oct-Dec) 2018/2019 was 35.6%. The Rotherham data shows that SGA detection appears to be falling. The peak detection was back in Q2 of 2017/18 at 49.5%. The reasons for this are unclear however the information provided below will attempt to provide some context and the plans to improve moving forward.

Rotherham has a higher incidence of SGA than average (16.1 vs 12.1% for the last quarter). This is likely to be due to a high incidence of raised BMI and smoking in our area. Both are strong risk factors for SGA and we currently do not scan smokers at all and do not scan women with raised BMI (or any women routinely) to term. This data is reported by the Perinatal Institute but is a result of data entered by midwives on labour ward after birth of the baby. A recent audit has questioned the accuracy of this data entry (data fully correct for only around 55% of births). This is currently being addressed via education and introduction of a sticker to improve data accuracy. Once this is implemented we can be sure that the report is accurate as a baseline.

The figure of 36% detection is actually what might be expected with our current practice of scanning until 36 weeks as the literature show that SGA detection rate with scan at this gestation is 36.1%.
The reason that 100% detection cannot be achieved is

- Not all women are scanned. Detection of SGA in low risk women relies on Symphysis Fundal Height (SFH) measurement (this is a measure of the size of the uterus used to assess fetal growth and development during pregnancy. It is measured from the top of the mother's uterus to the top of the mother's pubic symphysis which is less accurate than scan)
- Even with best scanning there is inaccuracy of 10-20% in the estimated fetal weight

A Business Case was submitted to the Business Investment Committee in August 2018. The Committee supported the need for increased scanning provision but no additional finance was provided. From November 2018 a number of discussions have taken place including liaison with the Director of Finance and a plan is now in place to progress.

The additional sonographer input will enable the women to have a scan undertaken at 28, 31, 34, 37 and 40 weeks instead of currently the provision is a scan at 28,32 and 36 weeks (2 additional scans in theory but in practice shown to be an average of 1.5 additional scans – 4.5 scans per high risk woman due to the number of women giving birth spontaneously or being induced before the last scan). This will be for all high risk pregnancies and will identify SGA for appropriate management plans to be put in place to prevent a poor outcome. The additional scanning will also be for women who smoke; therefore this will also support our on-going improvements for this work stream. The SGA detection and actions also forms part of the improvement work following the NHS Improvement collaborate work stream.

How was progress monitored and reported?

Reports were provided to the Clinical Governance Committee and Quality Assurance Committee.

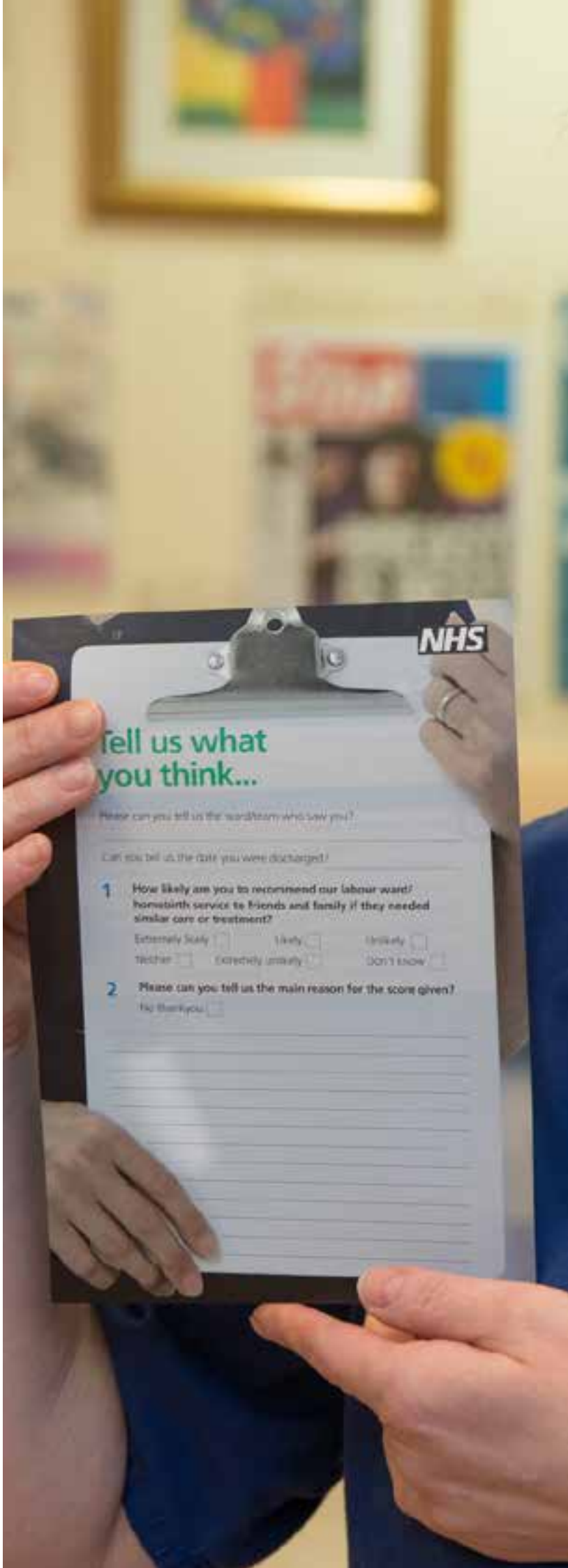
What further actions need to be undertaken?

- To continue to maintain a high focus on the Quality Priority - effective outcomes for women and baby
- To progress the improvements via the NHS Improvement SGA Group and additional working groups as appropriate
- To implement the plan for increased sonography service provision
- To finalise the review and updating of the Reduced Fetal Movement Guideline and embed into practice
- To ensure accurate data is reported to the Perinatal Institute
- Progress of the Better Births and Place Plan to deliver achievements of the 7 Key Lines of Enquiry (KLOEs) including smoking cessation – a number of key actions are progressing for this line of enquiry which will also support in reduction of small for gestational age babies
- Monitoring and oversight of priority actions and improvement trajectory via the Clinical Governance Committee and Quality Assurance Committee.
- Executive support.

3.1.3 Additional information about how we provide care

Friends and Family Test

The Trust continues to use the Friends and Family Test as one method of gaining feedback from patients and their families. The data is anonymised and reported to NHS England who publish the data each month. The latest data is for February 2019 and shows the Trust has approval ratings comparable to acute trusts across England. The 40% target for the response rate for inpatient areas is not being achieved in some areas, however the Trust continues to explore ways for increasing the completion rate. Whilst A&E response rates nationally are significantly lower than inpatient areas, the Trust remains an outlier. This is being addressed as a quality priority for 2019/20.



TRFT FFT results compared to England February 2019*

Service	Rate of return	% recommending	% not recommending
A&E			
TRFT	0.4%	71.4%	23.8%
England	12.2%	85.0%	9.0%
INPATIENTS			
TRFT	42.0%	96.8%	1.6%
England	24.6%	96.0%	2.0%
OUTPATIENTS			
TRFT	n/a	98.2%	0.8%
England	n/a	94%	3%
MATERNITY SERVICES			
ANTENATAL			
TRFT	65%	100%	0%
England	1.54%	95%	2%
BIRTH			
TRFT	25.0%	98.1%	1.9%
England	22.2%	97%	1%
POSTNATAL WARD			
TRFT	79%	100.0%	0%
England	1.41%	98%	1%
POSTNATAL COMMUNITY			
TRFT	46%	100%	0%
England	1.21%	98%	1%
OVERALL COMMUNITY SERVICES			
TRFT	4.40%	94.6%	1.1%
England	6.70%	96%	2%

*Please note February is the latest published data by NHS England.
(Source: NHS ENGLAND Friends and Family Test data)

Friends and family Test Positive scores 2017 / 2018 (1st April 17 - 31st March 2018)

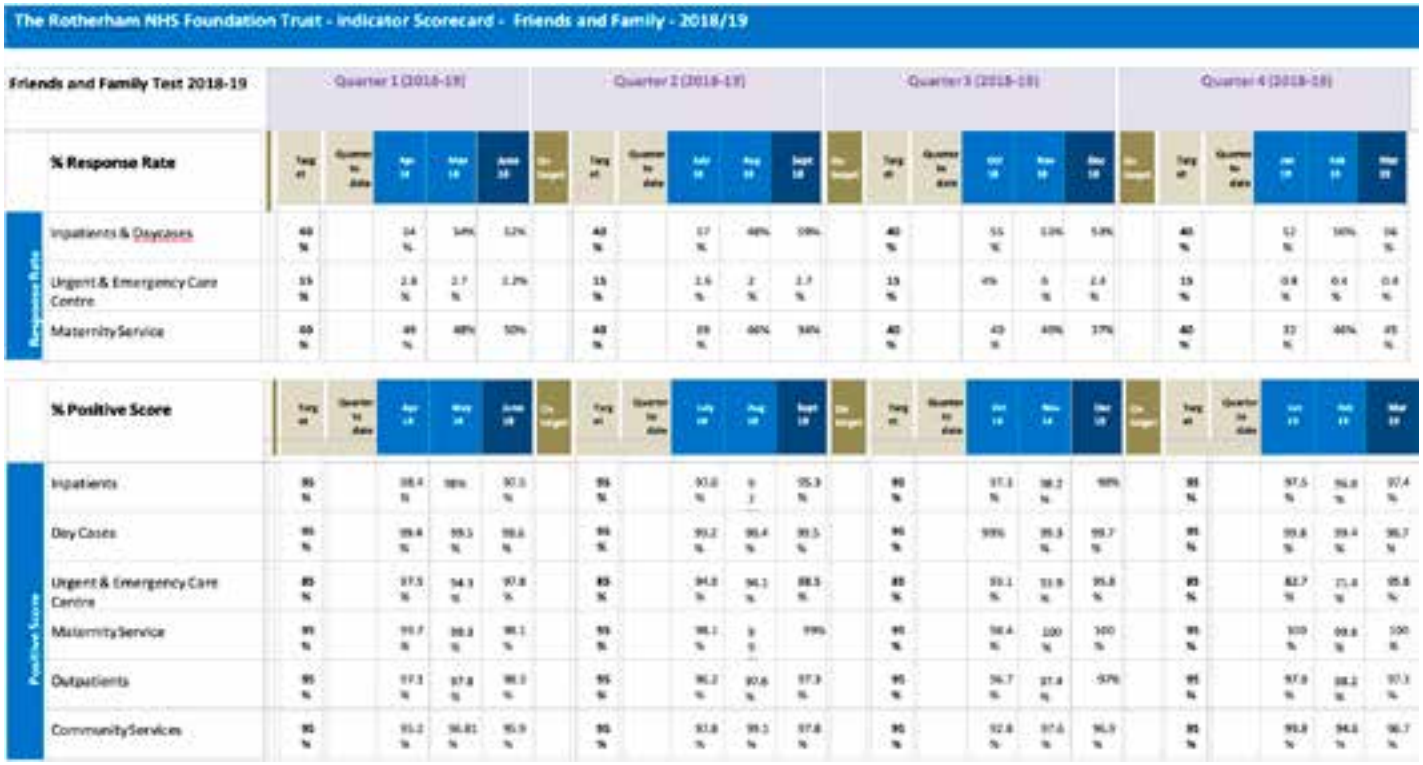
	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Inpatients	95%	97.5%	97.5%	97.5%	97.5%	96.3%	96.0%	97.2%	97.3%	95.8%	95.3%	96.3%	96.7%
Day Cases	95%	98.9%	99.5%	98.5%	100.0%	99.5%	99.0%	99.5%	99.7%	97.7%	99.4%	99.1%	99.1%
Urgent & Emergency Care Centre	85%	83.7%	91.2%	95.5%	91.4%	97.0%	93.7%	92.7%	93.7%	93.1%	99.1%	99.1%	92.8%
Maternity Service	95%	99.6%	98.9%	98.2%	97.3%	97.4%	98.9%	99.7%	100.0%	98.4%	96.7%	98.4%	98.5%
Outpatients	95%	98.0%	98.0%	97.2%	95.2%	98.1%	97.6%	98.2%	95.6%	97.9%	97.2%	97.0%	98.0%
Community Services	95%	98.0%	99.0%	98.1%	96.8%	99.0%	99.5%	98.1%	96.3%	98.4%	97.9%	98.1%	98.8%

Data Source TRFT data capture system.

Friends and family Test Positive scores 2018 / 2019 (1st April 18 - 31st March 2019)

	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Inpatients	95%	98.4%	98.0%	97.5%	97.0%	97.0%	95.3%	97.3%	98.2%	97.6%	97.5%	96.8%	97.4%
Day Cases	95%	99.4%	99.5%	98.6%	99.2%	98.4%	99.5%	99.0%	99.3%	99.7%	99.8%	99.4%	98.7%
Urgent & Emergency Care Centre	85%	97.5%	94.3%	97.8%	94.5%	94.1%	88.5%	93.1%	93.9%	95.8%	82.7%	71.4%	95.8%
Maternity Service	95%	99.7%	99.3%	98.1%	98.1%	99.0%	99.0%	98.4%	100.0%	99.6%	100.0%	99.6%	100.0%
Outpatients	95%	97.1%	97.8%	98.3%	96.2%	97.6%	97.3%	96.7%	97.4%	97.0%	97.8%	98.2%	97.3%
Community Services	95%	95.2%	96.8%	95.9%	97.8%	99.1%	97.8%	92.8%	97.6%	97.0%	99.8%	94.6%	96.7%

Data Source TRFT data capture system.



Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and, since CQC inspection in 2015 and 2018 there have been zero occurrences within inpatient wards. 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. Internal standards require reporting at 4 hours and 6 hours; an external report is made at 8 hours. There have been four instances of an external report in the last 12 months. This has been due to bed capacity in the correct specialty.

Additionally, there is also an internal process for monitoring and reporting 'pass by' breaches of mixed sex accommodation. In 2017/18 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 is part way through a programme of refurbishment of wards and development of more toilet facilities within bays.

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 NHS Improvement (NHSI) Never Events policy and framework.

All Datix incidents are checked daily by the Patient Safety Team so any incident reported which hasn't 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 as such once these have been identified are presented at the weekly Serious Incident Panel for confirmation with the panel that this does meet the NHS Improvement criteria.

During 2018/19 the Trust has reported four Never Events within the following categories:

- Wrong Site Surgery – three events reported
- Misplaced naso- or oro-gastric tubes – one event reported

Although there have been three incidents within the Wrong Site Surgery category, the circumstances and teams involved have been variable.

A robust Root Cause Analysis 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 Trustwide sharing of the learning from these incidents to improve the quality of care for patient's and prevent future occurrences.

Patient-led assessments of the care environment (PLACE) 2018

The 2018 PLACE assessment was conducted in April 2018. Visits were made to 18 clinical areas at Rotherham Hospital and 2 at Breathing Space. The 2018 visits involved Governors, Healthwatch and Trust colleagues. The 2019 Assessment returns have been delayed until September 2019 as there is a current review of the process taking place nationally.

Trust results 2016 and 2017	Cleanliness		Food		Food (Organisational)		Ward Food	
	2017	2018	2017	2018	2017	2018	2017	2018
Breathing Space	98.52%	94.91%	92.69%	88.22%	86.78%	86.94%	93.36%	89.50%
Hospital	98.72%	97.13%	83.36%	85.36%	87.53%	88.27%	82.47%	84.56%

(Source: The Health and Social Care Information Centre)

Trust results 2016 and 2017	Privacy Dignity and Wellbeing		Condition Appearance and Maintenance		Dementia		Disability	
	2017	2018	2017	2018	2017	2018	2017	2018
Breathing Space	90.91%	100%	90.48%	86.48%	88.35%	70.99%	84.02%	76.36%
Hospital	72.08%	80.13%	93.07%	92.11%	62.49%	66.47%	73.93%	74.52%

(Source: The Health and Social Care Information Centre)

Whilst organisational food and ward food scores have increased from 2017, work is currently being undertaken around the organisational questions and where improvements can be made.

Although there has been a slight decrease in the condition of the environment, there have been a number of areas refurbished this year, the assessment outcome is dependent on what locations are chosen for a visit on the day.

Inpatient Survey Findings

The results from the 2017 Adult Inpatient Survey were published by the Care Quality Commission in June 2018. The annual national inpatient survey (2017) showed an improving picture when compared to the 2016 survey but with further improvements still required to meet the targets set for the 2018 survey.

