NHS
The Rotherham
NHS Foundation Trust
The Rotherham NHS Foundation Trust
Quality Account
2020/21
Ambitious
Caring
Together

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## Part One: Statement on Quality from the Interim Chief Executive

The Trust and the NHS have undoubtedly faced the most challenging year in their history. The COVID-19 pandemic impacted on every NHS service and required changes to the way that they were delivered. Our staff have continued to deliver healthcare throughout the year at a time when the Trust was one of the most severely COVID-19 affected hospitals in the country. Every day, colleagues went above and beyond to make a massive difference to patients, families, in community settings and the hospital, frontline and corporate areas. The speed at which the Trust was able to implement the required new ways of working, and our colleagues' ability to cope with a quickly changing environment was, and has remained, inspiring.

During the final few months of 2020/21, a number of our colleagues rapidly established our COVID-19 vaccination centre at our Old Greenoaks site. By the end of March 2021 10,667 colleagues had received a vaccination, administered not only to our own staff, but also to other health and care colleagues.

The achievement of national targets both across the wider NHS and at the Trust was severely impacted by the pandemic. At the height of the second wave of COVID-19, 35% of our inpatient bed base was occupied by inpatients suffering from COVID-19. In the twelve month period from April 2020 to March 2021, the Trust cared for 2,532 in patients with COVID-19.

Whilst the year was clearly dominated by the pandemic, the Trust achieved success in several key areas. The following paragraphs touch on both areas where the Trust encountered challenges during the year, but also areas where there were tangible improvements that should be celebrated.

We increased the number of critical care beds from 13 to 22 by creating a separate unit adjacent to the main unit; we developed a standalone non-COVID resuscitation unit within our Urgent & Emergency Care Centre and ward staff supported patients by creating COVID-19 specific wards.

The diagnostic waiting time target, which aims to support patients receiving their diagnostic test within six weeks, has traditionally been a standard the Trust has reliably achieved. However, along with a number of other standards we did not deliver against this performance measure during 2020/21 with all specialities reducing planned activity to support emergency COVID-19 services.

The cancer service team had spent a great deal of time over the previous year decreasing the Patient Tracking List (PTL) from in excess of 1,000 patients to 700 patients by the end of 2020. Unfortunately the first phase of the pandemic meant we had to modify our cancer services to support emergency patients. This resulted in the numbers on the waiting list going back up to the previous year's numbers of over 1000.

We have since recommenced the majority of our cancer services, although the need to socially distance, allow time between patients, and the reduction in face-to-face appointments has meant we have lost a lot of our normal capacity. In order to counter this teams have staggered appointments, undertaken a significant number of phone and video consultations, and reviewed all patients on the PTL to ensure anyone who needs treatment can get it as soon as possible.

The main cancer standard of 62 days to treatment from referral also deteriorated as predicted with only 60% of patients seen against a national target of 85%. Further work is taking place to improve this position as we recover from the pandemic.

Given that we have been a field test site for the proposed new A&E standards during 2020/21, we are unable to compare our urgent care performance against some of the well-known national indicators, such as the 4-hour access target. Nevertheless, we continued to track our performance through existing indicators and the new pilot measures.

Length of time spent in A&E by our patients is an issue that the Trust has been focused on; having seen a number of 12-hour trolley breaches during the previous year (2019/20). This year we have seen a marked reduction in patients waiting for long periods with no patients reported as waiting over 12 hours from a decision to admit (compared to 27 in 2019/20). The Trust has taken significant steps to address this position, a number of which were influenced by the pandemic and the requirements to stream COVID-19 and non-COVID-19 patients. We have also dramatically reduced our ambulance handover times.

Clearly there is a lot of work to be undertaken, and as we move out of this phase of the pandemic and plan for the next phases we will continue to strive to ensure that services are improved and patients and their families receive the care they need. The Trust has an improvement plan in place and will continue to further improve the quality and performance of Urgent and Emergency services and the care of our inpatients.

The Trust continues to strive to deliver the highest quality of compassionate, patient-centred and harm-free care as possible, and to continue its improvement journey. Whilst this has been challenging during the COVID-19 pandemic, the Trust has seen a number of positive improvements. The fundamentals of care will be a key objective for 2021/22.

The Trust will continue its proactive engagement in the national 'Get It Right First Time' (GIRFT) programme, for which the Trust has one of the best reputations for improvement and engagement in the whole of Yorkshire and the Humber.

The Trust's mortality scores (HSMR and SHMI) continue to be significantly higher than the national average and mortality will therefore continue to be a key improvement priority for the Trust and the Trust's Medical Director throughout 2021/22. The impact of COVID-19 on death rates has made it difficult to measure the effect of the work the Trust has done in this area but there has been recent evidence of a fall in underlying mortality rates.

We will continue to ensure that we fully understand and address the drivers of this performance, focussing on the '3C's' of quality of Care; Case mix; and Coding, and will continue monthly reporting to the Trust's Clinical Governance Committee, Safe & Sound Mortality Group, Quality Committee, and the Board of Directors.

The Trust has made progress on key patient flow initiatives throughout 2020/21, such as the 'SAFER flow bundle', but key work streams will continue to focus on flow throughout 2021/22, supported by a new, central Trust Control Room, which will be fully integrated into the Trust's IT systems. Such patient flow initiatives will also be supported by the introduction and embedding of new 'Safe & Sound Ward Round and Acute Assessment Standards' and 'Safe & Sound Discharge Standards'.

As stated previously, our workforce has responded fantastically to the management of the pandemic. During the year we launched our Trust's People Strategy, which has a core

theme of the importance of the health and wellbeing of our people. During 2020/21, we took part in the National Staff Survey exercise and achieved the highest response rate that the Trust has ever achieved. In addition, when published the results demonstrated that the Trust is the third most improved in the country. Whilst accepting that we are on a journey of improvement, the survey results were really positive and give the Trust a strong platform from which to move forwards.

We continued to develop and build upon our Trust 5-year strategy, although the normal centrally-led annual planning processes for 2020/21 were paused when the pandemic started. As a result, for 2020/21, we had a condensed operational plan which became our key focus. The plan included a number of COVID-19 specific objectives which were a key focus throughout the year.

As we move forward into the recovery phase of the pandemic, we will take with us lessons learnt from this unprecedented period in the history of healthcare, and continue to apply our knowledge to making our services better and more sustainable for the population of Rotherham and beyond.

Dr Richard Jenkins
Interim Chief Executive
June 2021

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

## 2.1 Priorities for improvement during 2020/21

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

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

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

For 2021/22, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process, including communication with colleagues, governors, patients and members of the public, who were given the opportunity to comment on the draft proposals and shape how these priorities were delivered, along with using the findings from the recent Care Quality Commission (CQC) inspection.

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

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

The quality priorities for 2021/22 are:

<u>Patient Safety</u>

- Reduce Hospital Standardised Mortality Ratios (HSMR) and improve Learning from Deaths
- Falls
- Pressure Ulcers Prevention

Clinical Effectiveness

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

Patient Experience

- Volunteers
- Responding and Learning from Friends and Family Test Survey
- Engagement with seldom heard groups with the aim of addressing any health inequalities

**Domain: Patient Safety**

*Title - Reduce HSMR and improve Learning from Deaths*

Executive Lead – Executive Medical Director
Operational Lead - Medical Examiner (to be replaced by new role of Associate Medical Director (AMD) – Mortality & Learning from Deaths once appointed).

Current position and why is it important?

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

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

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

- The Trust will improve its HSMR and Summary level SHMI to within the accepted normal range, aiming for a target of 110 or less.
- The Trust will improve its Learning from Deaths by:
    - ensuring that regular, multi-disciplinary timetabled Structured Judgement Review (SJRs) take place within each relevant Division (medicine; surgery; family health; community; and Urgent and Emergency Care Centre (UECC) within 2 months of death, with appropriate monitoring of compliance via the Trust's new mortality dashboard and Safe & Sound Mortality Group. The outcomes of all respective divisional SJR's will be timetabled for presentation at the relevant Divisional Safe & Sound Mortality Sub-Group meeting (medicine; surgery) and/or Divisional Governance meetings (family health; Urgent and Community

Care Centre (UECC); community), with agreement of any problems in care as outlined within the Standard Operation Procedure (SOP). Assurance will be provided to the Trust's Safe & Sound Mortality Group and Clinical Governance Committee via monthly submission of minutes.

  - ensuring and evidencing that the learning from the Trust's Stage 1 and Stage 2 mortality reviews is widely cascaded throughout the organisation, via a new fortnightly mortality bulletin, 'Mortality Matters' (alternating between a Medical Examiner (ME) bulletin and a case-example Learning from Deaths bulletin) - by Q1.
  - the creation (and appointment to) of a new AMD – Mortality & Learning from Deaths role, supported by the Clinical Effectiveness Department - by Q1.
  - ensuring that the Divisions of Surgery and Medicine have regular, separate mortality meetings ("Safe & Sound Mortality Sub-Groups"), the agendas for which mirror the Trust's overall Safe & Sound Mortality Group – by Q1.
  - full recruitment to the ME Service (2 MEs; Medical Examiner Office (MEOs) and administrative support) – by Q1.
  - the creation of a new Learning from Deaths Manager (subject to relevant Business Case approval) to work within the Clinical Effectiveness Department, supported by the new AMD – Mortality & Learning from Deaths – by Q2.

- The Trust will continue to focus on 3 key areas to improve quality of care, identified through recurrent mortality alerts:
  - Sepsis:
    - Early and improved recognition of Sepsis – we aim to achieve 100%. However, we set a realistic goal of over 90% in the short term. Our recent audit showed we are recognising them as infection (uncomplicated sepsis) but not using the word possible Severe Sepsis or red flag sepsis.
    - Timely application of Sepsis 6 tool and compliance with the Sepsis tool – Our recent audit showed we use the term sepsis in only 39% (22/56) of the cases but treated 100% (56/56) cases with antibiotics, of which 86% received antibiotics within an hour from the doctors' review.
    - We continue to improve both of the above figures by promoting and disseminating knowledge on the Sepsis among our workforce by a Sepsis mandatory training package.
  - Community-acquired Pneumonia (CAP):
    - Ensure that the Trust's newly reintroduced CAP care bundle, including calculation of the national CAP CURB65 risk-stratification tool, is imbedded within the organisation, supported by regular communication and education - achieve utilisation in 25% of all cases by end of Q1; 50% by end of Q2; 75% by end Q3; and 95% of all cases by end of Q4.
  - Improve End of Life Recognition and proactive implementation of appropriate ceilings of care:
    - Introduce palliative care training/End of Life training to all relevant medical staff with compliance of 25% by end of Q3; 50% by end of Q4.
  - Introduce ReSPECT documentation to organisation by end of Q2.

The planned activity to achieve this

The Trust will improve its assurance around the Learning from Deaths by monitoring the dissemination of learning from Structured Judgement Reviews (SJRs), inquests and Serious Incidents resulting in death within Clinical Service Units (CSUs) and Divisions, with reporting of relevant governance meeting and Safe & Sound Mortality Sub-Groups minutes to the Clinical Governance Committee.

The Trust will ensure that these monthly Divisional Safe & Sound Mortality Sub-Groups and/or governance meetings are consistently quorate, and that the Trust's Safe & Sound Mortality Group is represented by all relevant Divisions.

How will progress be monitored and reported?

Progress will be monitored and reported monthly by the Trust's Safe & Sound Mortality Group, Clinical Effectiveness Group, Clinical Governance Committee and Quality Committee, including via monitoring of the Trust's mortality dashboard.

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

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

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

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

Aim:

To reduce the number of falls with identified lapses in care resulting in harm.

Objectives:

A trust-wide falls audit was completed in October 2020 the results of which will be shared at the monthly falls meeting. This audit has been adapted for use on Perfect Ward and will be performed at regular intervals determined by the performance of each area. This will utilise the Plan, Do, Study, Act (PDSA) model.

The planned activity to achieve this

Re-engage with the trust falls champions and provide them with clear purpose and objectives of the role.
Re-establish the falls group.
The Falls dashboard will be collated and shared within each clinical speciality showing degrees of harm.

Ensure sufficient falls equipment is available where and when required. Establish and roll out trust wide training for staff in relation to falls, such as lying & standing blood pressure, and the falls policy.

How will progress be monitored and reported?

The Perfect Ward falls audit will monitor progress in clinical practice.
There will be a Falls Dashboard which will allow for data intelligence gathering, trending and areas of concern to be identified and addressed.
This will be reported through the falls group to Clinical Governance Committee.

*Title - Reduction in avoidable Pressure Ulcers*

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

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

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

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

**December 2019- December 2020 Community**

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

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

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

**Hospital**

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

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

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

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

To reduce the number of pressure ulcers due to lapses in care in acute and community settings by 50% of current rates. Long term aim is to have a tolerance rate of <10%.

The planned activity to achieve this

Learning from the Root Cause Analysis (RCA)
A pressure ulcer process
React to red hospital train the trainer program
Review of heel pressure relief
Re launch stop the pressure Bite sized training
Tissue Viability newsletter focusing on pressure ulcer prevention and learning from investigations
Tissue viability tool kit for ward managers
Perfect Ward audit tool

Community
Relaunch of stop the pressure program
Ongoing react to red for care homes (led by care homes team)
React to red for domiciliary carers
Tissue viability link group focusing on Bite sized training
Learning events

How will progress be monitored and reported?

Monthly reporting from RCA panels.

Weekly monitoring of Datix themes and trends. Monthly reporting on Quality scorecard. Target achievements to be monitored and reviewed through corporate governance and performance meetings. Perfect ward audit.

**Domain: Clinical Effectiveness**

*Title - Triangulation of Learning*

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

There are many opportunities, from a variety of sources, to make improvements to the quality of care. It is important to ensure that any learning generated as a consequence of an investigation, is acted upon to drive improvements and that this learning is shared with all relevant parties to ensure that the benefits are realised in all forums.

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

The aim is to ensure that action plans are used to drive improvements to quality and identified actions are embedded throughout the organisation. This will be enabled via the Organisational Learning Action Forum (OLAF). The objectives to achieve this are:

1) Create a standardised Trust wide action plan template and shared repository to ensure learning can be easily shared between services.
2) Implement a process for monitoring open actions centrally to ensure actions are completed within timescales.

3) Use the monthly OLAF meeting to share learning and quality improvements across Clinical Divisions and Safety, Experience and Effectiveness teams.
4) Identify themes and trends for learning that span Clinical Divisions or reporting processes and implement solutions to ensure learning is widely implemented.
5) Develop reporting tools to demonstrate that triangulation is occurring and to monitor the effectiveness of interventions.
6) To supplement this with information collated through the 'Perfect Ward'.

The planned activity to achieve this

The Organisational Learning Action Forum will meet monthly to discuss learning from incidents and meet the objectives described above. Each division will present an example of a quality improvement linked to learning from incidents monthly to support dissemination of learning. The shared space for action plan monitoring will promote the triangulation of learning across Clinical Divisions and Safety, Experience and Effectiveness teams.

A programme of quality audits will be introduced in all clinical areas with a focus on real time actions and monitoring for quality improvement.

How will progress be monitored and reported?

All activity will be reported through the monthly OLAF meeting. Minutes will be submitted to Clinical Governance Committee and a quarterly summary paper will be presented at Clinical Governance Committee and Quality Committee.

Outcomes from Perfect Ward audits will be monitored and themes for learning will be shared through relevant divisional and Trust wide governance meetings.

*Title - NICE and Policy Compliance*

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

Current position and why is it important?

NICE

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

Policies

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

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

| Financial Year | Percentage of Policies in Date |
|---|---|
| 2017/18 | 51.10% |
| 2018/19 | 54% |
| 2019/20 | 70% |
| 2020/21 | 79% |

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

NICE

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

The planned activity to achieve this

NICE

1. Engagement with Clinical Leads and Clinical Effectiveness Leads regarding awareness of their responsibility and accountability.
2. Review process for Risk Assessment and logging non-compliance.
3. Review the escalation process.

Policies

1. Review the policy management process including:

    - Policy for the Development, Monitoring and Review of Trust Documents
    - Role of the Document Ratification Group and Approving Groups
    - Escalation process

Both

1. Create new Clinical Effectiveness Group (with Research & Development (R&D) separated) with revised Terms of Reference, with greater focus on NICE compliance & newly incorporated responsibility for policy compliance.
2. New Clinical Effectiveness Group to be chaired initially by Executive Medical Director, in order to improve traction and attendance, with responsibility moving to Deputy Medical Director – Professional Standards once in post.

How will progress be monitored and reported?

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

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

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

Current position and why is it important?

The CQC well led framework W8 key line of enquiry asks "Are there robust systems and processes for learning, continuous improvement and innovation?" and within this:

- "Does the vision and strategy incorporate plans for supporting clinical research activity as a key contributor to best patient care?"
- "Are divisional staff aware of research undertaken…… how it contributes to improvement and the service level needed across departments to support it? "

There is good evidence published that hospitals that engage in clinical research have better outcomes for their patients. Further evidence has shown that even patients who are not involved in the trials themselves benefit from being in a research active hospital.

At present, the Trust strategy does not include reference to the research activity at TRFT and the level of engagement with research is limited to a small number of clinicians and staff undertaking academic qualifications. The aim of the Quality Priority is to raise awareness across the Trust to ensure that we are compliant with CQC requirements. 2021/22 is an ideal opportunity to undertake this due to the profile and successes achieved with COVID-19 research in the organisation.

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

The aim is to raise the level of awareness of the staff, patients and public that The Rotherham Foundation Trust (TRFT) actively participates in research – including awareness of "who, where & what" the R&D Department do and publicising the ongoing research studies.

Surveys with patients/public and staff will be undertaken in the first quarter to provide a baseline of awareness of TRFT as a research active Trust. This will be repeated in quarter 4 by which we expect to see an increase (by 20%) in the level of awareness and understanding of research at TRFT.

The planned activity to achieve this

A number of activities are planned to achieve this. Crucial to achievement is:

1. Appointment of R&D Manager (subject to relevant Business Case approval).
2. Inclusion of Research in the Trust strategy

Additional activities may include:
- Appoint Research Nurse as "Trust Research Champion" to proactively promote research at TRFT
- R&D website as part of the '*Best Patient Care, Clinical Research and You*" National Institute for Health Research (NIHR) pilot project
- Seek volunteers to appoint to Patient Research Ambassador
- Appoint CSU Research Champions
- Increase use of Social Media i.e. Twitter, Facebook
- Regular updates on Trust Bulletins
- Actively participate in International Clinical Trials Day
- Explore Trust support for provision of research PAs/advertising opportunities to participate in research in clinical recruitment
- Explore additional meetings to report R&D activity e.g. Clinical Effectiveness rolling program, governance, Clinical Governance Committee, and Quality Committee

How will progress be monitored and reported?

Ongoing activity will be monitored and reported to the Trust's new Research and Development Group and the Clinical Governance Committee.

**Domain: Patient Experience**

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

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

Current position and why is it important?

Many of the Trust's volunteers have been with the organisation for over 5 years, with several giving in excess of 15 years' service. The volunteers work from four to twelve hours each per week, often accepting two or three placements across Trust sites; including at Breathing Space and the Park Rehabilitation Centre.

New volunteering opportunities are regularly being developed within our services. These support patients and staff in a variety of settings across the Trust, performing a range of supporting roles including within Pharmacy, the Patient's Library, ward level support, in Chaplaincy and with gardening.

To increase our team of volunteers and also to develop new volunteering opportunities, this area was made a 'Quality Priority' for 2020/21. However due to the COVID-19 pandemic, this aim and the stated objectives had to be put on hold. It is however anticipated that

progress can be made in the second half of the current financial year and this Quality Priority remains a focus for 2021/22.

The aim and objectives for Volunteering including the measures and metrics

To increase the recruitment of new and diverse volunteers, to be placed across a wider range of services within our hospital and community services.

To maintain, support and build the confidence of existing volunteers to return to the hospital, post the removal of civil restrictions imposed during the COVID-19 pandemic.

To have the necessary infrastructure to enable and support all volunteers, to realise their full potential in their role and to value and enjoy the placements that they accept within this Trust.

As a Trust, we want to become an inspiration for NHS volunteering and for our patients and the staff to know that wherever there are volunteers placed, then we are providing an enhanced service with the benefit of their input.

We want to creatively develop new volunteering opportunities within our services, to support patents and staff in a variety of settings across the Trust and performing a range of roles. The vision for volunteers at this hospital and within the community is to have:

- An inclusive, comprehensive and flexible approach to volunteering that encourages, enables and supports individuals, groups and other organisations to contribute to volunteer activity within the Trust.

- A fully integrated team of volunteers who contribute to the services we provide, who are drawn from the diverse population that we serve, who feel valued, recognised and find their volunteer experience to be personally rewarding.

- To further develop and champion a voluntary service that offers a broad range of benefits to patients, wider service users, their families, friends, the staff and of course to volunteers themselves.

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

The planned activity to achieve this

Identify targeted audiences to promote volunteering, to ensure that our volunteers reflect the diverse local population and a representative patient demographic.

Increase the number and diversity of our volunteers through targeted recruitment and being proactive in engaging across all sectors and ages in the local communities and within any marginalised groups.

Champion an organisational culture that welcomes and celebrates volunteers as an integral part of the Trust’s teams.

Discover and apply innovative forms of volunteering to increase the flexibility and accessibility of our volunteering placements to both improve recruitment and volunteer retention.

Deliver a high quality volunteer experience that maximises the reciprocal benefits for patients, the Trust and the volunteers.

Prepare, develop and empower volunteers to achieve their roles safely and effectively.

Recognise and celebrate the value and impact of volunteering through dedicated support and placement evaluations.

Maintain clear policies and procedures to enable safe, legal and accessible hospital volunteering, ensuring training on Safeguarding arrangements for children and vulnerable adults in particular and compliance with the relevant Trust policies and procedures e.g. information governance, patient confidentiality, personal conduct and the uniform policy etc.

Following commencing the deferred pilot programme for dining companions, increase coverage for ward mealtime support within the Trust.

Develop the 'Dementia Friend' volunteer provision, to support the implementation of the Trust's Dementia Strategy.

Develop, test and evaluate new ways of involving volunteers to support patients and their families within the UECC.

Introduce Befrienders: They will be based within Outpatient departments, sitting and chatting with patients and relatives, supporting patients who may live alone or have no immediate family to accompany them to their appointment.

How will progress be monitored and reported?

A monthly report of volunteering activity features within the Quarterly Patient Experience Report. The following quality indicators will be progressed during 2021/22 once the volunteers return to the Trust sites. Progress will be tracked via use of the Volunteer's Experience Survey, to understand the involvement of our volunteers and we will aim for:

- 90% volunteers feeling that they are valued by this Trust.
- 90% volunteers are feeling prepared and confident to fulfil their roles.
- 90% achieving their own goals and personal satisfaction through volunteering.
- 90% would recommend volunteering with TRFT to their peers.
- Case studies and volunteer stories will be collated to demonstrate their significant contribution to the patient's experience, to staff support and the impact to the volunteers themselves through volunteering.
- Increases to volunteer numbers, roles and hours will be tracked.
- Demographic information on who is being attracted to join the Trust's Volunteer program will be gathered. e.g. including indicators of age, experience, gender, disability, faith and ethnicity.
- How frequently and for what duration per week people volunteer.

*<u>Title</u> - Responding and Learning from The Friends and Family Test Patient Experience Survey*

<u>Executive Lead</u> – Chief Nurse
<u>Operational Lead</u> – Head of Patient Experience

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

This was a quality priority for 2020/21, however due to the COVID-19 pandemic, NHS England issued a 7 months' stop upon the requirement to report this feedback.

It is essential that following the re-launch of the FFT survey in December 2020, that the Trust embeds the new questions and learns from the feedback received, in order to value the responses received and to improve patient experience.

<u>The aim and objectives including the measures and metrics</u>

To embed the new nationally set FFT questions and altered parameters for gathering feedback, to ensure that there is improved evidence of learning from patients' feedback, adopting a 'You said & We did' reporting approach.

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

This will be driven and measured by:

- The implementation of the new FFT survey in all areas since December 2020.
- Examples of learning from patient experience and actions taken as a result of the feedback, will be discussed and recorded as part of Divisional and CSU Governance Meetings. This will include sharing information and the service improvements termed "What's working better".
- Sharing learning through the monthly meeting of The FFT Steering Group, The Patient Experience Group (PEG) and the Organisational Learning Action Forum (OLAF).
- Standardised Quality Boards were erected in all general wards in March 2021. The boards are in public view and in keeping with the standard operating procedure (SOP) for their use, they will be updated on a monthly basis to display current FFT narrative feedback and the ward team's response to this, under the heading of 'You said & We did'.

Ward and Department Managers are responsible for designating a responsible person to encourage the uptake of FFT across all patients and to maintain good levels of participation each month. Each ward maintains their Quality Board each month and ensures that the

data displayed is current and complete. Support and guidance is available from the Divisional senior nurses and the Interim Assistant Chief Nurse for Patient Experience. Quality Boards for specialist services and Outpatient Clinics are being finalised and will be erected in quarters 2 and 3 of this year.

The planned activity to achieve this

Staff will work within their professional and clinical networks, to share examples of good practice across the Trust which can be replicated by others.

Divisions will have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any action plans required are developed and closely monitored to meet the expectations of listening to their patients' feedback.

Divisions will provide visible evidence in public places to show that FFT feedback is valued and to demonstrate what actions have taken place as a result of this opinion.

Displaying the feedback publically alongside the actions taken, aids clear communication and is vital to tell patients how we are responding to their feedback. In this way, patients can see the value of giving feedback and that it is important to the team, such as "You said & We did" as a key statement on notice boards and when sharing changes.

How will progress be monitored and reported?

Following the introduction of the new electronic survey option, to be used alongside an FFT card, patient and service users will have a choice of the preferred method to give feedback. Arising from this development, a new report and dashboard has been created, which will be used to provide performance data to the Divisions and the FFT Steering Group and the Patient Experience Group.

The activity and learning will also feature within the Quarterly Patient Experience Report for The Clinical Governance and Quality Committees.

*Title - Engagement with seldom heard groups with the aim of addressing any health inequalities*

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

The Current position and why is it important?

The international COVID-19 pandemic, has locally magnified and multiplied the health inequalities within Rotherham and its wider communities.

It has been very concerning that the more socio-economically deprived areas of the town, have seen both increased infection and mortality rates. Alongside this the effects upon benefit dependent and low waged households, the gig economy, furloughed employees and redundancies has also seen deprivation and food poverty increase, with greater numbers of local people relying upon food banks and charities for everyday essential and wider support.

Mortality rates during the first wave of the pandemic from March to July 2020, were higher in the North than the rest of England. An extra 12.4 more people per 100,000 died in that area, than in the rest of England due to COVID-19. An extra 57.7 more people per 100,000 died, than in the rest of England due to all causes (NHSA 2020).

Economic outcomes, particularly unemployment rates, were hardest hit in the North; Pre-COVID unemployment rates were higher in the North and rose fastest too in the first few months of the pandemic (NHSA 2020).

Pre-pandemic child health, a key predictor of life-long health and economic productivity, was locally poor and deteriorating. Since then, the pandemic's adverse trends in poverty, education, unemployment and poor mental health for children and young people have been exacerbated (NHSA 2020).

This will have a negative impact on the health of our own population and the public health issues presenting to TRFT services in the future.

Previous world pandemics have shown that the peak of health inequalities occurs five years post the pandemic (Bambra et al 2020), which is why it is so important to take action and engage with our local communities now.

The aim and objectives including the measures and the metrics

Aim: Reduce local health inequalities through the delivery of the following or make a contribution to these.

Objectives:

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

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

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

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

The planned activity to achieve this

- Share data across Rotherham Place to support a broader, more in depth understanding of local health inequalities.

- Working with wider NHS Trusts, Commissioners, the Local Authority, Public Health Professionals and third sector organisations, to create a collaborative strategy to strive for health equality locally.