The CQC compare the Trust results with other organisations and classify whether Trusts are performing about the same as other Trusts, better than other Trusts or worse than other Trusts. The results showed there were three areas where the Trust significantly improved the score from 2016: privacy in the Emergency Department, the hospital specialist having the necessary information about the patient's condition/illness from the referrer and having sufficient privacy during discussions. The Trust has been rated worse than others in two areas: Doctors talking in front of patients as though they were not there and the perception of having sufficient nurses on duty to provide care.

A summary of how the Trust has responded to the findings is described below:

- Following a review of the report at the Patient Experience Group, the previous action plan was updated to incorporate new areas of concern.
- Every month members of the Patient Experience Group have conducted interviews with inpatients to discuss their experiences. This has contributed to overall Trust reports but has also provided an opportunity to resolve issues in real time and provide localised, area specific feedback.
- The Trust Catering Group has continued to make good progress in addressing a number of areas to improve the quality of food. Regular reviews of the quality of food are held, with Governor involvement and feedback is provided to all concerned regarding the findings.
- Wards are reviewed daily by senior nurses to ensure the most appropriate deployment of nurses.

Governance – Monitoring and Compliance

- The Action Plan is monitored via the Monthly Patient Experience Group.
- Findings from the National Inpatient Survey are triangulated against other sources of patient feedback including concerns and complaints, Friends and Family Test, Governor's Surgeries and feedback from Healthwatch and other websites. This is analysed and reported within the quarterly Patient Experience Report.
- During 2018/19 there has been a quality priority in relation to Learning from the Views of Inpatients. The monthly local inpatient survey is used to inform this with questions based on previous results from the National Inpatient Survey. Findings are fed back in real time to Ward Managers and via reports to the Patient Experience Group, Clinical Governance Committee and Quality Assurance Committee. Further information on this quality priority can be found on page 47.

Healthcare Associated Infections

The Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in May 2018. The 2018/19 annual report will be published in June 2019.

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 Clinical Governance Committee. The Executive Medical Director was the DIPC at the commencement of the year and this changed to the Chief Nurse.

Locum Consultant Microbiologists worked during the year alongside the Associate Specialist in Microbiology pending the appointment of the new substantive Consultant Medical Microbiologist in September 2018.

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C-difficile) are both alert organisms subject

to annual improvement targets. The MRSA bacteraemia target for 2018/19 was 'zero preventable cases' which was not achieved due to the one case in April. The C-difficile trajectory was 25 cases to year-end and the Trust achieved better than trajectory with 8 cases for 2018/2019.

Number of reported cases of MRSA bacteraemia Target = 0	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1	1	0	0	0	0	0	0	0	0	0	0	0

(Source: Trust Winpath System)

Number of reported cases of C.diff Target = <24	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	8	0	1	0	2	1	0	2	0	1	0	0	1

(Source: Trust Winpath System)

All cases of hospital acquired Clostridium difficile (C. difficile) were reviewed in depth by the Infection Prevention and Control (IPC) team. Shared ownership of completion of the Root Cause Analysis (RCA) investigation with the clinical divisions has greatly improved with any enquiries into other care aspects being referred to the relevant team when identified. e.g. to the vascular access team regarding line care, the continence team regarding urinary catheter care, the patient safety team if there is any query regarding falls, pressure ulcers or prolonged length of stay, the antimicrobial subgroup regarding antimicrobial prescribing. Multi-disciplinary Team (MDT) meetings with the relevant Division take place in the following two weeks where a full review of the RCA is undertaken.

A post-infection review (PIR) is carried out each month with the Lead Nurse for Infection Prevention and Control for NHS Rotherham Clinical Commissioning Group (CCG). The PIR scrutinises not only the Infection Prevention practices but also examines if there is any other lapse of quality of patient care identified during the whole patient care pathway.

In 2018/19 four cases have been classed as unavoidable with no lapse

in quality of care identified, one case from March 2019 is still under investigation but three cases did have an identified lapse in quality of care. The lapses identified were:

- Not all appropriate samples obtained and antimicrobial prescribing
- Lack of communication of previous C.difficile history provided on handover between clinical teams
- Delay in stool sample being obtained and lack of stool chart completion

All samples of C-difficile are sent for Ribotyping at the Leeds reference laboratory in order to determine the exact identity type of the organism. In the event that any samples have the same Ribotype the epidemiology is examined further to determine if there could be any link in time and place between the cases, if such a link is possible enhanced DNA fingerprinting is requested via the Leeds reference laboratory which identifies if the cases are indeed linked and thus caused by cross infection or not.

National mandatory reporting for Gram-negative bacteraemia commenced in April 2017, Gram negative bacteraemia includes E.coli, Pseudomonas aeruginosa and Klebsiella species. All CCGs have been given a 10% reduction goal for E.coli however numbers of hospital acquired cases, those that occur after 48 hours from admission, are low and no reduction target has been specified for acute hospitals. The Infection Prevention and Control Team are working jointly with the Lead Nurse for Infection Prevention and Control at the CCG to review all cases and looking for any themes that may help with future reduction including following NHS Improvement updates.

The intravenous (IV) access care provision has been incredibly successful in enhancing IV antibiotic therapy in the community. The Vascular Access Team in collaboration with the District Nurses and other stakeholders have been instrumental in the delivery of this service which has reduced admission and length of stay for many patients.

Recent updates to the vascular access database that allows the capture of data (including Central Line Associated Blood Stream Infections (CLABSI) data) has resulted in gaps within the data. However, daily surveillance and twice daily 'huddles' continue to focus on the topic of CLABSI. Based on the data we have available and the clinical picture that is regularly reviewed by the Vascular Access Team we are maintaining our low levels of CLABSI. We are currently working with the Meditech and Sepia teams to identify integrated technological solutions so that we will no longer rely upon standalone IT systems to control the data. In addition, we are developing administrative solutions that will assist with the identification and analysis of suspected CLABSI incidents.

The winter of 2018/19 has been challenging with numbers of cases of Influenza in line with the national picture which appears relatively low compared with the previous season however acuity of patients has been much higher with many admissions into critical care. The point of care (POC) machine has been used for the first full season and has helped to support the rapid identification of flu results which assists the emergency department team to discharge with diagnosis and advice and for those admitted a more accurate use of individual rooms that support flow through the hospital. The use of POC had led to some under reporting to the voluntary sentinel trust scheme which only reports against laboratory confirmed cases.

Cases of Norovirus and Rotavirus gastroenteritis have been at low levels and have been well managed to reduce further cases and with a number of beds closed where indicated to reduce onwards transmission risk whilst maintaining the operational flow of movement across the site.

There have been additional challenges during 2018/19 of infections with potential public health impact, this has included an increase in cases of Measles in the UK, with outbreaks reported in parts of Yorkshire and some cases diagnosed in Rotherham. The very rare incidence of Diphtheria identified and subsequent contact screening and vaccination, involving large co-ordination between various health colleagues locally and in the region.

Post-operative surgical site infection (SSI) surveillance following Caesarean section continues and is led by a Consultant Obstetrician working in conjunction with the IPC team with all ladies being followed up and their wound reported upon by the community midwifery team.

Post-operative surgical site infection (SSI) surveillance is mandatory for one quarter per year of Orthopaedic lower limb procedures (either hip or knee replacement). This surveillance has occurred during 2018/19 to include continual local surveillance of all lower limb arthroplasty. The results of the surveillance were provided to the Orthopaedic Governance Group. The Consultant for Podiatric Surgery completes continual SSI surveillance via the speciality national database and has had zero post-operative infection.

In summary, whilst the Trust was disappointed that a case of MRSA bacteraemia occurred, the Trust is pleased with infection prevention in other areas such as central line associated blood stream infections, rates of C difficile against trajectory and the low SSI rates in podiatric surgery. Norovirus, Rotavirus and Influenza infections have been well managed. More patients are being treated in the community with I/V antimicrobials which means that patients are prevented from hospital admissions or discharged earlier.

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.

The current rate of falls per 1,000 bed days

	2016-17	2017-18	2018-19
Falls	611	675	668
Bed Days	144,505	145,153	132,557
Falls Rate per 1000 Bed Days	4.23	4.65	5.04

(Source: Datix / Bed Days are Figures taken from KH03)

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. Further actions for 2018/19 have been designed as a result of the National Survey. The Falls Group have also commenced a yearly audit against NICE Quality Standard 86 (Falls in Older People) – (quality statements 4–6) (National Institute for Health and Care Excellence, 2017) which identify how a patient is managed following a fall. This will help identify areas of weakness and improve the care of these vulnerable patients. The Trust is also reviewing its current falls assessment documents to ensure appropriate risk factors are identified and appropriate actions are put in place throughout a patient's pathway and the Trust's Falls policy has been reviewed to reflect all changes to the way falls are managed.

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 (Midstaffspublicenquiry.com, 2015) into Mid Staffordshire NHS Foundation Trust, 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 was undertaken by the Trusts internal audit service in March 2017 (reported April 2017). The review assessed the extent to which the Duty of Candour Policy requirements were being adhered to and that there was a culture of openness and transparency within the Trust. The results showed reasonable assurance with compliance with the Trust's policy.

During 2017/18 we introduced the use of stickers within the patients notes to help identify specific conversations with patients/relatives and carers which demonstrate compliance with the Duty of Candour. We have also introduced a Serious Incident Database within the electronic Datix system where all Duty of Candour compliance is recorded and monitored. A further internal audit of Duty of Candour completed in 2018 identified some additional training needs which have commenced in January 2019. The Patient Safety Team will continue to monitor compliance with all the requirements identified in the initial audit and a further audit will be carried out in 2019. This work will continue to be monitored through the Patient Safety Group.

Safe and Sound Framework

The Trust is committed to delivering consistently safe care and taking action to reduce harm. Following on from the national Sign up to Safety campaign in recent years, TRFT has now developed a bespoke framework to support high quality, safe patient care.

The Chief Nurse and Interim Medical Director have developed the Safe and Sound Framework to deliver the Quality Improvement Strategy and Quality Improvement Plan. The Framework is based around 7 key areas, each of which has an executive lead.

Safeguarding Vulnerable Service Users

The Trust is 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 Assistant Chief Nurse, Interim Head of Midwifery Nursing and Professions and the Interim Head of Safeguarding, who manages the Safeguarding Team. The Safeguarding Team provides specialist input and advice regarding Adult and Children's Safeguarding. The Team also includes a Lead Nurse for Learning Disabilities.

In relation to adult vulnerability, the work and support by the team includes the 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 continued challenges posed by the introduction of the Care Act 2014, and the Supreme Court 2013 judgement with regards to the Deprivation of Liberty Safeguards (DoLS).

The team also includes one Paediatric Liaison Nurse Specialist and one Paediatric Liaison Nurse who provide 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 – this team responds to all children safeguarding referrals
- 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

The Trust continues to be an active partner in the Rotherham Local Safeguarding Children Board (RLSCB), the Rotherham Local Safeguarding Adult Board (RLSAB) and the Health and Wellbeing Board. In addition, robust governance structures are in place to ensure The Rotherham NHS Foundation 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 Safeguarding Team around investigations and preparations for Outcomes Meetings – even where there is no TRFT involvement. 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 has been significant activity, in partnership with the TRFT Learning and Development Team and Heads of Nursing, to review the competency levels required by individual job roles to align them with the Safeguarding Adults Intercollegiate document.

A full review of Safeguarding Children Training has also been

undertaken in conjunction with colleagues from the Trust Learning and Development Team. This was to ensure all colleagues have the correct level of training aligned to their specific role and recorded via the Electronic Staff Record. Training compliance is monitored via Safeguarding Key Performance Indicators and reviewed at the Safeguarding Operational Group reporting to the Strategic Safeguarding Group.

The method of recording training has been reviewed to ensure a more complete reflection of compliance across the Trust in ensuring accurate information is contained in the Electronic Staff Record (ESR). From this work e-learning training has been provided to colleagues to improve access and availability of appropriate training.

On-going training is being provided to support practice in respect of the 2013 Cheshire West Ruling and the changes to the implementation of the MCA and DoLS procedures. The MCA forms have been developed, agreed and are now embedded throughout the Trust. A template which replicates this form has been developed and is available for practitioners on SystmOne.

A robust training programme is in place for Prevent, which is included in the Trust induction programme and is part of the Mandatory and Statutory Training 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. TRFT is represented at the Channel meetings, where all cases of those suspected of being exploited are heard.

The Trust's Safeguarding Vulnerable Service Users Strategy is embedded in the organisation and key performance indicators against which safeguarding performance is monitored are in place and reported to the Clinical Governance Committee quarterly. In addition, a number of safeguarding standards are in place and monitored externally via NHS Rotherham Clinical Commissioning Group. The Trust has two specific Safeguarding meetings; a monthly Safeguarding Operational Group chaired by the Named Nurse Adult Safeguarding and a quarterly Safeguarding Strategic Group chaired by the Assistant Chief Nurse, Interim Head of Midwifery Nursing and Professions. A quarterly Safeguarding Report has been provided to the Board of Directors and presented by the Chief Nurse. In addition, quarterly performance reports are provided to the Local Safeguarding Children Board and Local Safeguarding Adult Boards Sub Groups.

Responsibilities of all staff employed by The Rotherham NHS Foundation Trust (TRFT) for safeguarding vulnerable people are documented in TRFT Safeguarding Policies.

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

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.

Macmillan Cancer Information Support Service

The Macmillan Cancer Information Support Service (MCISS) provides awareness, information, signposting and first line support to anyone affected by cancer, face to face contact, drop in, telephone, email, direct and indirect referrals from clinicians and other health professionals. The MCISS works in alignment with the national charity Macmillan Cancer Support. The current and future aims of Rotherham MCISS are to:

- Extend the hospital based MCISS into the community of Rotherham to ensure equity of service provision and accessibility.
- Expand engagement with the MCISS both geographically and along the cancer journey working across Rotherham and other aligned organisations such as the MCISS within Barnsley, Sheffield, Doncaster and Chesterfield.
- Work in alignment with Macmillan Cancer Support to raise the profile of the service.
- Maintain the annual revalidation of the Macmillan Cancer Support Quality Environment Mark (MQEM).
- Maintain the National Macmillan Cancer Support 'Quality in Information and Support Services Standard' (MQUISS).

During 2018 a total of 5301 patients have accessed the service and prevented the need for:

- 6 A&E visits.
- 349 GP appointments.
- 25 Consultant contacts.
- 338 Nurse Specialist contacts.
- 445 other contacts, such as District Nursing and Social Care.

The MCISS works with primary care, Rotherham Metropolitan Borough Council, voluntary, charitable and statutory provider services. MCISS consults with these other agencies to ensure collaborative planning of services and to avoid duplication. MCISS works to improve accessibility for patients, carers and the general population from diagnosis through to discharge and/or transition to palliative care.

'Drop in Centres' are being established across the locality alongside the:

- Future development of community engagement.
- Future development of an extensive training programme.
- Current expansion and consolidation work to foster closer links and collaborative working practices with:
    - The South Yorkshire Cancer Alliance.
    - Living With and Beyond Cancer Project.
    - Rotherham Health Watch.
    - Voluntary Action Rotherham through their social prescribing programme and the Be cancer Safe project.
    - Rotherham Hospital Health Information Services and key stakeholders to deliver healthy living and cancer awareness campaigns to the local population.

The MCISS have developed Volunteer Services since 2015 and they continue to support the service in its entirety whilst also supporting the Macmillan walk and talk cancer support group. This year the service was nominated and shortlisted for 2 Trust Proud awards in Caring and Outstanding Volunteer, to which the volunteer nominated received an award.

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. This is consistent with national drivers.

The frailty team is now well established, providing nursing leadership for dementia care within the Trust. All wards have dementia link nurses and bi-monthly meetings have commenced to provide further support, development and training for these roles.

The Trust has started to review the ongoing provision of training to support people living with dementia. Currently this training is delivered through e-learning, however it is felt that face to face training would be more effective, therefore, the first person centred care training day, led by the frailty team, commenced in April 2019, which incorporated Tier 2 dementia training. The dementia training design and delivery audit tool will be used to monitor the effectiveness of the training.

The frailty team are now also supporting dementia screening for the trust, which has recently improved to 90% compliance. The two senior members of the team are undertaking their non-medical prescribing courses which will further enhance their service and the quality of care provided to patients living with dementia. The lead nurse is also currently in the process of securing a place on the Kings Fund Older Persons Fellowship, which, if successful, will include a quality improvement project to further improve care for patients living with dementia.