- Work with Health Informatics to ascertain the local effects of existing health outcome evidence and health inequality hypotheses, for example:

  'More mothers from black, minority ethnic origins suffer miscarriage or stillbirth'.

  'More socio-economically deprived children come through the Paediatric Dental Service because of their diet'.

If this evidence is replicated locally, or the hypotheses are supported when TRFT data is analysed, that insight as well as intelligence from local community groups, and gathering direct experiences from 'seldom heard' groups can be used to determine local health needs. Work can be done to help counter these disproportionately negative outcomes, generally and within specific specialties e.g. Maternity Services working with BAME groups, to encourage early booking, swift reporting of reduced fetal movements, or instigating care that is more frequent for the women.

- The Paediatric Dental Extraction Service, offering health and dental hygiene advice.

Engagement and Inclusion Lead meeting with seldom-heard groups and escalating any identified actions.

- Positively recruit to create a more diverse Public Panel and promote its use.

- Re-open the channel of communication with the Foundation Trust's Membership body.

- Gather views on Trust services from the staff networks and explore staff connections with different local communities to try to contact people not in touch with local community groups.

- Ensure policies and procedures meet local needs and are implemented equally and fairly. Endeavoring not to disadvantage the local population, via Equality Impact Assessment scrutiny at the Document Ratification Group.

- Work with the Smoking Cessation and Drug and Alcohol teams to help identify people who may need additional health advice or holistic support.

How will progress be monitored and reported?

An action plan will be formulated following intelligence from the Place Health Inequalities Group, which will be monitored by the Quality Priorities Group. Specific reports will be drawn to the attention of relevant departments and their staff members.

Progress will be reported quarterly in the Patient Experience Quarterly Report.

**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

During 2020/21 The Trust provided and/or subcontracted 64 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 64 of these relevant health services. The income generated by the relevant health services reviewed in 2020/21 represented 85% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2020/21.

### Clinical Audit

During 2020/21, 48 national clinical audits and 5 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation Trust provides. Due to the pandemic, 5 national clinical audits did not take place or were put on hold. During that period, therefore, The Rotherham NHS Foundation Trust participated in 39 (90%) of national clinical audits and 5 (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 2020/21, 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 |
|---|---|---|---|
| British Association of Urological Surgeons (BAUS) Urology Audits: Renal Colic Audit | Yes | 100% | NA |
| Case Mix Programme (CMP) | Yes | 100%* | NA |
| Elective Surgery (National PROMs Programme) | Yes | 56.6% * | NA |
| Emergency Medicine QIPs: Infection Control (care in emergency departments) | Yes | 100% | NA |
| Emergency Medicine QIPs: Pain in Children (care in emergency departments) | Yes | 100% | NA |
| Emergency Medicine QIPs: Fractured Neck of Femur (care in emergency departments) | Yes | 100% | NA |
| Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database | Yes | 100%* | NA |

| | | | |
|---|---|---|---|
| Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls | Yes | 100% * | NA |
| Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database / Vertebral Fracture Sprint Audit | Yes | 100% | NA |
| Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database | Yes | 100% * | NA |
| Mandatory Surveillance of HCAI | Yes | 100% | NA |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care | Yes | 100% | NA |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care | Yes | 28% * | NA |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care | Yes | 90%* | NA |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary rehabilitation-organisational and clinical audit | Yes | 100%* | NA |
| National Audit of Breast Cancer in Older People (NABCOP) | Yes | 100% | NA |
| National Audit of Cardiac Rehabilitation | Yes | 100%* | NA |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) | Yes | 100% | NA |

| | | | |
|---|---|---|---|
| National Cardiac Arrest Audit (NCAA) | Yes | 100% * | NA |
| National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM) | Yes | 100%* | NA |
| National Cardiac Audit Programme (NCAP): National Heart Failure Audit | Yes | 100%* | NA |
| National Diabetes Audit - Adults: National Diabetes Foot Care Audit | Yes | 0%* | NA |
| National Diabetes Audit - Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England | Yes | 100%* | NA |
| National Diabetes Audit - Adults: National Core Diabetes Audit | Yes | 100%* | NA |
| National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit | Yes | 100% * | NA |
| National Early Inflammatory Arthritis Audit (NEIAA) | Yes | 100% * | NA |
| National Emergency Laparotomy Audit (NELA) | Yes | 100% * | NA |
| National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer (NOGCA) | Yes | 100% | NA |
| National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit (NBOCA) | Yes | 100% | NA |
| National Joint Registry (NJR) | Yes | 100%* | NA |
| National Lung Cancer Audit (NLCA) | Yes | 100% * | NA |
| National Maternity and Perinatal Audit (NMPA) | Yes | 100% * | NA |
| National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) | Yes | 100% | NA |
| National Paediatric Diabetes Audit (NPDA) | Yes | 100% | NA |

| National Prostate Cancer Audit | Yes | 100% * | NA |
|---|---|---|---|
| Sentinel Stroke National Audit programme (SSNAP) | Yes | 100% * | NA |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes | 100% * | NA |
| Surgical Site Infection Surveillance Service | Yes | 100% * | NA |
| Trauma Audit & Research Network (TARN) | Yes | 23% * | NA |

| National Confidential Enquiry | Work stream | Participation yes/no? | % Cases (of those required) | Reason for non-participation |
|---|---|---|---|---|
| Maternal, New-born and Infant Clinical Outcome Review Programme | Perinatal Mortality Surveillance (reports annually) | Yes | 100% * | NA |
| Maternal, New-born and Infant Clinical Outcome Review Programme | Perinatal morbidity and mortality confidential enquiries (reports alternate years) | Yes | 100% * | NA |
| Maternal, New-born and Infant Clinical Outcome Review Programme | Maternal Mortality surveillance and mortality confidential enquiries (reports annually) | Yes | 100% * | NA |
| Maternal, New-born and Infant Clinical Outcome Review Programme | Maternal morbidity confidential enquiries (reports annually) | Yes | 100% * | NA |
| Medical and Surgical Clinical Outcome Review Programme | Physical Health in Mental Health Hospitals | Yes | No cases identified for inclusion | NA |

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

*Data for projects marked with * require further validation. Where data has been provided these are best estimates at the time of compilation. Data for all continuous projects and confidential enquiries continues to be reviewed and validated during April, May or June 2021 and therefore final figures may change.*

The reports of 16 national audits were reviewed by the provider in 2020/21 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (where appropriate). There are a further 8 national audit reports published which are under review.

| Title | Published | Report Reviewed | Action(s) to improve quality of care |
|---|---|---|---|
| Case Mix Programme (CMP) | Yes | Yes | No actions required |
| Myocardial Ischaemia National audit Project (MINAP) (2018/19) | Yes | Yes | Rates of angiography were excellent and no action required for that. However, the timeframe for angiography for non-ST segment elevation myocardial infarction (NSTEMI) patients within 72hrs was suboptimal at 57% (similar to national average) compared to target of 100%. Quality improvements have already been put in place for this. Re-audit of this metric is required and will be undertaken when COVID pandemic is over and cardiology consultant of the week rota is established. |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care | Yes | Yes | Recommendations and appropriate actions are still under review |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary rehabilitation-organisational and clinical audit | Yes | Yes | Recommendations and appropriate actions are still under review |
| National Audit of Breast Cancer in Older People (NABCOP) | Yes | Yes | Recommendations and appropriate actions are still under review |
| National Cardiac Arrest Audit (NCAA) | Yes | Yes | Discuss and agree with colleagues in Acute Medical Unit (AMU), which is the most appropriate place to keep Do Not Attempt |

| | | | Cardiopulmonary Resuscitation (DNACPR) form |
|---|---|---|---|
| National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM) | Yes | Yes | Further training is required with staff to ensure data fields are completed correctly. Need to ensure that re-intervention data is submitted within 1 year for both pacemakers and complex devices. |
| National Diabetes Audit - Adults: National Diabetes Inpatient Audit (NaDIA) -reporting data on services in England and Wales | Yes | Yes | Recommendations and appropriate actions are still under review |
| National Emergency Laparotomy Audit (NELA) | Yes | Yes | Phase out paper notes by implementing Meditech notes and creating a Meditech MELP form. Discuss further improvements to include electronic theatre booking and a NELA prompt on World Health Organisation (WHO) checklist |
| National Heart failure audit (2018/19) | Yes | Yes | Rotherham hospital guidelines for management of heart failure (HF) are needed. Capacity needed within community and hospital teams to ensure HF discharges are followed up, and in a timely fashion. These should be considered as Amber or high Amber referrals. |
| National Joint Registry (NJR) | Yes | Yes | No actions required. |
| Royal College of Emergency Medicine Care of Children | Yes | Yes | Psychometric social assessment tool for the risk assessment of adolescents to be introduced. |
| Royal College of Emergency Medicine Mental Health | Yes | Yes | Mental health tool for use on arrival to the department to be identified and put into Meditech. |
| Royal College of Emergency Medicine Assessing Cognitive Impairment in Older People | Yes | Yes | To implement the 4AT delirium assessment tool in the department. |

| | | | |
|---|---|---|---|
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes | Yes | Serious Hazards of Transfusion (SHOT) report forwarded to the Head of Patient Safety to emphasize that Healthcare organisations should incorporate the principles of both Safety-I and Safety-II approaches to improve patient care and safety. Hospital Transfusion Team members undertake human factors video/presentation training from Serious Hazards of Transfusion (SHOT) |
| Surgical Site Infection Surveillance Service | Yes | Yes | No actions required. |

**Review of Local Clinical Audits**

The reports of 87 clinical audits were reviewed by the provider in 2020-2021 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (See Appendix 1).

Participation in Clinical Research - The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2020/21 that were recruited to participate in research approved by a research ethics committee was 2326. A significant number of recruits (1983) are the result of participation in the Clinical Characterisation of Severe Emerging Infections, a COVID-19 observational study [data taken from the NIHR Open Data Platform 25 May 2021].

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

The table below shows the total number of studies that have been supported by the Trust (i.e. actively recruiting or in follow up) during 2020/21:

| **Study Type** | **Number of studies** |
|---|---|
| NIHR Portfolio Commercially sponsored | 2 |
| NIHR Portfolio Non-commercial | 26 |
| NIHR Portfolio Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC) | 1 |
| Non-portfolio The Rotherham NHSFT Sponsored | 6 |
| Other Non-portfolio (supporting academic qualifications) | 5 |
| Studies undertaken at TRFT which required no Capacity & Capability review | 1 |

(Source: TRFT Research Database)

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

**CQUINs (Commissioning for Quality and Innovation)**

Due to COVID-19 the 2020/21 CQUIN schemes were postponed and as per the guidance on finance and contracting arrangements for H1 2021/22, the block payments approach for arrangements between NHS commissioners and NHS providers in England will now remain in place for the first half of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage.

**Care Quality Commission Registration and Periodic Reviews/Specialist Reviews**

The Rotherham NHS Foundation Trust is required to register with the 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 CQC 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 taken enforcement action against the Rotherham NHS Foundation Trust during 2020/21.

During 2020/21 the Trust received two inspections/reviews by the CQC. In July 2020, concerns were raised about the safeguarding children pathway and in November in relation to quality of health in the Acute Medical Unit and learning throughout the organisation. As a result, a Section 31 of the Health and Social Care Act 2008 and a Section 29A of the Health and Social Care Act warning notices were issued respectively. Immediate actions were undertaken in response to both inspections and an ongoing action plan was developed for each issue. Assurance continues to be provided to the CQC in relation to addressing the concerns identified on a regular basis.

The Trust was fully inspected by the CQC 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. Following this the Urgent and Emergency Care Service was inspected in August 2019. The above inspections during 20/21 have not changed the ratings.

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 below show the detailed ratings by key question and by core service.

CQC ratings for Trust Hospital services

| | **Safe** | **Effective** | **Caring** | **Responsive** | **Well led** |
|---|---|---|---|---|---|
| **Urgent & Emergency Services** | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement |
| **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:

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

(Source: Care Quality Commission)

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

**How the Trust makes use of the CQC 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 26 February 2018. The plan aimed for all actions to be in place by 31 October 2018, with the audits to confirm this completed by 31 March 2020.

Following the August 2019 inspection of the Urgent and Emergency Care Service, an additional action plan was developed and approved by the Board of Directors on 4 February 2020.

Following the July 2020 safeguarding inspection, an additional action plan was developed and submitted to the Board of Directors on 4 August 2020.

Following the November 2020 review in relation to quality of health in the Acute Medical Unit and learning throughout the organisation an additional action plan was developed and submitted to the Board of Directors on 5 March 2021.

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.

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:

*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, CQC Delivery Group and Quality Committee.

The Trust is also required to report any breaches of the **Ionising Radiation Regulations** to the CQC. Below is a summary of the radiation incidents that were reported to the CQC from 1 April 2020 to 21 January 2021.

| | **Reportable to** | | | | |
|---|---|---|---|---|---|
| **Date** | **MHRA** | **CQC** | **HSE** | **Dose (mSv)** | **Description** |
| 3/4/20 | | Yes | | 25.7 | A patient was referred for a CT Head examination. However, due to barriers put in place caused by the difficult situation of COVID-19, the patient was wrongly scanned for chest, abdomen & pelvis. The patient was confused and responded to the wrong name, when the date of birth was checked it was shouted through the glass screen to the operator to whom it sounded correct through mask and screen. The process has already been changed so that the checklist is positioned in front of the glass screen so that the radiographer in room can read and check directly and give the thumbs up to the operator. This is all due to infection control measures and change in workflow. The Radiation Protection Advisor's report was obtained and reported to Ionising Radiation (Medical Exposure) Regulations (IRMER) CQC. Notification that the CQC had closed this incident was received on the 21 April 2020. |

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

We have had no further radiation incidents that are reportable to external agencies from 1 April 2020 to 21 January 2021; this is due to the changes in the reporting criteria issued by IRMER CQC. Risk based criteria is now applied and only the radiation incidents with an effective patient dose of more than 3mSv for adults and 1mSv for paediatrics are reportable to them.

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

This incident has been investigated and has 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 CQC during the reporting period.

**Data Quality**

The Rotherham NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

99.9% (99.9% for 2019/20) for admitted patient care
100.0% (100.00% for 2019/20) for outpatient care, and
99.8% (99.6% for 2019/20) 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 2019/20) for admitted patient care
100% (100% for 2019/20) for outpatient care, and
100% (100% for 2019/20) for accident and emergency care.

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

**Information Governance Toolkit attainment levels**

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

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

Organisations are expected to achieve the ‘standards met’ assessment on the DSPT by 31 March each year but due to COVID-19, the new DSPT was not issued until 1 October 2020. Organisations now have until 30 June 2021 to submit this year.

The Trust will submit again by June 30 2021 and is aiming for full compliance.

The Trust’s Information Governance Assessment Report overall score for 2019/20 was Standards Fully Met.

**Payment by Results**

The Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission. (Note: NHSI Comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHSI. From 2016/17 this programme has applied a new methodology and there is no longer a standalone ‘coding audit’, with error rates as envisaged by this time in the regulations. It is therefore likely that providers will be stating that they were not subject to “Payments by Results clinical coding audit”.

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

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

The Trust was subject to the mandatory Clinical Coding Information Governance (IG) audit in November 2020, during the 20/21 reporting period as required by NHS Digital. The Trust again achieved an IG rating of level three (Advisory), for the fourth year running, which is the highest possible rating that can be achieved. An aggregate percentage score of 98.225% was achieved across the four domains audited.

An additional specialty audit was performed in this financial year which was utilised to establish if our respiratory conditions coding was robust enough to support the organisation’s needs, the outcome of this audit was very positive. An additional reason for the audit was due to the Trust’s Acute EPR (Meditech) being in a program of transition to fully digital records – the auditor was asked to review the documentation for suitability and highlight any significant causes for concern – although some issues were identified within the digital records these were not significant and most suggestions have been implemented with work streams in place to implement the others.

**Data Quality Index (HRG4+ based)**

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

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

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

**Clinical Coding**

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

| Area audited | % Diagnoses Coded Correctly | | % Procedures Coded Correctly | |
|---|---|---|---|---|
| | Primary | Secondary | Primary | Secondary |
| Overall | 97.5% | 98.3% | 97.5% | 99.6% |

(Source: The Rotherham NHS FT Information Governance Audit Report 2020/2021)

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

In 2019/20 the Trust worked with the following actions to improve clinical coding and data quality and these continued throughout 2020/21:

- 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 continues to be rated in the top quartile nationally for depth of coding, although this is not a clear indicator of clinical coding quality it does better demonstrate the complexity of the patients care for the respective episodes, and by also attaining the IG level 3 / Advisory the auditors are of the opinion that we are also rated in the top quartile nationally

from that perspective too. Combined these indicators demonstrate a continued improvement in the quality of the clinical coding.

Improvements and actions to further improve clinical coding during 2020/21 included:

- Reviewing the department structure against its peers and the Trust making the decision to invest significantly to bring us in line with our peer group. The Board of Directors acknowledged a need for a Senior Management Qualified Clinical Coding role and funding has been approved to appoint to this post, at the point of publication the Trust is out to recruitment.

| | Areas selected for focussed improvement activity | Baseline period FY | Baseline Value | Target | Qtr 1 2020-21 | Qtr 2 2020-21 | Qtr 3 2020-21 | Qtr 4 2020-21 | YTD 2020-21 | Progress |
|---|---|---|---|---|---|---|---|---|---|---|
| IMPROVING DATA QUALITY | IDQ-1 DQMI ECDS* | 2020-21 ** | 74.2 | Increase | 72.6 | 77.1 | 77.7 | | 77.7 | |
| | IDQ-2 DQMI APC* | 2020-21 ** | 95.8 | Increase | 98.5 | 99.0 | 98.9 | | 98.9 | |
| | IDQ-3 DQMI CSDS* | 2020-21 ** | 75.8 | Increase | 80.7 | 87.8 | 87.8 | | 87.8 | |
| | IDQ-4 DQMI MSDS* | 2020-21 ** | 95.9 | Increase | 98.9 | 99.0 | 99.9 | | 99.9 | |
| | IDQ-5 DQMI OP* | 2020-21 ** | 91.1 | Increase | 99.9 | 99.9 | 99.9 | | 99.9 | |
| | IDQ-6 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard) | 2015 - 16 | 99.80% | Increase | 99.90% | 99.90% | 99.90% | | 99.90% | |
| | IDQ-7 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard) | 2015 - 16 | 100.00% | Maintain | 100.00% | 100.00% | 100.00% | | 100.00% | |
| | IDQ-8 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard) | 2015 - 16 | 99.90% | Increase | 100.00% | 100.00% | 100.00% | | 100.00% | |
| | IDQ-9 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard) | 2015 - 16 | 99.90% | Maintain | 100.00% | 100.00% | 100.00% | | 100.00% | |
| | IDQ-10 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard) | 2015 - 16 | 86.60% | Increase | 99.70% | 99.70% | 99.80% | | 99.80% | |
| | IDQ-11 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard) | 2015 - 16 | 99.10% | Increase | 100.00% | 100.00% | 100.00% | | 100.00% | |

* DQMI Data from external sources only available up to Oct 2020 in a complete state & IDQ6 to IDQ11 available to December 2020

** Baseline set utilising 2020-21 DQMI national average

(Source: NHS Digital)

The baseline was established in 2015-16 for IDQ6 to IDQ11 and the Trust uses that baseline to compare against.

**Learning from Deaths**

During 2020/2021, 1319 of TRFT patients died (exclusive of deaths occurring in the Trust's Urgent & Emergency Care Centre). This comprised of the following number of deaths which occurred in each quarter of that reporting period.

- 376 in Q1
- 194 in Q2
- 390 in Q3
- 359 in Q4

By 31 March 2021, 946 case record mortality ('Stage 1') reviews have been carried out in relation to the 1319 deaths included in the above (71.7%), which in turn triggered a 'Stage 2 SJR in 101 deaths (7.7%).

The number of deaths in each quarter for which a case record mortality ('Stage 1') review was carried out was:

- 263 in Q1
- 179 in Q2
- 206 in Q3
- 298 in Q4

Since 1 April 2020, the Trust has had a new Medical Examiner (ME) service, which provides independent scrutiny of all Trust deaths and determines whether the record should be scrutinised in more depth by a multidisciplinary team from the individual divisions, via a SJR.

Over the space of the last year, the Trust has fully implemented the ME service. Since the service's introduction, it has been a specific aim of the Trust to complete 100% of 'Stage 1' case record mortality reviews by the ME service within one month of death, with many deaths being scrutinised within 1 week of the death, despite the COVID-19 pandemic. The Trust has also been conducting in-depth case record mortality reviews SJRs on patients within the separate divisions, with the aim to complete these within two months of death.

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

In order to strengthen the Trust's learning from deaths, the Trust set up a new Safe & Sound Mortality Group and are in the process of introducing a new Associate Medical Director – Mortality and Learning from Deaths. Furthermore, the Interim Chief Executive Officer has set up a time-limited, focussed Mortality Improvement Group, with external support and scrutiny, in order to drive forward improvements in mortality and learning from deaths, in particular focussed on making improvements around quality of care, coding, and the care and support of patients at the end of their lives.

The Executive Medical Director has continued to Chair both the Trust's Safe & Sound Deteriorating Patient and Sepsis Group, focussed on improving the recognition and management of acutely ill patients, and the Trust's Patient Safety Group. Part of the quality improvement initiatives that has arisen from the learning from deaths, include the roll-out of electronic community-acquired pneumonia and revised acute kidney injury care bundles.

To reduce the incidents in medication errors, the Trust has now fully implemented electronic prescribing throughout the hospital, and is now starting to introduce this into several community areas. This has resulted in a reduction in medication omissions.

The Trust has also approved plans for the implementation of an Acute Response Team (ART), which will incorporate the Hospital@Night team and the Critical Care Outreach Team. The unified team will provide a single and consistent pathway for the escalation and management of deteriorating patients, enabling quicker and more effective management. This will improve the standard of care and reduce unplanned admissions to critical care. Whilst implementation has been slowed through the COVID-19 pandemic, work has continued and work is now progressing again.

## 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 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 the Trust is "higher than expected". **The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of 'as expected'. For the SHMI, a comparison should not be made with the highest and lowest Trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between Trusts and, in particular, it is inappropriate to rank Trusts according to their SHMI.*

Please note: the data is now reported monthly 6 months previous. - *data source now a Power BI report on NHSD and raw data table file.

| Indicator name | Latest & previous reporting periods | TRFT value Oct 19 – Sept 20 | TRFT previous value Sept 19 - Aug 20 | Acute Trust average Oct 19 - Sept 20 | Acute Trust previous average Sept 19 - Aug 20 | Acute Trust highest value Oct 19 – Sept 20 | Acute Trust previous highest value Sept 19 - Aug 20 | Acute Trust lowest value Oct 19 - Sept 20 | Acute Trust previous lowest value Sept 19 – Aug 20 |
|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Summary Hospital Mortality Indicator – Value | Oct 19 - Sept 20 Sept 19 - Aug 20 | 117 | 117 | * | * | 118 | 119 | 68 | 69 |
| Summary Hospital Mortality Indicator – Banding | Oct 19 - Sept 20 Sept 19 - Aug 20 | 1 | 1 | * | * | 1 | 1 | 3 | 3 |
| SHMI: Percentage of patient deaths with palliative care coding at diagnosis level | Oct 19 - Sept 20 Sept 19 - Aug 20 | 28 | 30 | 36 | 36 | 60 | 61 | 8 | 9 |

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 2018 - 31st March 2019** | 119 | 0.226 | 0.757 | 0.532 | 110 (92.4%) | 3 (2.5%) | 6 (5.0%) |
| | **1st April 2019 - 31st March 2020** | 50 | 0.210 | 0.802 | 0.592 | 44 (88.0%) | 3 (6.0%) | 3 (6.0%) |
| | **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 2018 - 31st March 2019** | 135 | 0.405 | 0.761 | 0.356 | 115 (85.2%) | 12 (8.9%) | 8 (5.9%) |
| | **1st April 2019 - 31st March 2020** | 38 | 0.377 | 0.667 | 0.290 | 29 (76.3%) | 5 (13.2%) | 4 (10.5%) |
| | **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 19 - March 20 and subject to change until the publication of finalised data.***

| Domain4: Ensuring that people have a positive experience of care. | Indicator name | Latest & previous reporting periods | TRFT value | Acute Trust average | Acute Trust highest value | Acute Trust lowest value |
|---|---|---|---|---|---|---|
| | *CQUIN: Responsiveness to patients personal needs | 2017/18 | 68.6 | 68.6 | 85 | 60.5 |
| | | 2018/19 | 64.9 | 67.2 | 85 | 58.9 |
| | Staff who would recommend the Trust to their family or friends (Acute Trusts for comparison | July 18 - Sept 18 | 68% | 81% | 100% | 39% |
| | | July 19 - Sept 19 | 76% | 81% | 100% | 50% |

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

| Domain5: Treating and Caring for people in a safe place. | Indicator name | Latest & previous reporting periods | TRFT value | Acute Trust average | Acute Trust highest value | Acute Trust lowest value |
|---|---|---|---|---|---|---|
| | *Percentage of patients admitted to hospital and risk assessed for Venous thromboembolism (VTE) | July 19 - Sept 19 | 81.95% | 95.47% | 100% | 71.72% |
| | | Oct 19 – Dec 19 | 81.04% | 95.04% | 100% | 71.59% |
| | *Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over | Apr 18 -Mar 19 | 16.4 | 22.1 | 168 | 0 |
| | | Apr 19 - Mar 20 | 38.9 | 37.4 | 142.8 | 0 |
| | *Patient safety incidents: rate per 100 admissions (medium acute for comparison) | Oct 18 - March 19 | 46.7 | Awaiting data - national not yet available | | |
| | | Apr 19 - Sept 19 | 56.5 | Awaiting data - national not yet available | | |
| | Patient safety incidents: % resulting in severe harm or death (medium acute for comparison) | Oct 18 - March 19 | 0.18% | 0.15% | 0.5% | 0.0% |
| | | Apr 19 - Sept 19 | 0.17% | 0.14% | 0.6% | 0.0% |