Learning Disability

The Rotherham NHS Foundation Trust is committed to improving the experience for people who have learning disabilities and/or Autism. A specialist nurse is employed to focus on all aspects of patient care and experience at the hospital, whether people attend as an outpatient, planned inpatient or are admitted through the Emergency Department.

- There is an electronic flagging system in place to identify that a person has a learning disability. This then populates a live database for the Lead nurse in learning disabilities to access. This enables them to have an overview of inpatients with a learning disability.
- Championing the use of the Health Passport system, a person centred assessment tool for people with learning disabilities and Autism that helps staff to learn about how to care appropriately for each individual.
- Providing training that supports staff to improve their skills and knowledge. Developing a training package that is service user lead and talks about actual patient experience to help to change professional practice and behaviours.
- Continue to build links with established organisations to support learning, such as Speak Up, CHANGE organisation, Health Education England and Royal Mencap.
- 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 sub group, which has members from community learning disability teams, care providers for people with learning disability, such as Mencap, Voyage and Exemplar Health care and the local authority. This enables the Trust to learn from patient experience to change and alter practice/systems and pathways.
- Working closely with the volunteer coordinator at the Trust to mentor and support our volunteers in the Trust who have a learning disability/Autism.
- Working closely with colleagues within the Trusts 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.

Future plans:

- To work with the CCG and Local authorities to look at an electronic flagging system to identify people with Autism with an electronic flag on their medical records, with obtained patient consent.
- To have secured funding for a Trainee Nurse Associate Specialising in Learning Disabilities to be based within UECC and AMU areas to assist with the urgent and emergency care pathway into hospital for a person with a learning disability.
- Continue to encourage the role of the Learning Disability champion on all wards and departments.
- To work with service user focus groups to help the Trust adapt and change the environment of the hospital to be accessible for people, for example the signage around the Trust.
- Applying guidance from the Accessible Information standard (2015) to ensure all patients have information about their care/treatment/appointments in a format that they are able to understand.
- To work with the Trust 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 responsiveness of the Trust.
- The lead nurse in Learning disabilities and/or Autism is commencing the Non-Medical Prescribing course to assist with timelier discharges and a more evidence based treatment plan for that individual patient pathway.
- To plan towards the Trust obtaining an 'Autism Friendly Award', which is accredited by the National Autistic Society.

Engaging with Colleagues

The Trust remains committed to continue its journey of continual improvement. It recognises that staff are fundamental to delivery of quality patient services and care. Every staff member counts and to this end despite the challenges faced in the NHS both financially and to the workforce the Trust continues to seek out opportunities to involve and empower the workforce to shape the future both in local services and as part of the transformation agenda.

The NHS Annual National Staff Survey

The annual NHS National Staff Survey (NSS) gives colleagues in the Trust an opportunity to tell the organisation what it is like to work at the Trust. It also gives an opportunity to reflect on and help to prioritise the focus and actions to support continual improvement. The Trust response rate to the survey saw a small decline to 38% from the previous year (41%).

Nationally the results of the 2018 NHS Staff Survey still show a service struggling to provide care against increasing demands and the Trust mirrors this position. Since the last survey the Trust has seen an improvement in staff recommending the Trust as a place to work but this is not where the Trust wants to be. There has also been a small improvement in staff being treated fairly when involved in errors.

Staff have reported that the Trust needs to do more to support their health and wellbeing and again this mirrors the national position. The challenges remain in the following areas; Colleagues being happy with the standard of care if a relative or friend needed treatment, patient care being the Trust priority, communication between senior managers and staff being effective and having supplies and equipment.

A new question measuring morale reported a score of 6.1 (out of 10) nationally. The Rotherham NHS Foundation Trust scored 5.8 compared with similar combined acute and community trust organisations scoring 6.2 (average).

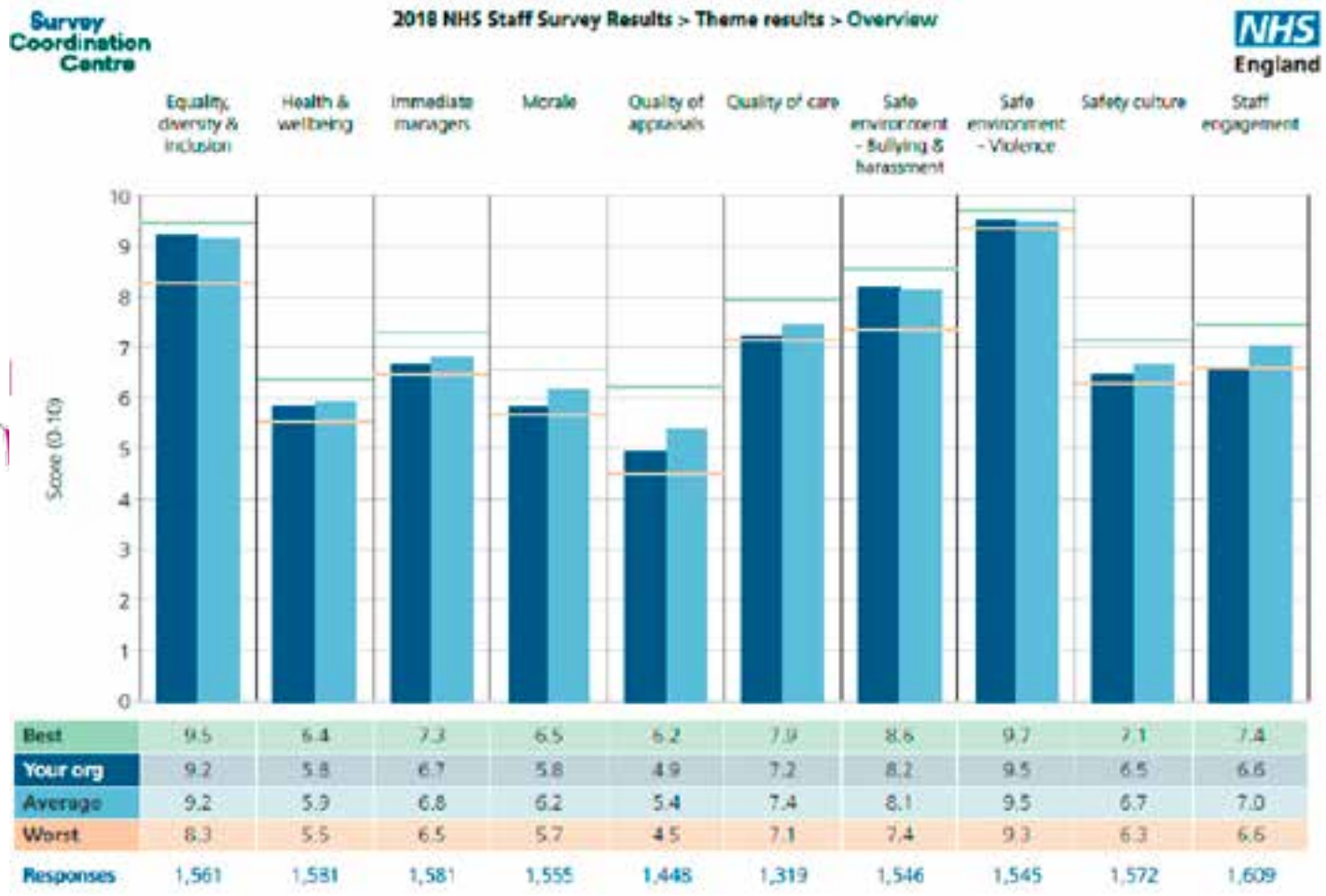
The Trust has made staff engagement an organisational priority over the next 2 years.

Focus will be placed on working to improve colleague wellbeing in particular how the Trust supports staff with maintaining good mental health and work to improve muscular skeletal injury as a result of work.

In quarter 3 2018/19 steps were taken to implement an Employee Assistance Programme. Working with the new provider to promote and analyse the wider colleague requirements to optimise colleague health. Data will be regularly available to support programmes and underpin our focus.

Themes

This year the National Staff Survey results have been themed rather than key findings. The graph below shows this year's results.



Of the ten themes in the survey the Trust is slightly above average on 3 key themes:

- Equality diversity and inclusion.
- Safe environment- bullying and harassment.
- Safe environment-violence.

The Trust performs significantly below average on:

- Quality of appraisal.
- Morale.
- Staff engagement.

The chart below summarises the Trust findings from the national staff survey 2018, carried out by Picker who were also commissioned by 19 similar Acute and Community Trusts. The chart represents the results in comparison to those organisations.

A total of **90** questions from the survey be positively scored. **82** of these can be compared historically between NSS17 and NSS18. Your results include every question where your organisation had the minimum required 11 respondents.

4353	4232	38%	40%	41%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (1628)	Average response rate for similar trusts	Your previous response rate

		Historical comparison*	Comparison with average*
52%	Q21c. Would recommend organisation as place to work		
54%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation		
66%	Q21a. Care of patients/service users is organisation's top priority		

Picker

*Chart shows the number of questions that are better, worse, or show no significant difference

The following eight questions from the staff survey indicate a significant improvement compared to previous Trust performance:

- Staff satisfied with the recognition for good work.
- Staff satisfied with the amount of responsibility given.
- Staff satisfied with the extent the organisation values their work.
- Staff satisfied with levels of pay.
- In the last three months staff not coming to work when not feeling well enough to perform duties.
- Staff not seeing error/near miss or an incident that could hurt staff, patients or service users.
- The organisation treats staff involved in errors fairly.
- Would recommend organisation as place to work.

The following four questions show significant deterioration:

- Adequate materials, equipment and supplies to do your work.
- Do not work any additional paid hours for the organisation over and above contracted hours.
- Organisation definitely takes positive action on health and wellbeing.
- Last month have not seen errors/near misses that could hurt patients.

The tables below show the top 5 scores, improvement and deterioration including the least improved.

Performance against priority areas

The Trust has maintained its commitment to undertaking key projects, activities and approach to engagement. Whilst the results of the staff survey are disappointing, increased focus on meaningful staff engagement will be a priority for the Trust over the next two years. This will include revitalising the Wellbeing offering focusing on stress, mental health and musculoskeletal (MSK). The Trust will also seek to continue with Together We Can engagement methodology building on last year's work with an aim for services to own and utilise change methodologies. The ambition last year was to undertake 10 engagement events using Together We Can, this has been exceeded during the year. Examples of teams include: Understanding the challenges of the surgical wards and recognition of areas of high performance; development of patient friendly sheets to aid bed making and maintain good pressure areas; Executive led sharing of the results of the 2017 staff survey; Finance - planning the year ahead with the team; developing a 24 hour community service. Each of these focused on putting staff at the heart of service development and improvement in working practices.

The Trust performed well against the Influenza vaccination programme. Achieving 80% of frontline workers vaccinated. The Trust was shortlisted for a NHS employers award for its work around Flu.

	Top 5 scores (compared to average)
95%	Q16a. Had appraisal/KSF review in last 12 months
72%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours
86%	Q16a. In last month, have not seen errors/near misses/incidents that could hurt staff
76%	Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
45%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours

	Bottom 5 scores (compared to average)
54%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
41%	Q4f. Have adequate materials, supplies and equipment to do my work
66%	Q21a. Care of patients/service users is organisation's top priority
52%	Q21c. Would recommend organisation as place to work
33%	Q9b. Communication between senior management and staff is effective

	Most improved from last survey
68%	Q20b. Disability: organisation made adequate adjustment(s) to enable me to carry out work
52%	Q17a. Organisation treats staff involved in errors fairly
54%	Q5a. Satisfied with recognition for good work
41%	Q5f. Satisfied with extent organisation values my work
52%	Q21c. Would recommend organisation as place to work

	Least improved from last survey
41%	Q4f. Have adequate materials, supplies and equipment to do my work
27%	Q11a. Organisation definitely takes positive action on health and well-being
44%	Q13d. Last experience of harassment/bullying/abuse reported
74%	Q16b. In last month, have not seen errors/near misses/incidents that could hurt patients
72%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours

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Picker

Staff Friends and Family Test

The Trust invites colleagues to participate in the staff friends and family test. Data is collated from colleagues each quarter, asking two key questions;

- How likely are you to recommend The Rotherham NHS Foundation Trust to friends and family as a place to work? The table below shows the responses collected during the year.

	Quarter 1 2018/19		Quarter 2 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	14.4	24	23.6	34
Likely	33.5	56	31.3	45
Neither likely or unlikely	21.6	36	14.6	21
Unlikely	15.0	25	11.8	17
Extremely Unlikely	15.5	26	18.0	26
I don't know	0	0	0.7	1
No response	0	0	0	0
	Quarter 3 2018/19*		Quarter 4 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	11.8	184	9.2	6
Likely	39.8	620	36.9	24
Neither likely or unlikely	30.8	479	9.2	6
Unlikely	12.1	188	15.4	10
Extremely Unlikely	5.5	85	26.2	17
I don't know	0	0	3.1	2
No Response	0	0	0	0

- The second question asked, how likely are you to recommend The Rotherham NHS Foundation Trust to friends and family if they needed care or treatment?

	Quarter 1 2018/19		Quarter 2 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	17.2	29	28.3	41
Likely	40.8	69	40.0	58
Neither likely or unlikely	23.1	39	9.0	13
Unlikely	11.8	20	4.8	7
Extremely Unlikely	7.1	12	13.8	20
I don't know	0	0	4.1	6
No response	0	0	0	0
	Quarter 3 2018/19*		Quarter 4 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	11.5	178	6.3	4
Likely	42.4	655	48.4	31
Neither likely or unlikely	29.9	462	14.1	9
Unlikely	12.0	186	10.9	7
Extremely Unlikely	4.2	65	18.7	12
I don't know	0	0	1.6	1

(Source: TRFT Survey Questions)

Monitoring Arrangement and future priorities and how they will be measured

The Trust is currently developing its new engagement and wellbeing strategy to ensure it continues to improve the approach to staff engagement. The key underpinning principles include ensuring the Board is cited on the Trust position in terms of how staff feel and that staff drive this. In response to this the Board have developed the Operational Plan which includes the following engagement priorities:

- Introduce PULSE surveys: with a continuous improvement in participation each quarter and improved baseline results.
- Implement staff inclusion networks: with a minimum of 2 networks established (BAME, Disability).
- Establish new Together We Can teams: with agreed deliverables and outcomes across a range of priority areas, targeting 10 teams.

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. In September 2016 a Lead Guardian was appointed, which enabled the separation of the FTSU Guardians from the HR functions of the organisation. Subsequent to this appointment six further FTSU Guardians have been recruited to ensure that all Divisions have representation. All of the FTSU Guardians have a suitability interview and undertake the role on a voluntary basis in addition to their substantive post. A new FTSU lead was appointed in January 2019, covering 0.1WTE. 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 the National Guardian, Dr Henrietta Hughes, there has been increased direction from the National Office regarding the role of FTSU Guardians. The regional network meets every two months and there are biannual national events which our FTSU Guardians have been supported to attend. In June 2018 TRFT hosted the Regional Meeting which was attended by a representative from the National Guardians Office. October 2018 was national FTSU month where the Trust ran a joint promotion with South Yorkshire Police to raise awareness of hate crime and FTSU. The FTSU Guardian month aimed to raise the profile of FTSU Guardians across the Trust and saw several events including the launch of a monthly drop in clinic at each of our sites.

The FTSU Guardian Lead has direct access to the Chief executive and other board members and is now line managed by the Chief Nurse. They formally meet quarterly, together with the Senior Independent Director and Executive Director of Workforce.
In its response to the Gosport Independent Panel Report, 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 TRFT 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 to the FTSU Lead.

All concerns are responded to 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 complainant. 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 FTSU Guardians. 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.

In 2018/19 the FTSU Guardians received 26 concerns. The concerns have related to attitudes and behaviour (nine), with colleagues being directed to HR or union support for further advice. Of the remainder, nine related to quality and safety of patient care, two to policy and procedures, and six to patient experience. An increased number of concerns have been raised to the FTSU guardians over the past 12 months, compared to the previous 12-month period. This may be due to The Rotherham NHS Foundation Trust being one of the only trusts nationally to have FTSU as a MAST 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 with regular reporting to the Operational Workforce Committee.

Key learning from the issues raised over the last 12 months, includes the development of a new Freedom to Speak Up strategy, in line with national guidance. National reviews and cases raised locally have informed the content of the strategy. It was also evident that the process for escalation of concerns was not robust whereas there are now formal routes into the serious incident investigation process, when required, and into Trust governance processes.