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

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

| Core Indicator | The Trust considers that this data is as described for the following reasons | 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.<br><br>The Trust has experienced an increase in SHMI for the reporting period. This was due to the increase in HSMR and the number of observed deaths exceeding the number of expected deaths. | The Trust has a monthly Safe & Sound Mortality Group meeting and all Divisions within the Trust now hold regular mortality meetings, which feed into this overall Trust Group. This Group in turn reports to the Clinical Governance Committee, chaired by the Executive Medical Director.<br><br>The Trust also has a time-limited Mortality Improvement Group, chaired by the Interim Chief Executive Officer, supported by a Mortality Analytics Group, with a view to driving improvements in the Trust's mortality data.<br><br>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.<br><br>Mortality data and actions being taken are reported monthly in the Mortality and Learning from Deaths Report to the Board. |
| 12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. | The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only patients receiving care from the team are included in the data. | To improve the percentage score, the Trust's Consultant-led Specialist Palliative care Team continue to identify and assess all patients receiving palliative care. The Trust has also approved additional investment to increase the number of |

| Core Indicator | The Trust 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: |
|---|---|---|
| | | medical and nursing specialists in palliative care. |
| 18. Patient Reported Outcome Measures scores for<br><br>(i) groin hernia surgery;<br><br>(ii) varicose vein surgery;<br><br>(iii) primary hip replacement surgery<br><br>(iv) primary knee replacement surgery during the reporting period. | The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital.<br><br>The latest reporting periods vary between the types of surgery performed.<br><br>Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement. | PROMS are measures recorded pre and postoperatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision.<br><br>(i) No longer collected.<br><br>(ii) No longer collected.<br><br>(iii) 95.2% patients stated they noticed an improvement post surgery.<br><br>(iv) 64.7% patients stated they noticed an improvement post surgery. |
| 19. Percentage of patients aged—<br><br>(i) 0 to 15; and<br><br>(ii) 16 or over, | Internal TRFT data is used for reporting of re admissions for the performance reports for the Board of Directors, the Divisions, the CSUs and for the Service Line Monitoring (SLMs) reports. The | The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data.<br>The Transfer of Care Team works to reduce readmission rates through better planning of discharge. |

| Core Indicator | The Trust 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: |
|---|---|---|
| Readmitted to any hospital within 28 days of discharge from the Trust | methodology has been matched to the Model Hospital methodology to ensure consistency in benchmarking with other organisations. | The Care Home Team identifies factors leading to admission and readmission of Care Home Patients and works with the sector to improve effectiveness.<br>With observations and assessments now being recorded as non-elective admissions, there will be a natural increase in the number of reported readmissions each month. These are reviewed by divisional teams so the true readmissions can be investigated and appropriate actions taken. |
| 20. The Trust's responsiveness to the personal needs of its patients during the reporting period. | The Trust's 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 2018 and January 2019. Full results are available later in this report. | The CQC published the 2019 patient survey results in July 2020. Following publication, the Trust reviewed its position and the areas to be addressed. An agreed action plan was disseminated, through the bed holding Divisions for all adult wards and the Patient Experience Groups. The Divisions of Medicine and Surgery then formulated their own local actions and have worked through this with their own clinical teams. |
| 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. | For staff survey data and staff Friends and Family data. |

| Core Indicator | The Trust 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: |
|---|---|---|
| 21.1 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:<br>- Inpatients<br>- Day Cases<br>- Accident and Emergency<br>- Outpatients<br>- Maternity<br>- Community | NHS England and NHSI advised all acute providers that they should resume collecting and submitting monthly Friends and Family Test (FFT) data from 1 December 2020. The first month for collection will be December's data, submitted in early January 2021. | NHS England and NHSI, advised all acute providers that they should resume collecting and submitting monthly Friends and Family Test (FFT) data from 1 December 2020. The first month for collection will be December's data, submitted in early January 2021. |
| 23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period. | Data is validated and published by NHS DIGITAL | The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the Clinical Governance Committee. |
| 24. The rate per 100,000 bed days of cases of C.Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.= 18/ 93807 * 100,000= 19.19 (last year for same period 15.91) | Data is validated and published by NHS DIGITAL | The Trust will continue to monitor rates through RCA and audits and report through local clinical governance structures to the Clinical Governance Committee; for further actions to reduce rate of C-difficile see Part 3. |

| Core Indicator | The Trust considers that this data is as described for the following reasons | TRFT intends to take or has taken the following actions to improve this score and so the quality of its services by: |
|---|---|---|
| 25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. | Data validated and published by NHS Digital (National Reporting and Learning System (NRLS)); latest data is for the period January to December 2020<br><br>This was the latest reporting period where TRFT has submitted its data and it has been validated by the NRLS Team.<br><br>Number of NRLS reportable incidents occurring in this period was 7,170. The percentage of severe harm or death was 0.39%. | 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 2020/21**

The number of new Inquests opened during this time frame averages around one new matter per week; Inquests heard over this period average between 4-5 per month. This is a reduction compared to the position in the previous financial year and is as a result of COVID-19 as many inquests have had to be vacated and postponed, particularly between April and September 2020.

For those inquests heard, around 20% (10 cases) have been particularly complex. The most common issues and risks identified in these cases were around the handover and communication of clinical information, the recognition and response to deterioration and the need to undertake more timely and considered risk assessments in relation to patients at risk of falling.

Trust wide learning on these points continues to be a priority and the Coroner has been sufficiently assured both by the Trust's progress in relation to improvements in these areas, as well as by the organisation's candid and transparent approach where shortcomings were identified. The Trust's engagement and commitment to improving care for our patients has been well received by the Coroner and mitigated any need for the issue of any Prevention of Future Deaths' Reports.

## Part Three: Other Information

### 3.1 Overview of quality of care based on performance in 2020/21

A summary of the Trust's quality priorities for 2020/21 is provided below with an indication as to whether the priority was achieved or not by the year end.

Patient Safety

- Learning from Incidents
- Embed Human Factors & Introduce Schwartz Rounds Within the Organisation
- Roll-Out Medical Examiner Office

Clinical Effectiveness

- Utilisation of Trust Wide Audit to Facilitate Improvement in three Key Areas:
    - Sepsis Management
    - Medicines Management (incorporating compliance with Anti-Coagulation and Insulin Script modules)
    - Completion of Learning from Incidents Action Plans
- Reduce HSMR and improve Learning from Deaths
- Ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability & Autism, with the implementation of 'The Learning Disability Improvement Standards' from NHSI.

Patient Experience

- Friends and Family Test (FFT) - embedding of new questions and process and FFT - improved evidence of learning from feedback, you said we did
- Diversity and Inclusion
- Maximising the potential of Volunteering - recognise, recruit, embed and celebrate

| Reference | Aim | Metric | RAG Rating |
|---|---|---|---|
| Learning from incidents | To ensure that the organisation responds, learns and improves from the outcomes of adverse incidents including Complaints, Inquests, Serious Incidents and SJR | Provide one day training for a range of medical/nursing and therapy staff in undertaking SJR. | |
| | | To ensure all investigations are undertaken by appropriate individuals who have received required training to complete the investigation/ review. | |
| | | To ensure all investigations/reviews are completed within agreed time scales and make clear recommendations for improvement. | |
| | | To maintain a register of action plans and audit programme to demonstrate completion of actions and ongoing compliance. | |
| | | To ensure a corporate monitoring process is followed to provide assurance of completion of action plans. | |

| | | | |
|---|---|---|---|
| | | To utilise a range of methods to disseminate learning and knowledge beyond the immediate team and to the wider Trust, including reviewing emerging themes and trends on a quarterly basis to ensure that any identified areas of concern can be acted upon. | |
| | | Hold regular learning the lessons events across the division, sharing the learning, the good practice and areas for improvement. | |
| Embed Human Factors & Introduce Schwartz Rounds Within The Organisation | Introduce a human factors approach to incident investigation and action planning.<br><br>Wider adoption of in situ simulation for team training in non-technical skills such as teamwork, leadership and communication. Simultaneous use of in situ simulation as a governance and quality improvement methodology to detect latent errors (hidden safety hazards) and lead improvements in work environment.<br><br>Re-introduction of Schwartz Rounds to the Trust. | Human factors training (1-day workshops) for staff involved in incident investigation and all Divisional Directors, Heads of Nursing and Managers, and relevant Safe & Sound Quality Directorate staff.<br><br>This has been adversely affected by the COVID-19 pandemic, but roll-out will continue throughout the next Financial Year. | |
| | | In situ simulation programme to be increased in size. To be rolled out into new areas of the Trust beyond the current programmes in UECC and Obstetrics. Reporting from each session to Divisional Governance structure and use of Datix (incidents from simulation) where required.<br><br>This has been adversely affected by the COVID-19 pandemic. | |
| | | Re-introduction of Schwartz Rounds to the Trust.<br><br>This has been adversely affected by the COVID-19 pandemic, but roll-out will continue throughout the next Financial Year, initially virtually. | |
| Roll-Out Medical Examiner Office | The aim is to ensure all deaths have scrutiny and that family members and carers have the opportunity to comment on the quality of care their loved ones received so that learning, both positive and negative, can be disseminated across the organisation.<br><br>At least 98% of all deaths within the Trust will have either a first-stage review within 1 month of the death or both a first and second-stage review SJR within 2 months of the death within each division.<br><br>A dashboard of the timely reviews and the outcomes of these reviews will be discussed monthly at Corporate level with performance monitored through the Trust Mortality and Morbidity Meetings.<br><br>Any death scoring 1 or 2 in any phase of care (significant quality of care issues) will be escalated within 1 month to the Trust mortality meeting and will be reviewed by the Serious Untoward Incident (SUI) panel.<br><br>All deaths involving learning disability patients and all deaths resulting in either a Coroner's investigation and/or inquest will undergo a stage-two mortality review (SJR) and report into the divisional Mortality and Morbidity meeting and Trust wider Mortality meeting and Trust Board. | The Trust has now fully recruited to the ME service, with 2 MEs, and Band 6 Medical Examiner Officer, Band 5 Medical Examiner Officer and a Bereavement Officer. | |
| | | The other arm of the Medical Examiner service was to have learning from deaths nurse in post to coordinate the outcomes of the reviews and ensure learning from these deaths.<br><br>Although the Trust introduced a new, fixed-term learning from deaths nurse as part of the Medical Examiner service, this role is now being changed to a new Mortality & Learning from Deaths Manager, to sit under the Trust's Clinical Effectiveness team. | |
| | | Each division will implement robust, multi-disciplinary SJR reviews, which will be timetabled within the Division.<br><br>Whilst these have been introduced, further work needs to continue to ensure that these are multi-disciplinary, completed within 2 months of a patient's death, and that any learning identified is appropriately shared and disseminated. | |
| Utilisation of Trust Wide Audit to Facilitate Improvement in 3 Key Areas:<br>- Sepsis Management<br>- Medicines Management (incorporating compliance with Anti-Coagulation | The aim will be to undertake an audit and use the results to identify areas where other quality improvement techniques can be used to improve the service/patient outcomes. Measures and metrics will be confirmed once the area of focus has been agreed. | Sepsis Management<br><br>Compliance with Sepsis 6 tool and specifically the administration of antibiotics within 1 hour of diagnosis.<br><br>Q1/Q2 – Continue training and educating the workforce about the detection of Sepsis and its management using the U.K. Sepsis Trust training package and the Sepsis 6 tool in the Meditech. Our goal remains more than 90% for detecting and administering antibiotics in an hour in the short term.<br><br>Q3/Q4 – | |

| and Insulin Script modules)<br>- Completion of Learning from Incidents Action Plans | | We will repeat the audit after the implementation of recommendations from the recent audit. An action plan has been devised and a meeting to discuss the implementation of this will take place soon. Sepsis lead has been promoting and educating junior doctors about Sepsis 6 with interactive discussion twice a year at the PGME centre and the next meeting is due in October. | |
|---|---|---|---|
| | | Medicines Management – compliance with anti-coagulation and Insulin Script modules mandatory training for identified medical staff and relevant non-medical prescribers<br>• Q1 – identification of those in scope which are then added to ESR and communicated to those staff<br>• Q2 - 50% compliance with those two mandatory training modules by end of the quarter<br>• Q3 - 70% compliance with those two mandatory training modules by end of the quarter<br>• Q4 – 85% compliance with those two mandatory training modules by end of the quarter | |
| | | Completion of Learning from Incidents Action Plans<br>• Q1 - set up meeting for the monitoring of learning from complaints, claims and incidents and process for monitoring action plan compliance.<br>• Q2 - 30% of actions implemented and learning embedded<br>Q4 – achieve 75% for the re-audit of actions which were not implemented and embedded in Q2 | |
| Reduce HSMR and improve Learning from Deaths | The Trust will improve its HSMR and SHMI to within the accepted normal range, aiming for a target of 108 or less.<br><br>The Trust will improve the Learning from Deaths by ensuring and evidencing that the learning from the Trust's external mortality review is shared and disseminated at local/specialty level and that this informs positive changes in practice. | The Trust will also improve its assurance around the Learning from Deaths by monitoring the dissemination of learning from SJRs, inquests and Serious Incidents resulting in death within CSUs and Divisions, with reporting of relevant governance meeting minutes to the Clinical Governance Committee. | |
| | | The Trust will ensure that regular, timetabled SJRs are taking place in each division, with appropriate monitoring of compliance via the Trust's new mortality dashboard. | |
| | | All SJRs will be timetabled for the presentation at the divisional M&M meetings, with agreement of any problems in care as outlined within the SOP. | |
| | | The Trust will ensure that there are monthly, quorate Safe & Sound Mortality Sub-Group meetings within each Division and that the Trust Safe & Sound Mortality Group is represented by all Divisions. | |
| Ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability & Autism, with the implementation of 'The Learning Disability Improvement Standards' from NHSI. | To increase awareness around the needs of people with learning disabilities for TRFT staff to enable support to people with LD in the most frequented areas of the Trust in the first instance.<br>Audit the current staff knowledge with a questionnaire, to gauge the current level of knowledge and then undertake a follow up questionnaire to assess whether the training has improved their knowledge level;<br>Quarter One – Baseline of knowledge obtained<br>Quarter Two and Three – Training sessions held<br>Quarter Three – Re audit of knowledge to aim for an improved position by 30% | Identify which staff groups and Trust areas would most benefit from the training, by identifying where people are most often admitted from the flagging of Patients with a Learning Disability (PLD) | |
| | | Audit the staff group's level of knowledge with a questionnaire to obtain benchmark and identify areas for concentrated effort. | |
| | | Look at flexible training sessions for staff groups, ward meetings, face to face training sessions, information on wards, Tuesday lunchtime lecture at Post Graduate Medical Education (PGME) | |
| | | Involvement from experts by experience to deliver some training sessions (outreaching to advocacy groups within Rotherham for people with Learning Disability (LD) and Autism) | |
| | | Provide access point to staff with a LD to discuss issues on urgent basis if necessary. | |
| | | Identify those staff who might need more support than others and have plan how to do so effectively. | |
| | | Create culture of confidentiality and trust with the LD staff. | |