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

On 8 November 2018, The Rotherham NHS Foundation 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.

Held at Magna and hosted by Heart Yorkshire's Dixie, the event saw more than 250 colleagues, partner organisations and guests alongside the shortlisted nominees.

This year, more than 460 nominations were received, including a fantastic response from patients and members of the public who submitted over 150 entries for the Public Recognition category alone.

Chief Executive Louise Barnett was joined by the Chairman, Martin Havenhand, the Executive Team as well as the Deputy Mayor and Mayoress of Rotherham. The Health Reporter from the Rotherham Advertiser, Dave Doyle, was also in attendance to help present the Public Recognition Award.

The 2018 winners and runners-up are:

Strategic Objectives Award - Patients
Winner: Immunisation and Vaccination Team, 0-19 Service

Strategic Objectives Award - Colleagues
Winner: Dr Kim Russon, Day Surgery

Strategic Objectives Award - Governance
Winner: Derek Stowe, Information Governance

Strategic Objectives Award - Finance
Winner: Lynette Evans, Dermatology

Strategic Objectives Award - Partners
Winner: The Winter Beds Project Team, Care Coordination Centre, CCG, Private care homes

Values Award - Ambitious
Winner: Paediatric Acute Rapid Response Outreach Team, Children's Community Nursing

Values Award - Caring
Winner: Jennifer Turedi, Learning Disabilities

Values Award - Together
Winner: Sitwell Ward, Urology

Outstanding Volunteer
Winner: Samina Nawaz,
Macmillan Cancer Information and Support Service

Learning and Development
Winner: Mary Dougan, Chief Nurse Team

Unsung Hero
Winner: Janet King, Labour Ward
Runner up: Allen Blore, Estates

Our Top Leader
Winner: Sandra Whiting,
Community Occupational Therapy Single Point of Access

Team of the Year - Clinical
Winner: Acute Medical Unit

Team of the Year - Non-Clinical
Winner: Pharmacy Stores and Procurement Team

Public Recognition Award
Winner: Kelly Guest, Early Attachment Service
Runner up: Alcohol Liaison Service

Shining Star Award
Winner: Samantha Pritchard, Wentworth South District Nurses

Innovation Award
Winner: Joanne Cook and Midwives, Maternity

Chief Executive's Award
Winner: Radiology Team, Clinical Support

Chairman's Award
Winner: Alison Cooper, Anaesthetics

Lifetime Achievement
Winner: Dr Dave Harling, Critical Care

Three Rotherham community nurses receive prestigious award

Three community nurses working for The Rotherham NHS Foundation Trust have been recognised for their commitment to nursing at a ceremony held in London in June 2018.

Sharon Hunter, District Nurse; Paula Boyer, Community Matron and Sharron Roberts, Advanced Nurse Practitioner and Community Matron have been given the prestigious title of Queen's Nurse by community nursing charity The Queen's Nursing Institute. Between them, they have nearly 60 years' nursing experience.

The title is not an award for past service, but indicates a commitment to high standards of patient care, learning and leadership. Nurses who hold the title benefit from developmental workshops, bursaries, networking opportunities, and a shared professional identity.

Chris Morley, who was the Trust's Chief Nurse at the time, said: "It is fantastic news that Sharon, Paula and Sharron have been awarded the title of Queen's Nurse and testimony to the quality of the care that they provide. I have had the privilege of seeing first-hand the difference that these nurses make to the health and wellbeing of their patients. This is a prestigious award and I am very proud of their tremendous and well deserved achievement."

Dr Crystal Oldman CBE, Chief Executive of the Queen's Nursing Institute said: "On behalf of the Queen's Nursing Institute I would like to congratulate Sharon, Paula and Sharron, and welcome them as Queen's Nurses. Queen's Nurses serve as leaders and role models in community nursing, delivering high quality health care across the country. The application and assessment process to become a Queen's Nurse is rigorous and requires clear commitment to improving care for patients, their families and carers. We look forward to working with all Queen's Nurses who have received the title this year."

In their roles, Sharon, Paula and Sharron work collaboratively across a number of partner organisations, ensuring patients with complex and long term conditions receive high standards of care and helping to reduce the number of hospital admissions.

Sharon Hunter has been a nurse for 14 years and has been working in the community since 2009. In 2015, she became a Community Practitioner Specialist (District Nurse).

Paula Boyer has spent her nursing career in the community since qualifying in 2004. She has been a Community Matron since February 2017.

Sharron Roberts has been working in the NHS for 30 years and is an Advanced Nurse Practitioner as well as a Community Matron.

Abiola excels in World Skills competition

A talented Rotherham health worker scooped the silver medal at the UK finals of the World Skills competition in November following his successes in the regional heats earlier in the year.

Abiola Lugboso, aged 29 and lives in Brinsworth, works as a Therapy Support Worker at The Rotherham NHS Foundation Trust and helps provide rehabilitation treatment for elderly patients and those requiring intermediate care following a stay in hospital.

Abiola, who works at a variety of locations across the Rotherham community, including Lord Hardy Court and Davis Court care homes, is undertaking training with Rotherham College as part of an apprenticeship course.

During the regional heats and the finals, Abiola took part in a variety of healthcare based scenarios in which his skills, knowledge and ability to deliver excellent quality care was assessed by a panel of judges. Abiola said: "Being involved in this process has allowed me to learn new skills and broaden my knowledge which I can now use in my role.

"I've got a passion for what I do, work with a supportive team, and I get lots of satisfaction knowing that I am able to help people get the rehabilitation they need to regain their independence and live at home. The recognition I've received is great as it has reaffirmed that I am doing the right thing for my patients."

Angela Wood, Chief Nurse at The Rotherham NHS Foundation Trust, said: "We are all very proud of Abiola's achievements and getting so far in the competition. He has a great passion for the work he does and it is great to see his hard work and dedication recognised in this way as he strives to do the best for his patients."

Two teams shortlisted for Clinical Support Services award

Two teams from the Trust were shortlisted for the Clinical Support Services category at the Health Service Journal (HSJ) Value Awards in June 2018. The teams were:

- Rotherham Dietetic Led Nutrition Prescribing – 10 years of improved patient care
- Occupational Therapy Single Point of Access

The Dietetic team, working in partnership with Rotherham CCG, has improved patient care over the last 10 years by changing the way nutritional prescribing is carried out. Across the country, the norm is for the Dietitian to carry out an assessment, decide on the supplements, enteral feeds, specialist baby milks or gluten free products needed and contact the GP for a prescription. However, in Rotherham the Dietitians do the prescriptions themselves, saving time for consultants and GPs and reducing the wait time for the patient from 2-3 months to 2-3 weeks.

The team also looked at the incidence of pressure ulcers in care homes. Pressure ulcers are linked with nutrition, and in the same period as the team have been doing the prescribing, the incidence of pressure ulcers has fallen.

Over the last 10 years, this model, now known nationally as the Rotherham Model, has saved the CCG around £5.6 million, with prescribing costs reducing while the rest of the country has seen them increase 99.3%.

In the last year, three CCGs have implemented the Rotherham Model while some others have partially implemented it. The team have also been contacted by others interested in the model. The work of the team has also been recognised by the British Dietetic Association who used the Rotherham Model as a case study to support their case to the Department of Health and Social Care for Dietetic Led Nutritional Prescribing nationally.

The Occupational Therapy team developed a pilot where a Community Occupational Therapist was based within the Adult Social Care Single Point of Access team to assist the Wellbeing Officers to provide prompt and appropriate advice to people phoning the service. The pilot expanded and reduced the waiting list for Community Occupational Therapy referrals, and is now a permanent team.

The whole Occupational Therapy team remained committed and adapted to change quickly and efficiently throughout the pilot. Engagement and support from the Single Point of Access Team and Social Care Managers has been vital to the success of integrated working.

The team have previously been recognised in the Proud Awards and boast the RMBC Employee of the Year.

While both teams entered into the HSJ Value Awards missed out on the top prize, it is still a huge achievement to be shortlisted as finalists. It also highlights their successes on a national stage and shows some of the Trust's dedicated and hard-working colleagues working in different areas of the Trust.

Dietetic led Rotherham Enteral Tube Feeding (RETF) Service

Rotherham Enteral Tube Feeding Service (RETF) was created in February 2018 with support from the Consultant Nurse in Endoscopy and Interventional Radiology and the Innovation and Improvement team. Data has been collated; for the first 6 months, RETF have:

- Prevented 28 A&E/ AMU visits and 18 hospital admissions (reducing pressure in A&E and a saving of approximately 126 bed days based on historic data of an average hospital stay of 7 days per admission).
- Prevented 30 GP/District Nurse Visits.
- Established a robust out of hours pathway via Care Coordination Centre (CCC) which has further prevented hospital admissions.
- Established Parenteral and Enteral Nutrition (PEN) Multi Disciplinary Team (MDT) meetings which has ensured decisions on the most appropriate mode of feeding were made in collaboration with all clinicians involved in the patient care. This process has dramatically reduced the waiting time for patients needing a Gastrostomy placement (from 3-4 weeks to within a week). This has also reduced length of stay. In addition there has been a 50% reduction in use of Parenteral Nutrition due to reduced inappropriate referrals and prompt availability of alternative feeding options.
- Developed relevant governance paper work e.g. patient information material, referral documents and care plans, Rotherham wide Guidelines, competencies packs, pathways of care and emergency protocols.
- Established a programme of training and education for staff, patients and carers.
- Performed audits to assess current performance and implement changes to improve the service.
- Included Gastrostomy tubes, ancillaries and syringes in the Enteral Feeds and Supplements contract which has ensured further saving on these items.

Patient satisfaction survey conducted at the end of the 6 months has shown a 28% increase of patient confidence in the service and 29% increase in patient satisfaction.

The team have received several compliments and also a nomination for TRFT 'Public Recognition Proud Award'.

Dietetic led Enteral Tube Feeding service facilitates patients to access the right care, in the right place at the right time.

Electronic Observations (e-obs)

The Trust launched electronic observations (e-obs) on Meditech in January 2018 to mark the beginning of an exciting new digital era for TRFT. The Practice Development Team (PDT) have supported the launch alongside Health Informatics Team and IT, ensuring staff are trained on how to input patient observations and vital signs electronically.

All ward areas will have launched e-obs by the end of April 2019.

Undertaking nursing observations electronically is more efficient, safer and will save time in the long run. It also allows patients' observations to be accessed from anywhere in the hospital. Meditech is already being used by the Trust so there has been no extra expense incurred by installing a new system.

Deputy Chief Executive Chris Holt said: "The roll-out of electronic observations is a real benefit to the Trust and helps provide teams with real time information and visibility on patient acuity from any network connected device in the Trust."

Additionally, the PDT have also been supporting the Critical Care Outreach Team with the training of ward colleagues on NEWS2, which was launched at TRFT at the end of March 2019.

NEWS2 (National Early Warning Score) is a revised scoring system which will reliably detect deterioration in adults and trigger escalation of care when appropriate. NEWS2 replaces the MEWS scoring system previously used to record a patient's vital signs. It will help to improve the identification and management of sepsis and other serious conditions, and also includes a new plan for escalation.

Band 2 Health Care Support Worker Competency Package

In 2018 the PDT introduced a new competency package for all Band 2 Health Care Support Workers to ensure equity and consistency in the standard of care delivered across TRFT.

The package, which was launched in February 2018, consists of a competency log book alongside a one day workshop which all Band 2 Health Care Support Workers (HCSWs) working at the Trust must attend. The log book covers twenty competencies which are divided into two types: professional skills and core clinical skills.

These competencies are linked to the Care Certificate Framework, the Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England and the 6 Cs of Nursing.

The competency workshop is designed to reinforce the value of the Healthcare Worker in a modern healthcare setting. Attendees are provided with their own log book at the end of the workshop, which is to be completed and then signed off by their Ward Manager within 12 weeks. Colleagues are issued with a certificate of completion.

So far over 100 HCSWs have attended one of the workshops and the feedback has been extremely positive.

Laboratory Medicine

Following initial inspection in July 2017 and subsequent closure of findings raised during the inspection, Laboratory Medicine received notification in September 2018 of Accreditation to the International Standard ISO15189 (Medical laboratories – Requirements for quality and competence). In January and February 2019, Laboratory Medicine received their first surveillance visit as part of accreditation to ISO 15189 and subject to closure of findings raised during the visit, the department has been recommended for maintenance of accreditation. Excellent feedback was received for all departments. The assessment team unanimously commended the competence and quality of service observed and the development and improvements since the visit in 2017. Assessors also commented on the excellent knowledge and competence of staff.

Service Developments - Maternity

Continuity of Carer – New Model commenced in March 2019

As set out in Implementing Better Births: Continuity of Carer (CoC) means each woman has consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour, and the postnatal period. In order for the Rotherham Maternity Services to provide this continuation the following actions and plans have developed and progressed led by the Midwifery Lead for Community and supported by the Associate Head of Midwifery.

The Maternity Service have commenced the new model of one team comprising 8 whole time equivalent Midwives that have been identified as a pilot.

The Team is a gradual transition to community for those midwives who are moving from the hospital but the team will be fully operational from June 2019 and undertaking births from September 2019. The Team are planning to have annualised hours during the pilot. Each midwife will build up their caseload over the year aiming for a ratio of 1:35. The team will provide on call from August or early September to start to cover those women with an expected date of delivery in September 2019. Community Colleagues have decided to name their teams after trees, the first team is called The Willow Team. This Team will be caring for women on a standard maternity pathway hoping to increase the home birth rate, providing assessment at home when women go into labour.

There have been a number of documents that have been developed to provide good strong governance regarding this care provision including the development of an inclusion criteria, an information leaflet for women and a Standard Operating Procedure (SOP) for labour and delivery. Further Teams are planned including a high risk team focusing on twin pregnancy, diabetes and vaginal birth after caesarean section.

Personalised Care Plans (PCPs) – Commenced March 2019

The Trust has piloted a new Personalised Care Plan (PCP) from 1 March 2019 and this will help women to choose and make decisions in relation to their care and place of birth. The Trust will continue to evaluate this and are working with other providers across the Place within the LMS and with the Maternity Voices Partnership (MVPs). This links and supports Continuity of Carer to make care more personalised and woman centred.

Maternity Voices Partnership (MVP)

As part of Better Births each service has to work with local service users to create services that are woman centred. The Trust has developed its MVP and work in partnership to deliver service improvements. They are part of the trusts Better Births Governance Group. We will be evaluating Continuity of Carer and plan to devise an evaluation for women and staff. The Maternity Voices Partnership are also involved in the evaluation process and plan to undertake some focus groups with women for both the Personalised Care Plans and our Continuity of Carer later in the year.

Rotherham First Contact Physiotherapy service

The First Contact Physiotherapy (FCP) service has been established to deliver a high quality assessment service for primary care patients with musculoskeletal (MSK) conditions. MSK pain is a very common reason for patients to present to primary care clinicians. The NHS England Long Term plan (NHS England, 2019) prioritises MSK conditions as part of its vision; including expanding the role of other healthcare professionals within the general practice team to meet the growing demand. The FCP service offers patients the opportunity to attend an appointment with an Advanced Physiotherapy Practitioner rather than their General Practitioner (GP), allowing patients to have access to earlier MSK intervention and reducing the demand on GPs.

The FCP service within Rotherham consists of six advanced physiotherapists, who possess advanced clinical knowledge and expertise to accurately assess, diagnose and treat MSK conditions. The practitioners are based in various GP practices across the Rotherham borough and any registered GP patient can access an appointment with one of the FCP practitioners. The patient accesses an appointment via an agreed care navigation process. Patients receive expert advice on the management of their MSK problem; the FCP practitioners have an enhanced understanding of the MSK pathways and also have access to relevant diagnostics tests if required.

The Rotherham FCP is currently one of the largest in the country; both in terms of population served and number of FCP practitioners employed.

Neonatal Outreach Team (NOT)

The neonatal outreach team was launched in September 2018 to support some of the Trust's most vulnerable patients and their families. Admission to Special Care Baby Unit (SCBU) is not a planned part of a family's pregnancy journey and the time spent on Special Care Baby Unit can be frightening and daunting. These feelings are experienced again when being discharged home from SCBU. The development of NOT supports baby's and families following the discharge from SCBU by having experienced neonatal practitioners to support them in the community setting. The creation of earlier discharge pathways allow parents to take their babies home earlier receiving oxygen and/or naso-gastric tube feeds supported by the NOT. The NOT are able to undertake procedures that previously families would have had to return to outpatients for. In the short space of time this service has been running it has been invaluable for families and is well supported by colleagues in the Trust.