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| | | A learning disability can be associated with other complex co morbidities, therefore provide complex management where required. | |
| | | Review the care of PLD within 3 days of admission, ensuring reasonable adjustments are being made for PLD & Autism across our care pathways | |
| | | Test that our flagging systems working and identify a person at point of admission | |
| | | Ensure that patient passports are requested, read and care is implemented based upon content | |
| | | Engage PLD & Autism, families and carers | |
| | | Monitoring any restrictions in place, application of Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DOLs), working in a person's best interests | |
| | | Appointment of learning disability champions on each unit/division | |
| Friends and Family Test (FFT) - embedding of new questions and process and FFT - improved evidence of learning from feedback, you said we did | The aim and objective of this change is that anyone using any service should be able to give quick and easy feedback to the provider of that service. The FFT is designed to be a quick and simple mechanism for patients and users of NHS services to give their feedback, which will be in a format that enables the Trust as the provider, to hear what is working well and to focus upon all areas for attention that will improve the quality of an aspect of the patient's experience | Divisions will have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any action plans required are developed and closely monitored to meet the expectations of their patients' feedback. | |
| | | The Trust will provide visible evidence in public places to show that FFT feedback is valued and to demonstrate what actions have taken place as a result of this. | |
| | | The Trust will use feedback from the FFT alongside other measures of patient experience and quality and as a valuable insight into the patient journey. | |
| | | Staff will work within professional and clinical networks to share examples of good practice across the Trust which can be replicated by others. | |
| | | The Trust will support staff to promote the FFT to their patients to encourage them to engage and to give their feedback. | |
| | | Using clear communication is also vital to tell patients how you are responding to their feedback so they can see it is important to you, such as "you said, we did" as a key statement on notice boards or posters, using Trust website updates, or sharing changes made via local news stories. | |
| Diversity and Inclusion | To create a fully inclusive environment and to support the development of services that reflect the diversity within our local communities.<br>For all staff to have a full understanding of the privileges and disadvantages experienced by different groups, the concept of intersectionality and the impact of micro-aggressions on individuals and to practice inclusively.<br>For the Trust to comply with agreed targets for Diversity and Inclusion training.<br>For all proposed service changes / developments to include an equality impact assessment<br>Quarterly Patient Experience Report to report incidences of Diversity and Inclusion themed complaints and concerns with an aim for these to be zero. | Implementation of the Engagement and Inclusion role to deliver the Diversity and Inclusion activities identified in the Patient and Public Involvement Strategy. | |
| | | Monthly monitoring of compliance with Diversity and Inclusion training at Divisional and Corporate level. | |
| | | Development of community initiatives to assess service need – First initiative to be with the deaf community. | |
| | | Development of listening events to support individuals and groups with protected characteristics to ensure their views are being heard and needs being met. | |

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| Maximising the potential of Volunteering - recognise, recruit, embed and celebrate | We want to see more volunteers across a wider range of services within our hospital and community services. We want to, have the necessary infrastructure to enable and support the volunteers to realise their potential here and enjoy every placement they accept within this Trust. We want to become an inspiration for NHS volunteering and for our patients and the staff to know tha wherever there are volunteers placed then we are providing an enhanced service with their input.<br><br>The volunteer service has been awarded 'Kitemark Plus Award' status, after 'Voluntary Action Rotherham' praised and championed the way the Trust's service is co-ordinated and managed, especially by ensuring that all volunteers have a rewarding experience here.<br><br>Many of our volunteers have been with the Trust for over 5 years, with several in excess of 15 years' service and they work from 4 to 12 hours each per week, often accepting 2 or 3 placements across our hospital sites; including Breathing Space, Park Rehabilitation Centre and the Community Hospital.<br><br>New volunteering opportunities are regularly being developed within our services. These are to support patents and staff in a variety of settings across the Trust, performing a range of roles including within Pharmacy, the Patients' Library, for ward support, in Chaplaincy and in Gardening. The vision for volunteers at our hospital and within the community is to have:<br>• An inclusive, comprehensive and flexible system of volunteering that encourages, enables and supports individuals, groups and other organisations to contribute to volunteer activity in the Trust.<br>• A fully integrated team of volunteers who contribute to the services we provide, who are drawn from the diverse population that we serve, who feel valued, recognised and find their volunteer experience to be personally rewarding.<br>• To further develop and champion a voluntary service that offers a wide range of benefits to patients, their families and friends, to staff and of course to our volunteers themselves.<br>The volunteers complement and enhance the services provided by Trust staff and can thereby improve the experience of all patients. Through our approach to volunteering we will increase the wider involvement of and contribution to our local communities. | Identify targeted audiences to promote volunteering, to ensure that our volunteers reflect the diverse local population and a representative patient demographic | |
| | | Champion an organisational culture that welcomes and celebrates volunteers as an integral part of our Trust teams. | |
| | | Increase the number and diversity of our volunteers through targeted recruitment and being proactive in engaging across all sectors and ages in the local communities and within any marginalised groups | |
| | | Discover and apply innovative forms of volunteering to increase the flexibility and accessibility of our volunteering placements | |
| | | Deliver a high quality volunteer experience that maximises the reciprocal benefits for the Trust and the volunteers | |
| | | Deliver a high quality volunteer experience that maximises the reciprocal benefits for the Trust and the volunteers | |
| | | Prepare, develop and empower volunteers to achieve their roles safely and effectively | |
| | | Recognise and celebrate the value and impact of volunteering through dedicated evaluations | |
| | | Maintain clear policies and procedures to enable safe, legal and accessible hospital volunteering, ensuring training around safeguarding arrangements for children and vulnerable adults in particular, and compliance with relevant Trust policies and procedures e.g. the uniform policy etc. | |
| | | Increase coverage of the volunteer dining companions and ward support within the Trust | |
| | | Develop the 'Dementia friend' volunteer provision to support the implementation of the Trust's Dementia Strategy | |
| | | Explore volunteer-led activities for priority patient groups e.g. offering arts & crafts, singing & music and games etc. | |
| | | Develop, test and evaluate new ways of involving volunteers to support patients and their families in the UECC | |
| | | Introduce Befrienders: They will be sited in clinics/outpatient departments. Sitting and chatting with patients and relatives, supporting patients who may live alone or have no immediate family to accompany them to their appointment. | |

3.1.2 Performance against the 2020/21 Priorities

There were nine quality priorities for 2020/21, as follows;

Patient Safety

- Learning from Incidents
- Embed Human Factors & Introduce Schwartz Rounds Within the Organisation
- Roll-Out Medical Examiner Office

Clinical Effectiveness

- Utilisation of Trust Wide Audit to Facilitate Improvement in 3 Key Areas:
    - Sepsis Management
    - Medicines Management (incorporating compliance with Anti-Coagulation and Insulin Script modules)
    - Completion of Learning from Incidents Action Plans
- Reduce HSMR and improve Learning from Deaths
- Ensure staff have the knowledge and training to give excellent care to (PLD) & Autism, with the implementation of 'The Learning Disability Improvement Standards' from NHSI.

Patient Experience

- FFT - embedding of new questions and process and FFT - improved evidence of learning from feedback, you said we did
- Diversity and Inclusion
- Maximising the potential of Volunteering - recognise, recruit, embed and celebrate

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

**Domain: Patient Safety**

*Title - Learning from Incidents*

Executive Lead – Chief Nurse
Operational Lead - Deputy Chief Nurse

Current position and why is it important?

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

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

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

**What did we achieve?**

93 members of staff have completed training which evaluated well. Additional names that would benefit from training if further dates available have been identified – mainly from Clinical Support Division. Assessment being undertaken to identify any outstanding requirements within Divisions. This will be actioned during Q1.

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

The monthly Organisational Learning Action Forum (OLAF) continues to be well attended. The action plan format has now been agreed and training has been rolled out across Divisions. The new template format will be used for all new actions backdated to 1st January 2021. Discussions have commenced with IT to arrange for shared template to be accessed via Teams.

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

A page is being set up on the Hub to provide a repository for evidence of learning.

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

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

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

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

**How was progress monitored and reported?**

Progress was monitored and updates provided through weekly Divisional meetings with the patient safety team and monthly Divisional performance reports. There is a monthly CQC delivery group where all Datix incidents and serious incidents are monitored and progress against compliance and performance identified.

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

There is a Trust action plan tracker that has been implemented which collates, monitors compliance and triangulates all learning from incidents, complaints, concerns and coroners

investigations. Thematic analysis is completed through the patient safety team. This will then formulate the strategy for quality improvement initiatives throughout the Trust. Falls, pressure ulcers and medications management has been identified for the Q1 quality improvement plan.

**What further actions need to be undertaken?**

There will be a focus on ensuring further training for serious incident investigation is provided. This should incorporate the human factors element. There will be work ongoing to ensure that the Patient Safety Incident Response Framework (PSIRF) is fully embedded within the Trust.

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

There will be ongoing work through OLAF to ensure the triangulation of learning and ensure key actions are embedded throughout the Trust.

*Title - Embed Human Factors & Introduce Schwartz Rounds within the Organisation*

Executive Lead – Executive Medical Director
Operational Lead – Associate Medical Director for Human Factors

Current position and why is it important?

Human factors is the study of interactions between people and the system in which they work. It can be used to improve patient safety both by aiding our understanding of incidents and safe practice, and by making changes to the system and the culture that we work in. Historically, there has been limited use of a Human Factors approach within the Trust. However, the uptake of a Human Factors approach to patient safety is being increasingly advised by bodies such as NHSI and Health Education England and has much to offer; as such the Trust has now appointed its first Associate Medical Director for Human Factors.

The Quality Priority will focus on two distinct parts: the first which will focus on a number of areas that have the maximum scope for improvement using a human factors approach; and the second which will focus on improving colleagues' wellbeing within the organisation.

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

- Introduce a human factors approach to incident investigation and action planning.
    - Metric1 - Proportion of incident investigations completed by staff with human factors training.
    - Metric 2 - Proportion of investigation action plans including system change or other higher effectiveness interventions.
- Wider adoption of in situ simulation for team training in non-technical skills such as teamwork, leadership and communication. Simultaneous use of in situ simulation as a governance and quality improvement methodology to detect latent errors (hidden safety hazards) and lead improvements in work environment.
    - Metric 1 - Number of in situ simulations completed.
    - Metric 2 - Number of simulation reports leading to safety actions.

- Re-introduction of Schwartz Rounds to the Trust.
    - Metric 1 - Appoint Clinical Lead and link with Point of Care Foundation (POCF) Q1.
    - Metric 2 - Rounds arranged/communication plan in-situ Q2.
    - Metric 3 - At least 4 Schwartz Rounds within Trust by end Q4.

**What did we achieve?**

Implementation delayed due to impact of COVID-19 and, laterally, resignation of previous Associate Medical Director Human Factors. New AMD appointed 12 October 2020.

Introducing a human factors approach to incident investigation and action planning:

It has been identified that 21 and 8 members of staff have achieved Improvement Academy Bronze and Silver Human Factors certification. It is not yet clear what other training has been provided for staff, certainly nothing over the past 18 months, or whether all staff reviewing incident investigations have had human factors training - investigation work ongoing.

The Associate Medical Director Human Factors has been granted access to the Serious Untoward Incident (SUI) database and has started reviewing cases, however has noticed that the Datix system for reporting incidents is not well designed for collecting data regarding human factors, and that this information is not a mandatory requirement for submission. Subsequent meetings with the Datix manager have resulted in investigation into how this can be improved, including discussions with other Trusts on how they collate this data, with a view to improving the collection of this data. Ensuring that all staff have some human factors training will help staff identify some of the issues and help their abilities to input useful Human Factors data into their Datix submissions.

The Associate Medical Director Human Factors is endeavoring to source online Human Factors training that could be incorporated into Mandatory and Statutory Training (MaST), to ensure it is accessible to all, and is currently writing a business case to secure the funding to bring this training into the trust. If a company can be sourced which provides both online training and face to face workshops both could be introduced at a later date possibly post-pandemic.

Wider adoption of in-situ simulation for team training.

The Capital Monitoring Group approved a £17K bid for a second simulation mannequin. COVID continues to impact on both in-situ and PGME training, although some is being provided, including in UECC with appropriate social distancing. Clinical Negligence Scheme for Trusts (CNST) training had a brief return to the simulation suite but is currently online to ensure training continues as simulation is not possible due to social distancing requirements. As soon as limits on delegate capacity are lifted the training will return to face to face with simulation. There is little other simulation occurring due to distancing restrictions however the courses are ready to continue once the restrictions are lifted.

Efforts to continue training via a mixed media method have been tried and generally felt to be successful, for example, a Paediatric airway training session was held successfully in theatres with a mix of staff (both attending and viewing online) and with a contribution of trainers from Sheffield Children's Hospital.

Discussion between SAS Tutor (Associate Medical Director Human Factors) & CESR and fellow lead regarding training for SAS, Fellows and LEDs. Aiming to provide monthly training sessions including Sim for these groups. Aiming to start rolling programme January 2022. If successful, could then be expanded out to other staff groups.

There are no sim reports to document due to the general absence of Sim over the past year, however as the programmes hopefully occur in the summer, the data will be logged.

Re-introduction of Schwartz Rounds into the hospital.

Due to social distancing requirements Schwartz Rounds cannot be introduced into the hospital at this time. Instead the Point of Care Foundation have offered training and support to introduce a similar initiative called Team Time. This is an online forum aimed at departments and teams where they can share stories, socially and emotionally, in a safe facilitated manner.

The Trust has a Team time steering committee with 8 members, with a clinical lead and 14 Team time facilitators (of whom 10 have completed all the training) and are in a position to commence these sessions. This will commence with the therapy teams and will roll this out to the whole Trust. These sessions will be delivered via MS Teams. As social distancing requirements allow these will probably morph into the Schwartz Rounds.

**How was progress monitored and reported?**

Progress was monitored and updates provided through regular meetings with the Executive Medical Director, and monthly written submissions to the CGC.

Any Sim sessions that have been run have appropriate attendance and feedback associated with them.

The team time sessions will also have attendance and feedback requirements.

**What further actions need to be undertaken?**

It would be beneficial to improve the way human factors are recorded in the Datix data, particularly how it is entered into the system, whether this is by changing the way that information is collected or changing the system. By bringing in Human Factors training for all staff, the Trust can help them identify problems and processes which should also improve data entry.

As social distancing requirements recede, the Trust needs to support the reintroduction of simulation training into the Trust, and ensure that we allow our staff the time to attend the courses that are offered, and encourage them to engage in the in-situ simulations that occur in their working spaces.

Once established with the Therapy teams the Trust will roll out the Team time sessions to the whole Trust.

*Title - Roll-Out Medical Examiner Office*

Executive Lead – Executive Medical Director
Operational Lead – Medical Examiner

Current position and why is it important?

The Trust is currently strengthening the mortality process, such that all deaths are reviewed in a timely manner and that issues in the quality of care are highlighted and escalated quickly to ensure learning from deaths across all divisions.