Paediatric Acute Rapid Response Outreach Team (PARROT)

The service was launched in October 2017. The vision of the service was to provide care closer to home, reduce duration of inpatient stay, minimise hospital readmission, empower parents to manage their ill children in the home environment and enhance the patient experience. The team initially commenced working with Children's Ward and Children's Assessment Unit and this has also been successfully rolled out to the Urgent and Emergency Care Centre with referrals directly from the UECC, this reduces hospital admission through safe and supported care in the community. This has been received exceptionally well by colleagues in all areas and by patients and their families. The service is to be developed so that General Practitioners will be able to refer directly to the PARROT service to reduce the number of UECC attendances and referrals to the CAU

Paediatric Practice Development Team – In place from February 2019

Ensuring that high quality standardised training and education is provided across the Trust for paediatric nurses is essential in delivering high quality safe patient care. The practice development Team commenced in February 2019 and provides support and training across the Trust both acute and community perspective.

Enuresis Service – March 2019

This service was commissioned by the Rotherham CCG due to a gap in service provision following the retendering of the 0-19 service. Enuresis problems for children and young people can be extremely distressing and lead to isolation. This service is launched at the end of March 2019 and supports children/young people and their families through structured pathways to provide intervention, education and support.

Speech and Language Therapy Children's Service

The Speech and Language Therapy children's service has a thriving and growing traded service. This is predominately mainstream schools buying in a Speech and Language Therapist for a set time each week to improve speech and language levels across the school. Most schools are purchasing the service through pupil premium money which is a payment made to schools by central government to help raise the educational levels for children who fit the eligibility for free school meals. Schools are generally using their Speech and Language Therapy (SLT) time to: screen all children entering school at Foundation stage level (nursery and reception), targeting certain year groups or groups of children for intervention groups, training staff in school to identify

children with SLT needs and improve the general communicative environment in classrooms and training teaching assistants to run language groups.

Two of the Trust's highly specialist Speech and Language Therapists started a 3 day a week secondment in September 2018 to RMBC's Virtual schools team. This team has oversight of all Rotherham children in the Looked After Children (LAC) and Previously Looked After Children (PLAC) (post adoption) services. The aim of this post is to help raise educational attainment levels for this group of children and to ensure that a looked after child does not have unmet speech and language needs. As a result of this newly commissioned service every child who is taken into care will have a Speech and Language screening assessment. Children with identified needs will where possible be signposted to local NHS core SLT services wherever the child is placed or receive intervention from the 2 therapists if local services are not accessible

for any reason. Many LAC children have had missed opportunities for SLT assessment and intervention before they come into care or have unidentified needs because Social Emotional and Mental Health or learning difficulties are masking an underlying language difficulty. There are over 600 children monitored by the virtual schools team. The first year's priorities are to assess every new Rotherham child coming into care wherever they are geographically placed and also to target a cohort of Year 3 children (7-8 year olds) who have been identified as performing significantly behind their peers in literacy in their end of Key stage 1 SATs tests. The SLTs will also be working closely with the Educational Psychologists in the team to provide joint training for schools, foster carers and parents. This is a very exciting project that puts the Trust's SLT's at the forefront of joint working with local council services for this very vulnerable group of children.

Implementing the priority clinical standards for 7 day hospital services

The Trust has agreed the need to develop a 7 Day Services plan following the national guidance and local requirements. It is linked to the operational plan and the key work is around providing 7 day services with the acute facilities, ensuring that pathways are available 24/7. The initial priority in relation to this is the development of:

- Weekend board rounds.
- Consultant reviews.
- 7 day Hospital at night services rolled out to 24 hours at weekends.
- 7 day cover of the Ambulatory service.
- 7 day Consultant cover within the AMU.
- Increased Rating services (pilot commenced).
- Further roll out of the Advanced Nurse Practitioner (ANP) model to support 7 day working in ED AMU Hospital at Night teams.
- Review complete of outreach and Hospital at night teams business case produced to increase 7 day coverage.

The national focus is still only on four of the 10 clinical standards:

Standard 2: Time to initial consultant review.
Standard 5: Access to diagnostic tests.
Standard 6: Percentage of diagnostic interventions available.
Standard 8: Ongoing daily consultant reviews.

The Trust participates in the national 7-Day Services Survey and compares well to the national picture. The May 2018 survey was completed and shows compliance with the 4 national standards. The January survey was completed and the national team are feeding back initial findings from the results nationally. The Trust will be taking the learning and feedback from this into the formal self-assessment due in July 2019.

Management of Rota Gaps – Doctors in Training

Gaps in Junior Doctor rotas can occur for a number of reasons, most commonly vacancies but also due to sickness absence and doctors training on a less than fulltime basis. The current vacancy rate for training grades is 13.7%; the equivalent of 20 posts out of an establishment of 146 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.

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 ANP for a 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.

External Agency Visits, Inspections or Accreditations

During 2018/19 there have been 19 external agency visits. Details of these visits are included in Appendix 3 (page 106). 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 NHS Improvement, for 2018 /19 these are:

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

For the purposes of this Quality Account, 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.
6. Delayed Transfer of Care.

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 Target >=92%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	95%	95.00%	96.00%	95.50%	96.00%	95.20%	95.40%	95.90%	94.90%	95.41%	94.23%	93.42%	93.24%
2018/19	93.99%	94.35%	94.57%	94.32%	94.82%	95.07%	94.07%	94.43%	94.37%	93.80%	93.10%	92.01%	92.98%

(Source: Meditech)

The criteria for this indicator are defined in NHS guidance. These are used by TRFT 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 TRFT specialties are currently excluded from 18 weeks RTT report. These are excluded because (as per national guidance) TRFT do not provide these services or they are non-consultant led activity.

The Trust continues to maintain performance against the Referral to Treatment time indicator with a strong performance throughout the year. With 94% performance in year which is above the 92% target.

The A&E four hour waiting time target

% of A&E attendances seen within maximum waiting time of 4 hours from arrival to admission/transfer/discharge

Target >=95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	84.98%	87.15%	88.08%	87.20%	81.15%	82.41%	81.79%	85.50%	81.36%	85.64%	87.10%	87.70%	83.10%
2018/19	85.65%	83.54%	89.92%	92.09%	86.43%	87.54%	84.66%	88.71%	88.85%	84.32%	80.63%	76.75%	84.16%

Standard data from the Trust's Meditech system as reported to SUS (Source: Meditech patient information system)

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

'A&E attendances and emergency admissions data reported through a central return are split into two parts. These are A&E Attendances which collects the number of A&E attendances, patients spending greater than 4 hours in A&E from arrival to discharge, transfer or admission and the number of patients delayed more than 4 hours from decision to admit to admission and Emergency Admissions which collects the total number of emergency admissions via A&E as well as other emergency admissions (i.e. not via A&E). These are reported for type 1, 2 and 3 department types.'

This data was subject to External Audit assurance. (A)

The maximum wait time of 4 hours standard has proven difficult to achieve throughout the year as reflected in the national picture. There has been an increase in attendance numbers and the acuity of the patients. TRFT along with other acute providers have not managed to hit the 95% standard for admitted patients although the Trust has on a large number of occasions hit the non-admitted target. Reinforcing the ability of the Urgent Care Centre and Emergency Department team to treat patients in a timely manner, highlighting the issues with the admitted patients who are reliant on flow through the hospital and community facilities for beds.

In a major report published in March 2019, Professor Stephen Powis, the Clinical Director of the NHS, found a number of flaws with the current four-hour waiting target in A&E, specifically that it does not measure total waiting times or take account of the patient's actual condition. TRFT has been asked to field-test measuring the waiting time from an initial clinical assessment and measuring the average waiting time. The Trust will be working with NHS England/NHS Improvement over the first half of 2019/20.

Cancer National Waiting Times

Trust performance against national waiting times for cancer services 2014/15, 2015/16, 2016/17, 2017/18 and 2018/19:

Metric	Target	2014/15	2015/16	2016/17	2017/18	April 2018 to Sep 2018
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	94.90%	95.12%	95.89%	95.1%	93.4%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	94.70%	97.43%	94.98%	90.9%	81.4%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%	99.21%	97.6%	98%
Cancer 31 day wait for 2nd or subsequent treatment - surgery	94%	100%	98.67%	96.85%	98.8%	98.5%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100.00%	100%	100	100%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	92.70%	88.46%	86.93%	84%	85%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	100%	98.20%	96.28%	90.8%	98.9%
Consultant Upgrade	TBC	TBC	94.72%	91.95%	92.8%	89.4%

(Source: Infoflex/Open Exeter)

The criteria for this indicator are defined in the Cancer Waiting Times rules. These are used by TRFT 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 day classic).

Cancer Standards 62 Day 2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	89.7%	89.1%	88.9%	86.4%	87.5%	91.3%	76.4%	86.8%	80.2%	74.4%	80.5%	88.9%
Numerator	30.5	41	112.5	28.5	31.5	47	40.5	52.5	40.5	45	31	48
Denominator	34	46	126.5	33	36	51.5	53	60.5	50.5	60.5	38.5	54

Cancer Standards 62 Day 2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	81.8%	87.1%	83.5%	85.7%	85.2%	86.2%	80.0%	86.6%	75.7%	69.8%	75.7%	74%
Numerator	54	57.5	43	57	54.5	53	50	51.5	39	44	40.5	35.5
Denominator	66	66	51.5	66.5	64	61.5	62.5	59.5	51.5	63	53.5	48

* (Figures October 2018 to March 2019 are provisional at the time of production of this report. Final figures will not be available until 5 June 2019 which is after the production of this report.)

Performance Against Targets

	Quarter1	Quarter 2	Quarter 3	Quarter 4
62 day	No	Yes	No	No
Screening	Yes	Yes	Yes	No

Screening:
Achieving screening targets can be challenging due to the small numbers of patients within the screening programme which only allows for 2 breaches per quarter. We have achieved 3 out of the 4 quarters this year, which is an improvement on last year.

62 Day Cancer Waiting times:
Performance has overall deteriorated throughout the year. With the trust only achieving this target in Q2. This has been attributed to the following reasons:

- An increase on 2ww referrals
- Difficulty in recruiting consultants which has impacted on capacity
- Increase in COSD data requirements

Steps have been put into place to ensure better working relationships between cancer services and the divisions. Cancer action plans to cover all areas have been developed and cancer recovery meeting which has been set up and runs bi-weekly. The trust has recruited additional support within Cancer Services to review and manage the PTL.

This data was subject to External Audit assurance. (A)

Delayed Transfer of Care

Delayed Transfer of care	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	6.78%	7.50%	6.88%	5.74%	6.13%	5.34%	2.37%	2.80%	2.56%	2.49%	2.14%	3.02%
2018/19	3.10%	2.26%	1.82%	2.52%	4.42%	3.16%	4.24%	2.80%	2.61%	4.06%	1.78%	1.90%

(Source: Trust Information System)

The criteria for this indicator are defined in NHS guidance and details are on the NHS Digital indicator portal. These are used by TRFT and for ease of reference these are:

'Delayed Transfer of Care (DTOC) from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when a clinical decision has been made that patient is ready for transfer AND a multidisciplinary team decision has been made that patient is ready for transfer AND the patient is safe to discharge/ transfer.'

Current position:
Since October 2018 the Team have adopted and rolled out within the Trust a Single Referral Process. This new process replaces several previous referral processors within the IDT, now being a Single Point of Access for Discharge Planning and access to Discharge Pathways.

This has supported the Team to continue to achieve Delayed Transfers of Care figures within the National Standard, despite the pressures in winter and the increased acute and non-acute beds.

The Integrated Discharge Team will continue to be in a phase of development and endeavour to continue to improve practices and processes to sustain current DTOC performance within National Standard.

Cancelled Operations

Cancelled Operations 2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target <=0.80%	0.71%	0.89%	0.64%	0.65%	0.78%	0.43%	1.02%	0.84%	0.82%	1.10%	1.10%	1.15%
Numerator	19	27	20	19	24	13	33	26	20	33	30	33
Denominator	2684	3017	3147	2927	3061	3053	3234	3096	2448	3005	2728	2859

Cancelled Operations 2018/19	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target <=0.80%	1.18%	1.10%	0.71%	0.89%	0.64%	0.89%	0.49%	0.54%	0.67%	0.71%	0.73%	0.79%
Numerator	35	34	22	27	19	25	16	17	17	21	20	23
Denominator	2960	3094	3086	3042	2968	2802	3294	3149	2542	2963	2742	2903

(Source: Trust Information System)
This data was subject to the External Audit assurance (A)

Cancelled operations data is reported quarterly through a central return however, the information is also reported monthly to the Trust Board to show the Trusts 'performance against the <=0.80% target. The indicator applies to all admitted patients planned for surgery who get their operation cancelled at the last minute due to non-clinical reasons i.e. on the day of arrival in hospital, or after admission to hospital, or on the day of surgery. The Trust then has the responsibility of getting the patients re scheduled within 28 days of the original cancelled operation date. Should for whatever reason the Trust cannot comply with this national rule, the Trust has to fund the patients treatment at the time and hospital of the patients choice. The source of the information is the Trusts electronic system (Meditech). The numerator is the number of patients cancelled by the hospital for non-clinical reasons i.e. lack of equipment and the denominator is the number of operations carried out.

The standard applies to all planned or elective admissions where an OPCS-4 operation code procedure was to be carried out. This includes patients admitted for day surgery. Invasive X-ray procedures carried out on inpatients or day cases are counted as an operation for the purpose of monitoring this standard.

Some common non-clinical reasons for cancellations by the hospital, highlighted by NHS England, could include: ward beds unavailable; surgeon unavailable; emergency case needing theatre; theatre list over-ran; equipment failure. However, this list is by no means exhaustive.

Any patient who is cancelled on the day of their procedure, for non-clinical reasons, must be offered an alternative date within a 28 day period.

The total full year performance for 17/18 was 0.84%, which is slightly outside the agreed target of 0.80%. The total performance for 18/19 YTD is 0.78% which is within the agreed standard.

Should any services not meet the target then the contributing factors are investigated as part of their governance processes and could be questioned at service level performance meetings, which take place monthly. There is a robust validation process in place in order to ensure services are reporting accurately and any themes or learning can be shared.

The importance of achieving this target is well understood within the service, as cancelling patients on the day of their surgery provides a very poor experience for those individuals.

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
2017/18	15	0	0	0	2	0	2	2	0	3	2	1	3
2018/19	8	0	1	0	2	1	0	2	0	1	0	0	1

(Source: Trust Winpath System)

The Trust improved its performance on C difficile compared to the previous years and was well under the trajectory of 25 that it had been set.

All cases of hospital acquired C-difficile are reviewed in depth by the Infection Prevention and Control (IPC) team. Shared ownership of completion of the Root Cause Analysis (RCA) investigation with the clinical divisions has continued. Multi-disciplinary Team (MDT) meetings with the relevant Division take place in the following two weeks where a full review of the RCA is undertaken with any identified actions being reported via the relevant governance meeting.

National and local priorities and regulatory requirements:

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

Measure	Department of Health	NHS Improvments	2016/17		2017/18		2018/19	
			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	19	>24	15	>26	8	>26
Number of cases - MRSA	x	x	1	0	3	0	1	0
Delayed transfers of care	x	x	3.41%	3.50%	4.61%	3.50%	1.9%	3.50%
Infant health & inequalities: breastfeeding initiation	x	x	57%	66%	57%	66%	66.5%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	96.89%	95%	95.92%	95%	96.1%	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	84%	90%	84%	90%	84.4%	90%
Non - Admitted	x	x	96%	95%	95%	95%	95.4%	95%
Incomplete	x	x	95%	92%	95%	92%	95.01%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	2.40%	Less than 1%	0.60%	Less than 1%	0.49%	Less than 1%
Patients waiting less than 4 hours A&E	x	x	88.63%	95%	84.95%	95%	85.65%	95%
Cancelled operations for non-medical reasons	x		0.76%	0.80%	0.73%	0.80%	0.8%	0.80%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		92%	90%	91.34%	90%	93.6%	90%
Patients who spend at least 90% of their time on a stroke unit	x		85%	80%	75%	80%	81%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		66%	60%	81%	60%	70%	60%
Elective Adult patients 18years and over readmitted to hospital within 28 days of discharge from hospital	x		5%	6%	2.06%	6%	1.53%	6%
Non Elective Adult patients 18 years and over readmitted to hospital within 28 days of discharge from hospital	x		13.60%	12.50%	11.86%	12.50%	12.45%	12.50%
Elective patients 0-17 years readmitted to hospital within 28 days of discharge from hospital	x		0.60%	3%	1.19%	3%	0.29%	3%
Non-Elective 0-17 years patients readmitted to hospital within 28 days of discharge from hospital	x		6.50%	10.40%	8.30%	10.40%	8.33%	10.40%
Ensuring patients have a positive experience of care (Pt survey overall score)	x	x	8	10	8.1	10	Not Published until June 19	10

Measure	Department of Health	NHS Improvments	2016/17		2017/18		2018/19	
			Year end Position	National Target	Year end Position	National Target	Year end Position	National Target
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		96%	94%*	98.80%	94%*	97.5%	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		95%	90%*	90.80%	90%*	94.7%	90%*
Urgent GP Referral	x		87%	85%*	84%	85%*	81.2%	85%*
31-Day Wait For First Treatment (Diagnosis To Treatment)								
All cancers	x		99%	96%*	97.60%	96%*	97.5%	96%*
Two week wait from referral to date first seen								
All cancers (%)	x		95%	93%*	95.10%	93%*	93.8%	93%*
For symptomatic breast patients (cancer not initially suspected)	x		98%	93%*	90.90%	93%*	85.6%	93%*
SHMI	x		112.06	100	103.13	100		100

Please note : the data for April 18 - March 19 is not published until August 2019
(Source: Various Information Systems including InfoFlex/Open Exeter and Trust Information System)

For further details of readmission rates see Appendix 2.


Safe &
Sound

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 Governors.

We believe that the report is an accurate and true reflection in terms of actions taken by the Trust during the year and indicates both the significance and the emphasis placed on safety, quality, patient experience and clinical effectiveness by the Trust.

During the year, the Trust welcomed the Care Quality Commission who carried out inspections at the Trust, including the Trust's first CQC 'Well Led' review. This document provides substantial detail with regard to the CQC findings and follow up actions being taken.

Whilst improvement was seen in some areas, the overall rating for the Trust remains as 'requires improvement'. This was to be expected, partly because of changes to the inspection procedures whereby fewer areas are inspected meaning that it is difficult for the rating to move upward within one inspection cycle. However, it is without doubt, both disappointing and concerning, that services from our flagship Urgent and Emergency Care Centre were awarded an 'inadequate' rating by the CQC and that within their findings, the domains for safety and caring had both deteriorated since the last inspection.

The Council of Governors is assured that a substantial amount of work has been and will continue to be carried out by the Trust to remedy this and the other areas where improvement is required. The Council of Governors also wishes to thank colleagues for the unending compassion, strength, resilience and professionalism shown by them before, during and after the CQC visits.

The CQC identified digital progress as an area of outstanding practice across the Trust, not only in terms of the systems used but also in the level of clinical involvement and in the use of data to monitor and drive performance. The extended use of digital technology continues to support improvements in patient care. This includes the deployment of E-observations across inpatient and UECC areas, and the Trust continues to plan for Trust-wide implementation of E-prescribing in autumn 2019.

It has been a demanding year for the NHS in general, and the Trust has not been immune to system wide and local challenges. Whilst it is disappointing that some local standards were not met, such as the four hour A&E access standard, and some cancer standards, there is still some satisfaction with the strong performance in areas such as infection control, hip fracture best compliance, and reduced length of stay.

In January 2019 the Council of Governors chose cancelled operations as the local indicator to be audited by the Trust's External Auditors. The Council was pleased to note that the Trust's performance for 2018/19 had improved compared to 2017/18 and was within the agreed national standard.

The Governors are assured that the continual improvement in the quality of care delivered to the citizens of Rotherham is of the highest priority for the Trust. The Council of Governors will continue to question and challenge appropriately within the discharge of their statutory duties, in order to support the Trust in this endeavour. As Lead Governor I can attest to the open and honest dialogue and the high level of engagement the Trust leadership has with the Governors, and it is appreciated.

The Trust continues to work closely with partners throughout the South Yorkshire and Bassetlaw Integrated Care System, and the Rotherham Integrated Care Partnership. Governors are supportive of proposed arrangements, which, if taken forward and carried out successfully, will bring benefits for our patients in the future.

We look forward with interest to the next steps in these initiatives and hopefully, many further years of collaborative, joined-up working, leading to improved quality of health and social care in Rotherham and across the region.

Gavin Rimmer

Lead Governor, The Rotherham Foundation Trust.

Statement from NHS Rotherham Clinical Commissioning Group

Throughout 2018/19, The Rotherham NHS Foundation Trust (TRFT) have worked with NHS Rotherham Clinical Commissioning Group (RCCG) to secure continuous 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 had particularly strong representation during the latter part of 2018/19 with regular attendance from both the Chief Nurse and Interim Medical Director. The level of assurance provided at this forum in relation to actual and potential quality issues within the Trust has been robust and transparent.

RCCG are particularly keen to highlight the achievements of TRFT in relation to a number of areas which are detailed below.

RCCG recognises the significant improvements that have been made in clinical coding during 2018/19 resulting in TRFT being rated in the top quartile nationally for depth of coding and achieving the highest grade Level 3 for the Information Governance Audit. Depth of coding is important for Providers and Commissioners in ensuring that the complexity of patients is captured appropriately and accurately and supports in the planning of services to ensure patients' needs can be met.

TRFT's Infection Prevention and Control team and the lead Infection Prevention and Control Nurse for RCCG work in collaboration to attempt to prevent, manage and reduce the healthcare associated infections in Rotherham. Flu cases have been a particular challenge during 2018/19 however this has been managed well by the introduction of point of care testing within the Urgent and Emergency Care Centre which has helped to support rapid identification and admission avoidance.

TRFT provided RCCG with full assurance on the review process and governance arrangements for risk assessments and sign-off in relation to the quality impact assessments of cost improvement plans. Of particular importance was that for the 2018/19 cost improvement schemes these were either approved at Divisional Level having being assessed as having no risks to quality or safety, or discounted at concept stage, as having an impact on quality and safety to pursue. RCCG have noted the potential change to the QIA process for 2019/20 and will look forward to receiving the same level of assurances for the forthcoming year.

RCCG and TRFT participate in an annual programme of clinically led visits. The purpose of these visits is to facilitate assurance about quality and safety of healthcare services; providing an opportunity for commissioners to inspect facilities and engage directly with patients, clinicians and management to hear any concerns and ideas for improvement under a guarantee of anonymity. For 2018/19, there was a joint agreement to change the way that visits were conducted with a focus on the patient journey and full end to end pathway. Two visits have taken place during 2018/19, these being maternity and learning disabilities. Overall the two visits concluded with positive feedback from RCCG clinicians with a series of recommendations for improvement to be implemented. Also of particular note was the positive feedback from the patients during these visits. A programme of visits is in the process of being agreed for 2019/20.

TRFT's current registration with the Care Quality Commission (CQC) is 'registered with conditions' due to a number of conditions placed upon the Trust during 2018. The latest inspection in September and October 2018 gave the Trust an overall rating of requires improvement and subsequently a comprehensive action plan has been developed to address the inspection findings. TRFT have committed to sharing updates against these actions with RCCG and RCCG recognises the hard work that has been put into not only developing the plan but addressing the immediate concerns raised by the CQC. RCCG will continue to work in a supportive manner with TRFT as well as seeking assurance on delivery of the plan and identifying notable improvements.

TRFT have experienced challenges during 2018/19 with regards to medical staffing vacancies recognising that this is a national issue. RCCG have been assured that processes are in place to manage this.

RCCG is supportive of the Trust's key quality priorities for 2019/20 and is pleased to note that priorities have been agreed following a consultation process involving colleagues, governors, patient and members of the public. In particular, the focus on enhancing patient feedback and public engagement is welcomed.

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

Sue Cassin
Chief Nurse
NHS Rotherham CCG

11 April 2019

Statement from Rotherham Healthwatch

Healthwatch Rotherham continues to have an excellent co-operative working relationship with The Rotherham Foundation Trust.

Having read the Quality Accounts it is good to see Patient Experience included in the quality priorities for 2019/20, focusing on improving End of Life recognition, improved patient discharge and enhancing patient feedback and public engagement. Healthwatch Rotherham attend the Patient Experience Group meeting and feeds back any complaints, compliments or concerns that have arisen during the month. A snapshot of comments from social media channels are fed back to the group and we ensure that all comments in the feedback section of our website are responded to by the Head of Patient Experience.

A representative from Healthwatch Rotherham attended the PLACE assessment during April 2018, assessing privacy and dignity, food, cleanliness and general building maintenance. It is good to see that The Rotherham Foundation Trust are taking on board areas where improvements can be made.

Any information received by Healthwatch Rotherham via our engagement work from local residents is passed onto The Rotherham Foundation Trust. The majority of comments continue to be from residents who have received excellent care, and are praising the individuals involved. Any concerns or complaints received at these events are raised in the agreed way.

Healthwatch Rotherham looks forward to continuing to grow and develop a good working relationship with all at The Rotherham Foundation Trust.

Tony Clabby
Healthwatch Rotherham CEO

Statement from Rotherham Health Select Commission

The TRFT sub-group from the Health Select Commission (HSC) held a detailed discussion on progress on the quality priorities in January 2019. This was then followed by a similar session in April 2019, with Members also having had the opportunity to consider the draft Quality Account. Members value being presented with this information and asked questions in both sessions with regard to challenges, performance and delivering further quality improvements.

Clearly the HSC was concerned by the findings from the recent CQC inspections, in particular with regard to the Urgent and Emergency Care Centre and the Safe and Well-led domains, internal communications and safeguarding referrals. They held an in depth session on the CQC report in February and probed into the key issues and how these would be addressed. 47 Must Do actions have been incorporated in a comprehensive action plan and HSC expects to see these actions being taken to ensure the CQC report is acted upon. Members are keen to see that improvements lead to better relationships between managers and staff and improved staff morale. Scrutiny of progress with the action plan will be included in the Select Commission's work programme for early autumn.

It is positive to see the progress made on the quality priorities during the year, in particular with electronic results reporting in radiology and future expansion into other areas, and further progress on both End of Life Care and Mental Capacity Act compliance, which are difficult areas. Further work on discharge planning and increasing pre-noon discharge is welcomed by the HSC and it is hoped that the roll out of e-prescribing will facilitate this, for example with people not having to wait for take home medication to be dispensed. It is also envisaged that e-prescribing will enable further progress on medicines management overall and reducing medication omission errors.

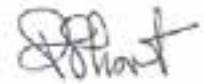
As Vice Chair I would like a continued focus on staff training on safeguarding to ensure all children and young people are protected and that signs of possible abuse are correctly recorded and concerns passed on to partner agencies.

Workforce challenges have been an ongoing issue for a few years with national shortages of nurses and doctors in various specialties. The Trust is being proactive on this issue with a number of initiatives to ensure the right skills mix and to encourage existing staff members to develop their careers at the hospital. Visits to local schools and colleges to talk to students about career opportunities and pathways are a positive move.

It was disappointing to see that the percentage of patients reporting that they were not bothered by noise at night had decreased and hopefully additional measures will be considered to improve this.

Overall there is a lot of work to do but Members are very supportive of the introduction of the new Safe & Sound Framework being developed by the Chief Nurse as the overarching means of delivering the long term changes needed and to embed a quality improvement culture. It is pleasing to hear that within this framework the Trust is planning to strengthen its approach to listening to the views of staff, patients and their families and carers.

The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members, by attending meetings and providing information, as well as taking on board their comments and concerns. The Commission expects this to continue and looks forward to working closely with the Trust again in 2019-20.



Cllr Peter Short
Vice Chair, Health Select Commission
16 April 2019

Annex 2: Statement of Director's 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 2018/19 and supporting guidance Detailed requirements for quality accounts 2018/19.
- 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 2018 to 31 March 2019.
    - papers relating to Quality Accounted to the board over the period April 2018 to 31 March 2019.
    - feedback from commissioners dated 18/04/2019.
    - feedback from governors dated 14/05/2019.
    - feedback from local Healthwatch organisations dated 08/05/2019.
    - feedback from Overview and Scrutiny Committee dated 17/04/2019.
    - the trust's complaints report published under regulation18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/2019.
    - the national patient survey 13/06/18.
    - the national staff survey 26/02/2019.
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 16/05/2019.
    - CQC inspection report dated 31/01/2019.
- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the Quality Account is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controzzls 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

Martin Havenhand
Chairman
22 May 2019

Louise Barnett
Chief Executive
22 May 2019

Post script
Regulation 5 statement

The draft Quality Account was sent to stakeholders within the timeframes stipulated by the guidance and regulations.

Since receipt of the responses which are provided on pages 87-90, the Trust has undertaken further work to enhance the content of the document regarding the layout of the sections in the document and updating information which was not available at the time.

Independent Auditors' Limited Assurance Report to the Council of Governors of Rotherham NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Rotherham NHS Foundation Trust to perform an independent assurance engagement in respect of Rotherham NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to our limited assurance conclusion are (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	***Specified indicators criteria*** (exact page number if possible, or title of section where criteria can be found)
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	See pages 106 & 107 of Quality Report
Percentage of patients with a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	See pages 108 & 109 of Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing the limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period;
- Feedback from the NHS Rotherham Clinical Commissioning Group dated 11/04/2019;

- Feedback from Governors dated 14/05/2019;
- Feedback from Rotherham Healthwatch dated 08/05/2019;
- Feedback from the Overview and Scrutiny Committee dated 17/04/2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/2019;
- The latest national patient survey dated 13/06/2018;
- The latest national staff survey dated 26/02/2019;
- Care Quality Commission inspection report, dated 31/01/2019; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/05/2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Rotherham NHS Foundation Trust as a body, to assist the Council of Governors in reporting Rotherham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Rotherham NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures;
- assessing the access controls in place surrounding the Meditech system; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

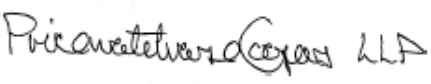
The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Rotherham NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.