The implementation of the ME Office will allow all deaths to be reviewed, supporting bereaved families to ask questions or raise concerns about the quality and safety of care of their loved one to ensure a full picture of the episode of care has been considered. A full SJR will be undertaken, to review the quality and safety of the care provided, by a multi-disciplinary team which will identify areas where quality of care could have been improved, taking into account the family and concerns they have highlighted.

Whilst the Medical Examiner's office is non statutory at present, it will become statutory in the near future. It is therefore important that the Trust has an adequately resourced Medical Examiner's Office in order for it to carry out the necessary duties.

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

The aim is to ensure all deaths have scrutiny and that family members and carers have the opportunity to comment on the quality of care their loved ones received so that learning, both positive and negative, can be disseminated across the organisation.

At least 98% of all deaths within the Trust will have either a first-stage review within 1 month of the death or both a first and second-stage review SJR within 2 months of the death within each division.

A dashboard of the timely reviews and the outcomes of these reviews will be discussed monthly at corporate level with performance monitored through the Trust Mortality and Morbidity Meetings.

Any death scoring 1 or 2 in any phase of care (significant quality of care issues) will be escalated within 1 month to the Trust mortality meeting and will be reviewed by the SUI panel.

All deaths involving learning disability patients and all deaths resulting in either a Coroner's investigation and/or inquest will undergo a stage-two SJR and report into the divisional Mortality and Morbidity meeting and Trust wider Mortality meeting and Trust Board.

**What did we achieve?**

The Trust has now appointed its second Medical Examiner, in order to expand the service and increase provision and resilience, and is now fully established. Further expansion will be required once the Trust takes on responsibility for reviewing all community deaths, however there is a national delay to this roll-out.

The Key Performance Indicator (KPI) set for the ME service relates to the timeliness of reviews and the percentage of Stage 1 reviews completed within 30 days of death.

Band 5 and Band 6 Medical Examiner Officers have now been recruited, and the ME service is now fully established. As such, the Lead Medical Examiner is in the process of arranging a quality assurance audit to provide assurance to the Board of Directors, the results of which will also be fed into the national Medical Examiners' service forum.

Additional funding has been approved for a new Mortality and Learning from Deaths Manager, following the invaluable impact that this had in driving improvements in mortality and learning from deaths at another NHS Trust, with whom the Trust has been collaborating. This new roll will work alongside the new Associate Medical Director for Mortality and Learning from Deaths.

Cases where significant lapses in quality of care are identified continue to be highlighted by the Medical Examiner and are in turn fed into the Trust's SUI Panel. The ME service quarterly reports the number of reviews undertaken, the number of cases where care was escalated, and the number of Coronial referrals. This quarterly database will be shared with the Trust's Clinical Governance Committee, Quality Committee and the Board of Directors moving forward.

Other care issues identified are escalated to the weekly Harm Free Care meeting, with the Medical Examiner in attendance to discuss any such issues or concerns.

The Trust's ME service is one of a few national services where most of the hospital deaths are being reviewed and has had commendation by the regional ME team. In view of this, the service has been put forward to potentially be one of the pilot sites for the National Medical Examiners' database.

The ME service is close to being fully electronic. The inpatient verification of death document on the Trust's electronic record system (Meditech) is mandatory and triggers notification to the ME service so that delays in paperwork are at a minimal. Other neighbouring Trusts are interested in our electronic processes and we will be working closely with neighbouring Trusts in order to share learning.

The "quick release" process for faith considerations has been recommended as best practice and the Trust will be sharing the ME processes with regional peers. There have been no Trust delays in release within 24 hours. This has been highly commended by families and the Registrar.

All Learning Disability deaths are fed into the divisional SJR process with input from the Trust's Learning Disabilities Specialist Nurse. Furthermore, all deaths going for HM Coroner's investigations and/or inquests are all reviewed at the Trust's Serious Untoward Incident Panel and have a SJR.

Concerns raised by families are highlighted via the ME service to the divisions for closure or signposted through the complaints process for formal intervention. All of these conversations are now documented on Meditech so that the divisions have easy access to the questions needing answered ("Medical Examiners Comms Note"). There has been divisional positive feedback regarding this functionality.

The Surgical Division had a well-established SJR process where all surgical deaths are scrutinised in this way. The Division of medicine have recently established a programme of SJR reviewers in a multi-disciplinary setting to scrutinise deaths which are highlighted by the ME as requiring an SJR review.

The rolling rota is available whereby medical colleagues in a multidisciplinary setting will review the cases brought forward by the ME or through the SUI investigation route. Escalations from these are fed into the monthly Trust's Safe and Sound Mortality Group meeting.

**How was progress monitored and reported?**

Progress was monitored and updates provided through the Safe & Sound Mortality Group, Clinical Governance Committee and Quality Committee.

**What further actions need to be undertaken?**

Further work needs to continue in the Trust focussing on the learning from deaths identified from Stage 1 and Stage 2 mortality reviews, and local and Trust-wide dissemination of this learning, such that it results in sustained quality improvements. This will be strengthened through the introduction of a new Mortality and Learning from Deaths Associate Medical Director and Manager.

**Domain: Clinical Effectiveness**

Title - *Utilisation of Trust Wide Audit to Facilitate Improvement in 3 Key Areas:*

- *Sepsis Management*
- *Medicines Management (incorporating compliance with anti-coagulation and Insulin Script modules)*
- *Completion of Learning from Incidents Action Plans*

Executive Lead – Executive Medical Director
Operational Lead – Associate Medical Director for Clinical Effectiveness and Research, Innovation & Clinical Effectiveness Manager

Current position and why is it important?

Audit is a powerful tool but is often considered to be useful for assurance purposes only. The Clinical Effectiveness department and the Safe & Sound Quality Directorate as a whole wishes to show that audit is a powerful quality improvement tool by using audit to identify gaps in standards in areas of Trust-wide significance and to use audit as a launch for Trust-wide improvement projects. National audits are often criticized at the local level as by the time results are reported changes to local systems and services have occurred, thereby reducing the value of results. By undertaking local audits, results can be more readily available and reported in a timely and useful way. It is important to focus on areas that staff believe are an area of local/Trust importance to encourage engagement if a Trust-wide systems approach is to be employed.

The first key area chosen for Trust-wide audit remains an ongoing area of challenge; the second key area chosen is to give the Trust further assurance of sustained learning from

incidents by auditing key action plans for significant actions and/or themes that are determined through the learning from incidents.

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

The aim will be to undertake an audit and use the results to identify areas where other quality improvement techniques can be used to improve the service/patient outcomes. Measures and metrics will be confirmed once the area of focus has been agreed.

Sepsis Management - Compliance with Sepsis 6 tool and specifically the administration of antibiotics within 1 hour of diagnosis.

- Q1/Q2 – Continue training and educating the workforce about the detection of Sepsis and its management using the UK Sepsis Trust training package and the Sepsis 6 tool in the Meditech. Our goal remains more than 90% for detecting and administering antibiotics in an hour in the short term.
- Q3/Q4 – We will repeat the audit after the implementation of recommendations from the recent audit.

Medicines Management – compliance with anti-coagulation and Insulin Script modules mandatory training for identified medical staff and relevant non-medical prescribers

- Q1 – identification of those in scope which are then added to Electronic Staff Record (ESR) and communicated to those staff
- Q2 - 50% compliance with those two mandatory training modules by end of the quarter
- Q3 - 70% compliance with those two mandatory training modules by end of the quarter
- Q4 – 85% compliance with those two mandatory training modules by end of the quarter

Completion of Learning from Incident Action Plans

- Q1 - set up meeting for the monitoring of learning from complaints, claims and incidents and process for monitoring action plan compliance.
- Q2 - 30% of actions implemented and learning embedded
- Q4 – achieve 75% for the re-audit of actions which were not implemented and embedded in Q2

**What did we achieve?**

Sepsis – Sepsis Lead has been promoting and educating junior doctors about Sepsis 6 with interactive discussion twice a year at the Post Graduate Medical Education (PGME) centre & the next meeting is due in October.

Dr Arefin has carried out an audit on the detection/management of Sepsis and has put forward an action plan. A further meeting is going to take place soon about implementing this action plan.

Learning from incidents action plans - Q1 goal achieved.

It is recommended that this priority is rolled over to 2021/22 with the groundwork and preparation being undertaken in Q3/Q4 ready for commencements of audits in Q1 of 2021/22. Monitoring of progress will be picked up through Quality Priority 1.

The OLAF is up and running. Preparatory work is near conclusion having devised a system for identifying themes, Trust wide audits and monitoring of action plans.

Medicines Management - Significant delays in making Script modules available through ESR due to technical reasons. ESR Team has approached supplier about this and working with IT to enable as soon as possible with the aim of roll out in 2021.

**How was progress monitored and reported?**

Progress was monitored and updates provided through the Deteriorating Patients, Safe & Sound, Sepsis Group meeting and the Clinical Governance Committee.

**What further actions need to be undertaken?**

Sepsis-related documents, i.e., Sepsis Policy, Sepsis Screening and Action tool, NEWS2 and Escalation policy, are available in the Meditech for everyone to follow. An updated version of the Paediatric Sepsis Policy has been ratified and added to the trust's Sepsis Policy documents and is now available on the intranet. The Trust is about to add two training packages for the relevant medical & nursing staffs working with adult and paediatric patients. Education: On the Sepsis Study day, ALERT courses, Essential Nurse training, Management of the sick ward patient 5-day course, REACH (Rotherham Emergency Assessment Course for Health Care Support Workers (HCSWs). The Sepsis lead has started twice a year discussing Sepsis with the junior doctors at the PGME. The next session will be October. An action plan following the Sepsis audit has been formulated and further meeting is going to take place soon to execute this.

*Title - Reduce HSMR and improve Learning from Deaths*

Executive Lead – Executive Medical Director
Operational Lead – Medical Examiner

Current position and why is it important?

The Trust's HSMR and SHMI are both currently high at 116 and 118 respectively (December 2019 data).

It is vitally important that the Trust learns from deaths and implements change where necessary within a timely fashion so that care can quickly be altered to improve patient safety and outcomes, focussing on the '3 Cs' (Quality of Care; Case Mix; Coding).

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

The Trust will improve its HSMR and Summary level SHMI to within the accepted normal range, aiming for a target of 108 or less.

The Trust will improve the Learning from Deaths by ensuring and evidencing that the learning from the Trust's external mortality review is shared and disseminated at local/specialty level and that this informs positive changes in practice.

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

- Sepsis
    - Early and improved recognition of Sepsis – baseline and measure to be confirmed
    - Timely application of Sepsis 6 tool and compliance with the tool – baseline and measure to be confirmed
- Community-acquired Pneumonia (CAP)
    - Reintroduce the Trust's CAP care bundle and improve achieve utilisation in 50% of all cases by end of Q3 and 90% of all cases by end of Q4
    - Ensure that the CAP risk-stratification CURB65 tool is routinely documented and improve achieve utilisation in 70% of all cases by end of Q3 and 90% of all cases by end of Q4
    - Agree coding parameters, such that clinical coders can code severity of pneumonia based on CURB65 and/or where "severe" pneumonia is documented.
- Improve End of Life Recognition and proactive implementation of appropriate ceilings of care
    - Introduce palliative care training/End of Life training to all relevant medical staff with compliance of 25% by end of Q3 and 50% by end of Q4
    - Work with Rotherham Place partners to consider the introduction of either ReSPECT or the Gold Standard Framework (GSF) Hospitals Programme

**What did we achieve?**

The Trust has taken a range of actions to support its efforts to reduce its HSMR and ensure that it is learning from deaths. To support this work two-time limited forums have been established. These are the Mortality Improvement Group (MIG) chaired by the Interim Chief Executive Officer (CEO) and Executive Medical Director. The group also has representation from our partners within Primary Care and external support and scrutiny. The MIG has developed a focused action plan to support the existing work programme. The other Group is the Mortality Analytical Group (MAG). This group is chaired by the Associate Director of Information Services and has membership from Dr Foster Intelligence (or mortality information provider), clinical staff and our clinical coding teams. The purpose of this group is to explore and understand the data around mortality to ensure that we are focused on the right area for further investigation and work.

The MIG has commissioned two additional pieces of work to provide assurance on our quality of care. The first was a review of patients care within 'alerting diagnosis groups' on the Dr Foster Mortality report. These are groups where the level of deaths is statistically significantly above what would be expected. Over 50 case notes were reviewed under the SJR Methodology across Pneumonia, Aspirated Pneumonitis, COPD and Sepsis. No significant shortfalls in care across all patients were identified.

The second work commissioned was an independent review of investigations into care and treatment provided to patients who died and were subject to a SUI investigation or coroner's

inquest having been an inpatient at the Trust. The output of the report has confirmed that the actions we are and are planning to take are correct.

To support improvements in care the Trust has engaged with the Improvement Academy to support two pieces of work within the Trust using their Quality Improvement Methodology. One will be in our (UECC) and be focused on CAP and the other will be on our Acute Medical Unit and be a broader piece of work on general quality improvement within the unit.

Within the Trust's governance the Safe and Sound Mortality Group is now well established with meetings held monthly. The meetings are chaired by the Executive Medical Director with delegation to the Deputy Medical Director for Professional Standards as Vice Chair when necessary. The meeting is focused on identification of key themes and trends from mortality reviews and escalations from divisional Safe and Sound Sub Groups so that learning can be shared across the Trust. This group feeds into the Trust's overall Clinical Governance Committee.

The divisional Safe and Sound Mortality Sub Groups meet monthly and work to an agreed standard agenda format. However, evidence is required to provide assurance that the Safe and Sound Medicine Mortality Sub Group is regularly meeting, is quorate and minuted, and that appropriate discussions are being held around the themes identified from Stage 1 and Stage 2 divisional deaths, and that there is improved Learning from Deaths.

All divisions now have a multidisciplinary group of colleagues reviewing cases for SJR However, there are challenges within the division of medicine to achieve the KPI of reviews undertaken within 2 months. The impact of COVID-19 on the capacity of the teams within this division should not be underestimated.