PricewaterhouseCoopers LLP
Central Square
29 Wellington Street
Leeds
LS1 4DL

29th May 2019

The maintenance and integrity of the Rotherham NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendices

Appendix 1: Review of Local Clinical Audits

Review of Local Clinical Audits

The reports of 95 local clinical audits were reviewed by the provider in 2018-19 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
A&E	Paediatric Priority 2 audit	The priority of children within the department to be reviewed and discussed in huddles and Consultant meetings. The paediatric escalation policy will be reviewed and amended.	R955
A&E	Documentation 2017/18	Discuss the documentation in patient notes of when x-rays and blood results have been reviewed in staff huddles, display information on the department notice board and include in department information bulletin.	S1627
AMU	Investigations for cancer in unprovoked VTE as per NICE guidelines	Present the results in hospital weekly teaching sessions and display posters in the ambulatory care area.	S1689
Anaesthetics	Ventilator Tidal Volumes	Improve number of patients receiving lung protective ventilation by ensuring patient's weight and height are correctly documented and documenting target tidal volumes.	R1037
Anaesthetics	MRX Operational Check Audit (Rolling audit)	No actions required.	R984
Anaesthetics, General Surgery	Post appendicectomy analgesia in children	To ensure that all children will have an overall experience of no pain or mild pain, alter the dose of Ibuprofen on the Paediatric analgesia guideline. Ensure anaesthetists and recovery are aware of updates.	S1292
Community Adult Services	Quality of Radiographs taken in Doncaster Community Dental Service 2017	Feedback the results of the audit at the Doncaster Community Dental Service Staff Meeting and offer individual results to operators. Re-iterate to dentists that all radiographs taken must be graded for quality and that reasons for Grade 2 & 3 radiographs must be recorded. Re-iterate to all operators that Radiation Protection Supervisor (RPS) checks must be done quarterly i.e. 4 x per year or 3-monthly and to record collimator use and if not, the reasons why. Implement the buddy system for RPS checks as soon as practicable.	R951
Community Adult Services	Quality of Intra-oral Radiographs taken in 2017 in the Rotherham Community Dental service	To discuss at staff meeting and Clinical Governance Group that the standard of justifying and reporting of all radiographs should be done on the software of excellence custom screen and that all dentists/operators log all radiographs in the Ionising Radiation (Medical Exposure) Regulations practitioners' files as well as complete the x-ray custom screen for each radiograph taken.	R977
Community Adult Services	Compliance with NICE guidelines for referral for cochlear implant	Standardise the patient assessment to ensure all appropriate cases are identified and recorded.	S1720
		Develop a relevant information leaflet to provide to patients for whom cochlear implant is an option for use in clinic.	
Children and Young People (CYP) Service	SCBU discharge letters	To update the IT system "BADGER" with weekly summary.	R1050
CYP Service	Re-audit of CYP Multidisciplinary Documentation (April 2018)	To develop a poster to share audit results with the multidisciplinary team. To ensure documentation standards are included in trainees induction.	R1051

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service	Quality of paperwork provided at Looked After Children (LAC) clinic	Arrange a meeting with the appropriate people around the table to address escalation and implement 'No paperwork, No LAC appointment'.	R1069
CYP Service	Audit of recording of admin v clinical time in Speech & Language Therapy (SLT) children's SystmOne unit	All new starters to be given bespoke SystmOne training by a SLT SystmOne super user.	R942
CYP Service	Quality of assurance of initial health assessment for looked after children	Remind all registrars to record decision on how to allocate between consultants. Remind all registrars to record time frame for next appointment. Discuss with relevant registrar if recording of dental details on form not done. If child not registered with Dentist, remind registrars to include on action plan and inform foster carer/social worker.	R961
CYP Service	Asthma Management in Children's Outpatients 2017	Add information regarding the proforma stickers to training programme for Registrars. Place stickers on clinic desks to enable everyone to remember to use stickers. Email all doctors a summary of the audit findings and reminder to use checklist stickers.	S1602
CYP Service	Readmissions of term babies with jaundice to TRFT	Identify other causes that may affect the development of jaundice with the aim of identifying how to reverse such causes. Assess feeding within the first 24 hours for babies readmitted for the treatment of jaundice. Develop better information booklet for parents and implement 'Informed of signs of jaundice' sticker in Red Book, if any signs or risks of jaundice present on discharge.	S1667
CYP Service	Paediatric Acute Rapid Response Outreach Team referrals (PARROT)	Update referral guidelines to Include section on when would be appropriate to refer to PARROT.	S1804
CYP Service, Safeguarding	Audit of revised midwife to health visitor handover pathway	Standardise the use of the Midwife to 0-19 Service template for hand over from Midwife to 0-19 Practitioner in SystmOne (electronic health record) by re-affirming the SOP. Train staff in compliance with an open reciprocal share between the midwifery and the 0-19 Units on SystmOne. Improve communication with Midwifery teams that serve the borders of Rotherham Borough by requesting notification from Bassetlaw, Barnsley and Sheffield hospitals of new mothers booking.	R849
CYP Service, Safeguarding	Safe sleep assessment re-audit (2017)	Promote and review the Trust Safe Sleep Policy in both midwifery and 0-19 service to include undertaking repeat assessment when risk identified. Identify Link Health Visitor's within each locality to lead on safe sleep. Review the midwifery to 0-19 service handover template process for requesting repeat visit. Review reports on how many safe sleep assessments have been completed by 0-19 service to identify areas for further investigation. Develop safer sleep awareness campaigns in Rotherham by developing displays for Community clinics supporting the Yearly National Safer Sleep Week plan.	S1582

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service, Safeguarding	Documentation of names and relationships of adults attending with children to children's ward and out patients within child health	Review and amend Multi-Disciplinary Team (MDT) documentation proforma, enabling Medical and Nursing staff to be more aware of family structure. Share results at safeguarding training days in April and through team brief to ward staff. Discuss with medical and nursing staff the feasibility of use of Meditech (EPR) documentation template to record: • Family names, relationships, dates of birth, addresses. • Accompanying adults. • To be checked and updated every admission. • Printable so can form part of paper record for that admission. 0-19 service to review their documentation to include the names and relationships of accompanying adults, household contacts as part of their audit of SystmOne. Doctors to collect family names and relationships of household contacts carers and siblings at first new patient COPD attendance on OPD proforma (clerking sheet).	S1709
CYP Service, Safeguarding	Audit of child protection medical reports	Email all trainees and consultants to check that start and finish time of CP medical is always documented, as well as Persons present for history and during examination; to remember that Chaperone is essential for examination, and desirable during history taking, and to ensure that the full name and professional role of the chaperone is documented fully in CP medical reports; to ensure each report has a separate opinion section, and opinion should be clear, based on balance of probability as to likelihood of abuse and risk of significant harm; each report also to include differential diagnosis, reference and limitation if any; to remind everyone that A Police Protection Order (PPO) does not confer parental responsibility, and if it is known that a parent objects to the medical then legal advice should be sought before proceeding, as an Interim Care Order may be needed with a court direction to allow the medical examination. To write and implement guidelines for Child Protection Medicals.	S1708
Dermatology	An audit of initial assessment and discharge of patients undergoing phototherapy	Develop the current flowchart to have space for the doctor initiating phototherapy or the nurse leading the patient education session to list the full patient's medications. To redevelop the discharge letter to include a tick box confirming that a patient has been informed about accessing their GP for re-referral, a tick box that advises the GP to commence regular surveillance for changing skin lesions and dermatology referral if concerns arise and encourage staff to fill out the follow up section of a discharge letter template.	R1061
Dermatology	An audit of initial assessment and discharge of patients undergoing phototherapy	Develop the current flowchart to have space for the doctor initiating phototherapy or the nurse leading the patient education session to list the full patient's medications.	R1061
Dermatology	Excision Vs biopsy	A surgery list to be complied by a Consultant and Specialist Nurse of the procedures each medic and nurse are able to undertake.	R980
Dermatology	Audit of compliance with guideline: checking vitamin D levels in all newly diagnosed melanoma patients	The action regarding measuring vitamin D levels at diagnosis to be added to the skin cancer work programme and relevant clinicians emailed regarding the measurement of vitamin D. A proforma to be devised for the recording of vitamin D levels. A patient's GP to be contacted following identification of suboptimal vitamin D levels for treatment to be arranged.	S1598
Dermatology	British Association of Dermatologists national clinical audit on the management of bullous pemphigoid	Record blood pressure and blood tests in notes for all patients commencing on systemic treatments for bullous pemphigoid. Osteoporosis risk should be documented for all patients and all patients considered for bone protection when commencing on high dose steroids.	S1695

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Endoscopy	Colonoscopy Completion Rate (October 2016 - March 2017)	Increase lists for low volume endoscopists by identifying those permanent members of staff, or locums with low case numbers. Continue to monitor completion rates & provide upskilling training. Educate endoscopists to record discomfort rates, polyp detection and retrieval rates in appropriate part of Infoflex (database). Report polyp detection and retrieval rates by Endoscopist. Update Infoflex to add sedation score as a mandatory field and add rectal retroversion rate, colonoscopy withdrawal time & rectal retroversion, midazolam dose by age groups to ensure auditable outcomes are captured.	S1571
General Surgery	Audit of the adherence to the rib fracture pathway	Rib fracture pathway analgesia to be re-audited in more detail.	S1696
General Surgery	Audit of the adherence to the rib fracture pathway - analgesia	Improve rib fracture pathway with a multidisciplinary team approach between pain team, general surgery, physiotherapy & anaesthesia.	S1800
General Surgery	VTE Prophylaxis	VTE Risk assessment to be reviewed as part of the Post Take Ward Rounds on the Acute Surgery Unit.	S1807
Genitourinary (GU) Med	FSRH Emergency Contraception National UK Benchmarking audit 2018 (faculty of sexual and reproduction healthcare)	Provide teaching on Emergency contraception in weekly training sessions, including documentation of information on copper intrauterine devices (Cu IUDs), advice on Sexual Health, and advice on contraception. Suggest revision to the template on IT system 'Inform' to record when information and advice given.	R1036
GU Med	Audit of Contraception in women living with HIV	Review the 4 patients in whom drug interactions have been highlighted in MDT, to see if there are alternative antiretroviral (ARV) regimens. Establish on going team teaching sessions to educate team on guidelines to enable women to personalise their contraceptive choices better.	R940
Haematology	Documentation Audit 2018/19	Discuss the results at the Haematology governance meeting, highlighting the need for the ward location of the patient to recorded at each entry in the notes.	S1764
Laboratory Medicine (Lab Med)	Competency compliance of staff administering blood components and completion of pre-transfusion bedside checklist	Hospital Transfusion Team (HTT) to attend clinical areas that did not meet the 100% target for the presence of the checklist. Communication to be sent to all staff and relevant ward managers regarding the presence and completion of safe bedside checklist. HTT to review the integrated care pathway (ICP) document to make more user friendly and facilitate the mandatory checklists effectively for the staff using it.	R1035
Lab Med	Audit on the use of the Pre-Prescription Checklists for Chemotherapy	Prescribers and Checkers made aware of the need to ensure Pre-Prescription Checklist is signed by Biomedical Scientist (BMS) in Blood Bank when patient commences systemic anti-cancer therapy where components with special requirements required. Identify appropriate central location to be identified to retain copy of form to ensure access by all relevant staff an at all times.	R1059
Medicine	Adult Bronchoscopy	Leaflets regarding the bronchoscopy procedure to be made available on the medical wards, especially A1 and A7.	S1617
Medicine	Documentation 2017/18	Explore the possibility of a teaching session on the importance of documentation to Junior Doctors.	S1622
Medicine	Documentation 2017/18 (AMU)	Results to be discussed at the Acute Medical Unit (AMU) governance meeting, highlighting the areas where improvements are required.	S1628
Medicine	National Core Diabetes audit 2017	Improve HbA1c levels, by reducing the number of patients with levels between 58-86 by increasing follow up clinics for patients on insulin pumps.	S1658

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Medicine	Retrospective audit of Admissions to Stroke Unit via A&E	A re-audit to be undertaken which focusses on the improvements made in the previous audit.	S1675
Medicine	Audit of management of pulmonary embolism	A proforma to be developed for the assessment and management of pulmonary embolism, including pulmonary embolism severity index (PESI). Further discussions to be had amongst clinicians regarding the consideration of use of direct oral anticoagulant (DOAC) alone without need for Tinzaparin.	S1684
Medicine	Blood Glucose monitoring in diabetic inpatient	Create a blood monitoring (BM) chart which includes an action plan for completion when BM is >11 in type 1 diabetes mellitus patients. Consider the causes for the significant variation in BM levels during admission. Blood ketone machines to replace urine ketone machines to enable point of care testing for ketones on the wards.	S1688
Medicine	To improve first 24 hours acute care in Decompensated liver failure patients	To arrange an education session with junior doctors regarding the implementation of the cirrhosis care bundle. Undertake a quality improvement project with the aim of improving ascitic tap procedures performed within 24 hours of admission to AMU.	S1759
Medicine	Documentation Audit 2018 (Acute Medical Unit)	No actions required.	S1778
Neuro-rehabilitation	The National Service Framework Neurological Disability and Rehabilitation audit	A plan to be generated for therapeutic activities between formal therapy sessions. Continue with work already begun with equipment and real estate improvements. Review documentation of need for slow stream rehabilitation and nursing care following discharge. A similar audit to be undertaken with outpatient clinic and community patients subscribing to Rotherham Integrated Neurological Conditions Service (RINCS).	R1041
Obstetrics and Gynaecology (O&G)	Depth of Cervical loop biopsy and outcomes by individual colposcopists	Re-audit 2017-18 performance and monitor results by Quality Assurance process.	R1052
O&G	Compliance with legal completion of HSA1 form	Implement Surgical Termination of Pregnancy (STOP) and Evacuation of uterus preparation form checklist and Day Surgery Unit staff to check completion of forms before procedure. To raise awareness through training with Day Surgery team to ensure DSU return yellow forms and case notes to Pregnancy Advisory Service for submission.	R1054
O&G	Re-audit of Massive post-partum haemorrhage	To revise Datix review / audit proforma to include Drugs in Labour, whether Bimanual compression was applicable, whether all audit criteria documented at time of haemorrhage (consultant/ anaesthetist present).	R716
O&G	Ongoing audit of severe pre-eclampsia and eclampsia cases through the unit	Create poster and display outcomes of audit on notice board in Labour ward. Add definitions of hypertensions into mandatory training.	R833
O&G	Repeat antenatal membrane sweep audit	No action required.	R837
O&G	Case notes of babies unexpectedly below 10th centile (small for gestational age - SGA)	Approve business case for the Family Health ultrasound sonography for serial scans to delivery for women at risk of fetal growth restriction. Continue to review babies born below the 10th centile which were unexpected on a monthly basis. NHSI work stream -Multi-disciplinary task and finish group to explore the pathway of Small Gestational Age at Trust and an obstetrician to be part of the project.	R925

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G	Urinary retention post vaginal surgery	Write a comprehensive guideline to standardise bladder care post gynaecology surgery.	S1589
O&G	Enhanced Recovery after Caesarean Section	Create poster for Wharncliffe to congratulate staff on achievement. Discuss with Pharmacy Lead in respect to provision of prepared packs on Wharncliffe ward of common "to Take Out" (TTOs) to reduce waiting time for discharge.	S1591
O&G	Care of women in non-obstetric setting	Develop a simple educational programme to cover early and late pregnancies to provide regular educational programmes in ED on the pregnant woman attending. Revise Guideline for care of pregnant women attending ED or admitted non obstetric area and Signpost the guideline on the intranet. Modify Modified Early Obstetric Warning System (MEOWS) flowchart and add postnatal patients to guideline. Laminate flowchart and display in hospital. Develop and display a poster of care of pregnant women outside of obstetric unit.	S1597
O&G	Outcomes after TVT	Ensure patients are referred to Multidisciplinary Team prior to invasive procedures for Urinary incontinence. Ensure all Urogynaecology surgeons are registered for access to British Society of Urogynaecology (BSUG) database and enter patients into database for better follow up information. All patients to be assessed pelvic floor tone at initial appointment and refer to Women's' Health physio if required.	S1690
O&G	Obstetric Documentation Audit 2018	Reprint of labour ward booklet, to have spaces for stickers on every page.	S1777

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G	Re-audit of Induction of Labour	Check with network whether to include pre-labour rupture of membranes in the classification of induction of labour Introduce mechanical induction of labour to optimise patient flow and bed occupancy. Introduce patient leaflets. Continue using stickers to capture counselling for induction of labour in notes, and incorporate as mandatory in Meditech.	S1781
O&G	Review of surgical site infections in C Sections	Review local studies to seek evidence for increased dose of antibiotics for prolonged operation. Discuss at labour ward forum to review C section guideline re. increased duration of antibiotics. Make staff aware of protocol for reduced theatre traffic. Implement use of PICO ® Negative Pressure Wound Therapy dressing for BMI >45 agreed and add to guidance.	S1825
O&G, Safeguarding	Re-audit of Perinatal domestic Abuse Screening (Safeguarding)	Request template change on IT system SystmOne to reflect screening questions in booking and antenatal follow up templates. Request Meditech changes to reflect screening questions, to include free text to record reason if question not asked. To introduce seeing women on their own in Greenoaks at 12-week appointment for screening.	R1042
Oral and Maxillofacial Surgery (OMFS)	Re-audit of assessment and treatment of A&E patients: Are we keeping to the 4 hour rule?	Formal teaching session on what constitutes a good handovers as per Royal College of Surgeons (RCS) guidelines to be included as part of induction.	R1038
OMFS	Quality of histopathology request forms submitted by OMFS department	Ensure all clinicians are aware of the details required on a histopathology form.	R1063
OMFS	Assessment and treatment of A&E patients: are we keeping to the 4 hour rule?	Allocation of cupboard in A&E to permanently house OMFS equipment and use an itemised list of equipment to be re-stocked by on call Dental Core Trainee on Friday and Monday. Review and confirm that the clinical need to take precedence when prioritising on call task by educating how to triage effectively during on call. Investigate provision of on call IPad to allow Instantaneous review of Bassetlaw and DRI images.	R938
OMFS	Custom-made Medical Devices Prescription Compliance	Educate Orthodontic clinical staff of their responsibility to correctly complete Custom-made Medical Prescriptions.	R957
OMFS	Compliance with performing investigations for patients admitted with orofacial infection	Dental Core Trainees to be re-educated about importance of performing these investigations.	S1560
OMFS	Venous thromboembolism (VTE) risk assessment: quality of completion	To investigate what factors are contributing to a lack of compliance by monitoring completion of VTE assessment for every inpatient every day by checking VTE status at each ward round and document findings in clinical notes. Provide education on VTE and VTE assessment completion for Dental Core Trainees with a teaching session from a specialist nurse.	S1685
OMFS	Compliance with performing investigations for patients admitted with orofacial infections (re-audit)	Educate new Dental Core Trainees of which investigations need to be performed and why.	S1745

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
OMFS	Do all A&E patients receive a timely follow up in the OMFS departments at Rotherham & Mexborough Hospitals for hard tissue injuries - a re-audit	Improve appointment bookings at Mexborough Montagu Hospital by Dental Core Trainees confirming and recording Mexborough slots for the next week every Friday.	S1746
OMFS	VTE Risk Assessment: Quality of completion	New cohort of DCTs educated on VTE prophylaxis during induction.	S1782
Ophthalmology	Medical Retina local guidelines Implementation	No action required.	R1039
Ophthalmology	Astigmatic Keratotomy	No action required.	R1048
Ophthalmology	Retinopathy of Prematurity Audit	To consider introduction of local protocol for retinopathy of prematurity (ROP) and revise the referral form to clearly show date to ensure referral made one week before screening window overdue. To liaise with Special Care Baby Unit (SCBU) in investigation into cases of missed screening.	S1661
Ophthalmology	Cataract Pre-operative assessment audit	Liaise with opticians and nurse practitioners to obtain post-operative refraction data.	S1671
Ophthalmology	Intraocular pressure and gonioscopy changes after yttrium-aluminium-garnet laser (YAG) peripheral iridotomy	No action required.	S1694
Ophthalmology	Cataract surgery outcomes (TRFT 2018)	Nurse practitioners to auto refract 1st eye at appointment for 2nd eye surgery to measure differences.	S1698
Ophthalmology	Follow up against discharge guidelines	Review existing discharge guidance & ensure guidance available in each clinical room.	S1700
Ophthalmology	Emergency clinic re-audit	Morning clinics to be booked for same day referrals. Slots to be made available for patients with more than 2 follow ups. Guidelines for referral urgency of ophthalmic urgent care to be updated and distributed to doctors and nurses running casualty clinic, A&E and GPs to ensure appropriate referrals based on appropriate grading and follow up timescales.	S1701
Ophthalmology	Health risk from corneal Perforation due to peripheral ulcerative keratopathy in rheumatoid arthritis	Colleagues to be alert to condition and refer to Rheumatology as the condition could be considered as a predictor of impending serious medical problems.	S1703
Ophthalmology	Documentation Audit 2018/19	Remind & monitor colleagues on use stamps to ensure that correct details are documented per entry, and focus on legibility of documentation.	S1772
Ophthalmology	Out of hours patients follow up via HUB email	To ensure that confirmation of continuity of care is sent to the hub, clearly nominate the person responsible for checking the emails on daily basis and have cover in case of absence.	S1785
Orthopaedics	Duration of hospital stay after hip and knee arthroplasty surgery	None (re-audit).	R1072
Orthopaedics	Fluroscan Documentation	To develop local guidelines for radio graphic doses for wrist surgery.	R982

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Orthopaedics	Best practice for management of distal radius fractures	Implement virtual fracture clinic to give priority for distal radius fracture on [illegible] to ensure that surgical intervention planned for distal Radius fracture, this should be performed within 72 hours of injury for intra-articular fractures and within one week for extra-articular fractures.	S1794
Orthopaedics	Compliance with consent form 4	Increase awareness on consenting and capacity evaluation.	S1824
Pharmacy	Are PGDs compliant with NICE Medicines Practice Guidelines (MPG2) PGDs 2013 recommendations standards 1.5.2 and 1.5.7?	Leads for the Patient Group Directions (PGDs) to be sent a copy of the PGD policy and inform them of where this can be located on the intranet. To add a paragraph to the ratification letter to PGD leads as a reminder regarding obtaining staff signatures on the PGD and having a paper copy of the latest PGD accessible in clinical areas.	S1718
		A checklist to be produced and disseminated to all PGD leads on the process to follow after a PGD has been approved by the Rotherham Medicine Optimisation Group (RMOG).	
Radiology	Ultrasound DVT audit	To re-write the deep vein thrombosis (DVT) pathway with regards to imaging.	R1040
Radiology	Polytrauma CT audit	Meet with Emergency Department colleagues to discuss the results in relation to the concerning number of major trauma patients and delays in access times to CT. Present the results at TRFT meetings and arrange to present at the trauma network meeting.	R830
Safeguarding	Re-audit of compliance with the TRFT Health Records Policy	To recirculate the briefings across the Trust to remind all colleagues to record the name and contact details of the person/people accompanying the patient to a clinical consultation. Heads-of-service to be notified regarding the outcome of the audit so that they may decide what further action is necessary.	R962
Safeguarding	Quality of information and sections completed on the Multi Agency Risk Assessment Conference (MARAC) Research forms	To update MARAC guidance that is available to practitioners on IT system SystmOne. To email updated SOP guidance out to all 0-19 and midwifery practitioners who undertake completion of MARAC research. To complete training sessions with practitioners that undertake MARAC research forms.	R963
Safeguarding	Audit of Local Authority Designated Officer (LADO) meetings, looking at actions for safeguarding,	To inform the RMBC Local Authority Designated Officer (LADO) panel that TRFT do not need to be invited or attend LADO meetings, unless it directly involves a TRFT employee. Named Nurse to discuss with Deputy Chief nurse safeguarding Lead at next 1:1 session.	R964
Safeguarding	A comparative audit of Deprivation of Liberty Safeguards (DoLS) requests made by TRFT staff in Q2 of 2017 - 2018 and Q2 2018-2019	Promote a timely identification of patients requiring a DoLS, the team administrative support will continue to visit the wards 1 – 2 times a week to identify with the nurse in charge, in a timely manner and identify patients with extended admissions on a weekly basis. The team will continue to monitor the quality and number of DoLS for each ward area noting themes and trends by undertaking a re-audit.	R966
Therapy Services & Dietetics	Therapies and dietetics documentation audit (2017/18)	The results have been discussed and reviewed at team meetings and at the Therapy Services & Dietetics Clinical Effectiveness meeting. Areas where improvements are required in respect of documentation in paper notes and systm1 records, have been highlighted to staff and ongoing, regular reviews undertaken, where appropriate, within team meetings and supervision sessions.	S1588
Therapy Services & Dietetics	Is the process used for delivery of snacks and supplements as per dietetic recommendation effective?	Escalation and Involvement of senior nursing team and chief nurse to help support uptake of snacks being provided e.g. back to the floor days. Support catering team to update Catering Service Level Agreement (2015) and disseminate to all.	S1715

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Therapy Services & Dietetics	A review of the referrals received from Care homes for the elderly - to review if they are following the process advised by RNDS	Review the referral pathway and first line treatment plan and update the current care home pathway. Share results with the council to improve training.	S1716
Trust wide	Adherence to Trust Duty of Candour Policy	Governance leads in all areas to promote the Duty of Candour requirements and timescales and embed the use of the Duty of Candour Trust sticker in patient's records.	S1639
Urology	Intravesical Botox injection (re-audit)	To ensure that all staff involved in treatment of Over Active Bladder (OAB) patients follow the local protocol: Intra vesical Botulinum Toxin A injection is considered as third line treatment for Over Active Bladder patients; All female patients should be referred to Urogynaecological Multi-Disciplinary Team before offering Botox; All patients listed for Botox 100 or more; Units should be offered International Continence Society (ISC) training; the dosage of Botox recommended is as per NICE guidelines; Botox as a fifth line off label medication for Bladder Pain Syndrome should only considered after Multi-Disciplinary Team (MDT) discussion.	S1711

(Source: Audit Trust Database)


Measuring
K1
K2
AX
Setup
Mode
Temp
Data

Appendix 2: Readmissions within 28 days

Re admissions within 28 days of discharge from Hospital	1st April 2017 - 31st March 2018	1st April 2018 - 31st January 2019
Age 0- 15 years	8.33%	6.79%
Age 16 years and above	11.84%	10.85%

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.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table opposite details the external agency visits undertaken during 2018/19.

Detail of Visits	Date of Visit
PLACE inspection (hospital site)	2 May 2018
PLACE inspection (Breathing Space)	4 May 2018
Getting it right first time visit to Orthopaedics	13 June 2018
Public Health England Antenatal and Newborn Screening Programme Quality Assurance visit	19 June 2018
CQC unannounced Inspection of UECC, Children's Ward and A1	17 July 2018
CQC Unannounced Inspection	25 to 27 September 2018
External Audit of Pharmacy Technical Services Unit	27 September 2018
NHS Improvement Use of Resources assessment	28 September 2018
Police Counter Terrorism team review of Category Level 3 (CL3) containment facility in Laboratory Medicine	4 October 2018
Jonathan Slater, the Permanent Secretary for Education re: use of apprentices	8 October 2018
CQC unannounced inspection Children's and Young People's services in the community and wards A1 & A5	16 to 18 October 2018
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	22 to 23 October 2018
CQC Well-led assessment	22 to 24 October 2018
Health Select Scrutiny Commission visit to Health Village, the Care Co-ordination Centre and Single Point of Access	13 November 2018
Getting it right first time visit to Dermatology	11 December 2018
National Children's & Young People Diabetes Quality Programme Peer Review visit	9 January 2019
Getting it right first time visit to Endocrinology	17 January 2019
United Kingdom Accreditation Service (UKAS) ISO 15189 accreditation 1st surveillance visit	30 to 31 January 2019 and
5 February 2019	19 February 2018
Getting it right first time visit to Ophthalmology	28 February 2019
Police / Environment Agency visit (EA) to Medical Physics department	12 March 2018
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	12 – 13 March 2018
GIRFT ENT	20 March 2018
NHSE deep dive on Cancer as part of the Cancer Alliance	28 March 2018

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(Source: Trust Database)

Acronyms

A&E	Accident & Emergency Department
AMD	Associate Medical Director
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CGC	Clinical Governance Committee
CHID	Clinical Health Informatics Development Group
CHKS	Comparative Health Knowledge System
CLABSIs	Central Line Associated Blood Stream Infections
CoC	Continuity of Carer
CSE	Child Sexual Exploitation
C-difficile	Clostridium Difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
Datix	Computer software used by health services for risk management and reporting incidents
DIPC	Director of Infection Prevention and Control
DNACPR	Do not attempt cardio-pulmonary resuscitation
DoLS	Deprivation of Liberty Safeguards
DR (AGFA)	Digital Radiology
DSPT	Data Security and Protection Toolkit
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Estimated Date of Discharge
EMR	Electronic Medical Record
ENT	Ear Nose and Throat
EPR	Electronic Patient Record
FCP	First Contact Physiotherapy
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GAfREC	Governance Arrangements for Research Ethics Committees
GAP	Growth Assessment Protocol
GP	General Practitioner
GU	Genitourinary
HbA1c	HbA1c is your average blood glucose (sugar) levels for the last two to three months
HCSW	Health Care Support Worker
HDU	High Dependency Unit
HGD	High Grade Dysplasia
NHS DIGITAL	Health and Social Care Information Centre
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
IDT	Integrated Discharge Team
IG	Information Governance
IT	Information Technology
IV	Intravenous
Lab Med	Laboratory Medicine
LAC	Looked After Children
LOS	Length of Stay
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
MDTM	Multi-Disciplinary Team Meeting
MEWS	Modified Early Warning System
MQEM	Macmillan Cancer Support Quality Environment Mark
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MVP	Maternity Voices Partnership
NELA	National Emergency Laparotomy Audit
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OMFS	Oral and Maxillofacial Surgery
PAR	Patient at Risk chart
PCPs	Personalised Care Plans
PDSA	Plan, Do, Study, Act
PDT	Practice Development Team
PIR	Post Infection Review
PLAC	Previously Looked After Children
PLACE	Patient-led Assessment of the Care Environment
PROMS	Patient Reported Outcome Measures
QAC	Quality Assurance Committee
RCA	Root Cause Analysis
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RIS (AGFA)	Radiological Information System
RLSAB	Rotherham Local Safeguarding Adult Board
RLSCB	Rotherham Local Safeguarding Children Board
RMBC	Rotherham Metropolitan Borough Council
SAU	Surgical Assessment Unit
SCBU	Special Care Baby Unit
SGA	Small for Gestational Age
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident
SLT	Speech and Language Therapy
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
STOP	Surgical Termination of Pregnancy
TRFT	The Rotherham NHS Foundation Trust
TTOs	To Take Out
YTD	Year To Date
VTE	Venous Thromboembolism
WNB	'Was Not Brought'

Glossary of Terms

AGFA
Agfa Healthcare.

CHANGE organisation
Is a human rights organisation led by Disabled People, working to build an inclusive society where people with learning disabilities are treated equally.

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.

Comparative Health Knowledge System (CHKS)
A web based performance benchmarking system, utilised by many Trusts

Commissioning for Quality and Innovation (CQUIN)
A series of nationally and locally agreed improvement targets, linked to a proportion of Payment by Results funding as an incentive to achieve agreed outcomes.

Data Quality Index
A composite indicator reflecting data quality, provided by CHKS.

Datix
An Incident reporting system used by many NHS Trusts.

Exemplar Health Care
Exemplar is one of the UK's leading providers of specialist nursing care and neurorehabilitation for adults with complex needs.

FFFAP
Falls and Fragility Fracture Audit Programme, led by the Royal College of Physicians, gathering and analysing data on serious harms across the NHS.

HbA1c
HbA1c is your average blood glucose (sugar) levels for the last two to three months.

Healthcare Resource Groups (HRGs)
HRGs are standard groupings of clinically similar treatments which use common levels of healthcare resource.

HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

HRGs are currently used as a means of determining fair and equitable reimbursement for care services delivered by providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the service.

Presently, the Trust complies with HRG4 to code clinical activity.

Healthwatch
The independent consumer champion that gathers and represents the public's views on health and social care services in England.

Mencap
Mencap is a UK charity for people with a learning disability. Mencap also support their families and carers.

Monitor
Sector regulators for health services in England.

Mortality Rate
The rate at which patients die in a hospital. Data is collected nationally by HSCIC and enables Trusts to look at trends in Mortality Rates and make comparisons with other hospitals.

Mortality is generally measured in one of two ways: The HSMR measures the actual number of deaths occurring in a hospital compared to the number of deaths that might have been expected. The SHMI is a ratio of the actual number of patients who die against the number who would be expected to die on the basis of average England figures. The SHMI ratio includes those patients who die within 30 days of discharge from hospital.

Never Event
Defined by the DoH as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place.

NHS Digital
Provider of data for the NHS; formerly known as the Health and social care information centre (NHS DIGITAL).

NHS Improvement
NHSI was launched on 1 April 2016. It was formed from the two previous regulators, Monitor and the Trust Development Authority (TDA).

OPCS-4
The OPCS Classification of Interventions and Procedures (OPCS-4) is a Fundamental Information Standard which is revised periodically. The classification is used by Health Care Providers and national and regional Organisations.
OPCS-4 is used to support operational and strategic planning, resource utilisation, performance management, reimbursement, research and epidemiology. It is used by NHS suppliers to build/update software to support NHS business functions and interoperability.

Patient-led assessments of the care environment (PLACE)
PLACE is a new way of assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. They look at how the environment supports patient privacy and dignity, the meeting of dietary needs, cleanliness and general building maintenance.

Results from the annual assessments are reported publicly to help drive improvements in the care environment; they show how the Trust is performing by comparison with other Trusts across England.
For more information visit www.england.nhs.uk/ourwork/qual-clin¬lead/place.

Ribotyping
Ribotyping is a molecular technique that takes advantage of unique DNA sequences to differentiate strains of bacteria.

Risk Assessment Framework
This document sets out Monitor's approach to making sure NHS Foundation trusts are well run and can continue to provide good quality services for patients in the future.

Safeguarding
A process used to identify adults and children at risk and provide protection against further harm.

Safety Thermometer
The expanded national patient safety improvement initiative, promoting 'Harm Free Care' and linked to National CQUINs.

The Secondary Uses Service (SUS)
The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Voyage
Voyage Care supports thousands of people with learning and physical disabilities, brain injuries, autism and other needs across England, Scotland and Wales.
They offer person centred care and support in a range of settings and have experience of supporting people to move from one type of service to another as their needs change or they become more independent.

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