The Trust has established an OLAF with divisional representation and the ME in attendance. The forum brings together across all divisions the various actions plans, learning and insights across clinical safety issues. It provides a mechanism to review family concerns and complaints, learn from deaths, and to discuss serious incidents and inquests across the Trust.

The Meditech system is now live with the electronic CURB65 scoring tool. This has been accompanied by an education programme on the tool, its use to guide the management of Sepsis and Pneumonia. The Trust has also re launch the CAP care bundle alongside this work. Alongside this training, new sepsis e-learning is now live on ESR. UECC also hold regular "stop the shift" sessions to cover sepsis and pneumonia specific training.

The Mortality dashboard has been developed. This is shared and discussed at the Trust Safe & Sound Mortality Group meeting to enable discussions regarding timeliness of reviews and outcomes. The dashboard is continuing to be developed and will now interrogate the CURB 65 data so that the KPI can be reported. Currently the Trust is achieving 100% of Stage 1 reviews completed by the ME within 30 days of death in January 2021.

A fortnightly mortality newsletter was disseminated across the Trust with the first theme of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

**How was progress monitored and reported?**

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

A 360 Assurance audit report was commissioned to examine the effectiveness of controls in place relating to learning from deaths. 5 medium and 1 high risk were identified as part of the review and action plans to address these have been developed.

A monthly highlight report is submitted to Trust Board via the Programme Management Office. The report relates to delivery of the Operational Plan 2020/21 Priorities and in this case – Mortality and summarises progress made against the milestones and performance targets agreed in the original mandate signed off by the Board at the beginning of last year.

**What further actions need to be undertaken?**

- Completion of investigation and initial actions into Palliative Care processes and coding
- Completion of actions identified by Internal Audit review of Governance
- Transfer of work from MIG and MAG into Business-as-Usual governance and ways of working
- Appointment to AMD Mortality and Learning from Deaths and Mortality and Learning from Deaths Manager posts
- Implement CAP policy
- Completion and learning from Improvement Academy work in UECC
- Revision of the Trust's Mortality Policy to reflect the improvements and changes made around mortality reviews, including around mortality alerts.
- Implementation of ReSPECT end of life care plans to the Trust.

*Title - Ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability & Autism, with the implementation of 'The Learning Disability Improvement Standards' from NHS Improvement (NHSI).*

Executive Lead – Chief Nurse
Operational Lead - Lead Nurse in Learning Disabilities

Current position and why is it important?

Currently there is no systematic training provided for all Trust staff around Learning Disabilities (LD). The law has recently changed and there will be mandatory training provided to all health and social care staff in the near future around Learning Disabilities and autism. However, in the interim, it would help to improve the standard of care we give to people with Learning Disabilities at TRFT, in line with the standards outlined in the Learning Disability improvement standards for NHS Trusts by NHSI, focusing upon the 3 standards for acute Trusts: respecting and protecting rights, inclusion and engagement and workforce. This recognises that if we get it right for people with a learning disability we get it right for everyone.

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

To increase awareness around the needs of people with Learning Disabilities for TRFT staff to enable support to people with Learning Disabilities in the most frequented areas of the Trust in the first instance.

Audit the current staff knowledge with a questionnaire, to gauge the current level of knowledge and then undertake a follow up questionnaire to assess whether the training has improved their knowledge level;

- Q1– Baseline of knowledge obtained
- Q2 and Q3 – Training sessions held
- Q3 – Re audit of knowledge to aim for an improved position by 30%

**What did we achieve?**

Although, we achieved a limited response to the survey regarding training around learning disabilities and autism awareness we are implementing our training programme throughout the Trust to improve this current standard.

As part of the Autism accreditation award starting in our urgent and emergency care services, we will be setting out bespoke Autism awareness training which will be delivered by people with lived experience in the local area. The training will outreach to all disciplines of staff throughout our urgent and emergency care services – medics, nurses, administration teams, allied health professionals. Upon successful completion of this accreditation programme, we hope to roll out this award throughout the wider Trust – covering all wards and departments is the long term plan.

The team is also delivering ward bespoke training for Learning disabilities and autism awareness, including all of the Trainee Nursing Associate (TNA) programme, lunch time protected learning time for doctors and is also involved in the delivery of the training on the Trust Essential Nurse Training (TENT) programme for registered nurses. We also have allocated delivery time on the Trust surgery training programme.

The pilot of the Oliver McGowan programme Learning disability and autism awareness programme, was included in our training programme for the Trusts, however this has been temporarily suspended by Health Education England. It is hoped it will be picked up again for pilot later in 2021.

As part of the Learning Disabilities Mortality Review programme (LeDeR) the Trust will be involved in the wider learning from deaths in our local area and how we can affect these health inequalities. The changes in 2021 to the LeDeR process, will include reporting and learning from the deaths of people with Autism in this process. As part of our training, we will ensure of staff teams Trust wide are aware of the LeDeR programme and the current health inequalities which affect people with a learning disability and autism.

**How was progress monitored and reported?**

All attendances at the training, will be recorded for Learning & development on each staff member's individual learning log. The training, until the Oliver McGowan mandatory training for all Health and Social care organisations is live will continue every year within the Trust on this bespoke departmental level.

A re audit of staff skills and knowledge will take place later on this year, as one of the indicators of the training plan being successful.

**What further actions need to be undertaken?**

As a team we are re invigorating the role of the Learning disability and Autism champions, in line with our training plan. This will encourage each ward and department to have a number of staff champions within that area. This scheme will cover all departments of the Trust, not only clinical areas. The role of the champion, will be as an advocate for people with learning disabilities and Autism – someone who is familiar with the additional needs of this group of people. This covers both patients who use the Trust facilities and also staff who may have such additional needs.

The champions will receive bespoke training, again delivered by people with lived experience of learning disabilities and autism – enabling them to then increase the knowledge and awareness of their peers.

Further feedback from our patients with learning disabilities and autism, via the Friends and Family feedback route will be gained. We will actively encourage our patients with Learning disabilities and autism to feedback on their experiences within Trust. This information may be gained on behalf of the individual by their carers, family or advocates.

**Domain: Patient Experience**

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

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

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

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

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

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

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

In the three settings for which we have previously published Trust level response rates (general and acute inpatient, UECC and the second maternity touch point – Labour and Birth), this will no longer be possible because there is now no limit upon how often a patient or service user can give their feedback. We will therefore no longer calculate or publish a 'response rate'. We will however continue to collect and submit the same data items and will continue to publish the number of responses received in the context of the size of the service concerned, so that an under representation of users can be identified from the feedback received. It is intended that this will provide Trust teams with an indication on how well FFT is being promoted and taken up, and for Commissioners and Regulators it will give a sense of how effectively the FFT is being implemented by each provider.

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

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

**What did we achieve?**

FFT recommenced on the 1 December 2020. The aim and objective of the changes is that anyone using any service should be able to give quick and easy feedback to the provider of that service. The new FFT survey is designed to be a quick and simple mechanism for patients and users of NHS services to give their feedback. This will be in a format that enables the Trust as the provider, to hear what is working well and to focus upon all areas for attention that will improve the quality of an aspect of the patient's experience.

Implementation of the new FFT survey in all areas has been completed.

**How was progress monitored and reported?**

Examples of learning from patient experience and actions taken as a result of feedback are discussed and recorded as part of Divisional Governance Meetings. This will include sharing of information and improvements "what's working better".

Divisions have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any action plans required are developed and closely monitored to meet the expectations of their patients' feedback.

Following the introduction of the new electronic survey a new report and dashboard has been created which will be used to provide data to the divisions and the FFT Steering Group and the Patient Experience Group.

The activity and learning will also feature within the Quarterly Patient Experience Report for Clinical Governance Committee and Quality Committee.

**What further actions need to be undertaken?**

Continue monitoring

*Title - Diversity and Inclusion*

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Diversity and Inclusion is central to the successful delivery of high quality services that are responsive to the needs of patients from diverse backgrounds.

Services are generally well-designed to meet the needs of those with protected characteristics within the local community and the FFT feedback obtained is very positive.

Numbers of complaints are below the national average. Feedback obtained via the national FFT survey methodology is also positive with consistently good satisfaction scores.

However, it is important that we do not become complacent about Diversity and Inclusion and we need to ensure that all service users feel they are receiving a fair and equitable service, taking into consideration their views and ensuring assessments are made to ensure no discriminatory practice occurs.

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

- To create a fully inclusive environment and to support the development of services that reflect the diversity within our local communities.
- For all staff to have a full understanding of the privileges and disadvantages experienced by different groups, the concept of intersectionality and the impact of micro-aggressions on individuals and to practice inclusively.
- For the Trust to comply with agreed targets for Diversity and Inclusion training.

- For all proposed service changes/developments to include an equality impact assessment.
- Quarterly Patient Experience Report to report incidences of Diversity and Inclusion themed complaints and concerns with an aim for these to be zero.

**What did we achieve?**

Patient and Public Engagement and Inclusion Lead commenced employment at the Trust in March 2020. Initially redeployed to support COVID-19 but since August, working within their Engagement and Inclusion role.

New Patient and Public Involvement (PPI) strategy to be updated with accompanying action plan on how this will be achieved; to be presented at June Board Meeting.

As at the end of January 2021, training compliance had risen to 87.42%, which is above the Trust target of 85%. Corporate Operations compliance has improved slightly, but remains slightly below Trust target, with plans in place to support further improvement. Compliance within the Division of Medicine has deteriorated slightly, and is now below Trust target. This has been highlighted to the Divisional general Manager. All other divisions are meeting or exceeding the Trust target, and Emergency Care and Family Health are both exceeding 90%.

Google Live Transcribe approved by Information Governance for use throughout the Trust for anyone hard of hearing who can read transcribes verbal speech into text on screen. This can be used on tablets supplied to wards and departments through the pandemic, to aid communication as it has been impacted by the use of masks; lip-reading is often used by many people who are hard of hearing or D/deaf.

Engagement and Inclusion Lead working with clinics on provision for d/Deaf community; early clinic appointments, clear masks, transcribing software and video consultation when hardware is in place. Health and wellbeing clinic service with British Sign Language (BSL) interpreter to be planned (away from the main hospital site) when infection rates reduce. Engagement with community representatives on 16 December 2020 was undertaken. Report with actions circulated to key staff members for dissemination/action.

Personal Protective Equipment (PPE) to allow lip reading; use being discussed between infection control and patient safety for a member of staff. Leeds have found a private company who is going through IC testing now. We will monitor developments to explore this as a potential way forward. The issue has now been raised with NHSEI at equality meetings.

Next engagement meeting with d/Deaf community on 16/02/21.

15/02/21 Use of clear screens agreed by Chief Nurse and Lead Nurse/Assistant Director for Infection Prevention and Control with Engagement and Inclusion Lead. Taken to Gold by Head of Health & Safety & Compliance

Estates Governance, funding approved for 20 screens (£3-4K).

On 16 February 2021 feedback to the Deaf community was well received at the engagement event with group leaders. It was offered to the Deaf community to proceed with the health clinic that was planned, virtually. Representatives of Deaf Futures will consult with members and let the Engagement and Inclusion Lead know the suitability of this.

In April provision of translation services went out to tender jointly with other local hospital Trusts, including BSL. This required close work with the local community to ensure that this does not lower the standard of service provided. Their needs have been communicated to procurement staff involved in this process.

Poster produced for staff to have a concise source of the options to aid communication with deaf or hard of hearing people.

Engagement and Inclusion Lead given access to Trust Members. This will enable more targeted asks for participation in development of inclusive Trust services from Members that have identified that they have a protected characteristic. A meeting was also held with the Chairman, Engagement and Inclusion Lead, Deputy Chief Nurse in January 2021 to discuss next steps.

A Public Panel has been established for the Patient Information Group. This has already recruited founding members with protected characteristics, as well as Trust Governors. Trust Governors will be invited to join this at the next Governor Engagement Group Meeting. Then public recruitment will follow after the Public Panel is shaped further by Governor input.

Neuro-rehab engagement undertaken via telephone interviews, report sent to CCG and relevant internal stakeholders.

Community engagement being sought to help ensure the Accessible Information Standard is fully implemented. Working with REMA and Apna Haq to update our FGM policy sensitively.

Discussions taken place with the Diabetes team regarding Diabetes group re-start. Public engagement lead for this group explained that many members are in their 80s or 90s and recruitment has been difficult in recent years.

Cancer patient survey being undertaken focussed on experience of different consultation types before introduction of choice of consultation type.

Staff networks each have representation at Equality, Diversity and Inclusion Steering Group. Diversity and Inclusion Steering Group developing Diversity and Inclusion Action Plan for Patient Care which will require co-production with local communities.

On 23 February 2021 Trust Governors were invited to join the Public Panel and shape its inception. Collection of detailed demographic data of members will ensure diversity of the membership through targeted recruitment of any underrepresented groups.

Engagement and Inclusion Lead joined Migrant Heath Group for Yorkshire and the Humber for joint engagement activities.

Engagement and Inclusion Lead joined Homelessness Network for the region for joint engagement activities.

Engagement and Inclusion Lead presented at Rotherham Mental Health Awareness online event and regularly hears from Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH)'s group for people with mental health issues and their carers.

**How was progress monitored and reported?**

Progress was monitored and updates provided through the Quality Priority Group, Quarterly Patient Experience Report to Patient Experience Group, reports to the Equality, Diversity and Inclusion Steering Group and reports to the Accessible Information Task and Finish Group.

Compliance with training was monitored via the standard process: the Subject Matter Expert (SME) receives monthly compliance reports, discusses any challenges with training access with any areas that are not meeting the Trust's 85% target and escalates any significant issues and exceptions to People Committee. Overall compliance percentages for each training subject are also received by a number of committees and meetings each month, including Operational Workforce Group, Joint Partnership Forum and the Board.

Equality impact assessment scrutiny panel now a standard process of document ratification group.

Feedback was given to all members of the public who have contributed their time/views/expertise.

**What further actions need to be undertaken?**

Promotion of the 'Call it out, Work it out' campaign to report all instances of discriminatory behaviour on Trust premises.

The Trust Communications team suggested to have a section on the TRFT public website that would allow members of the public to contact their hospital Governor for their constituency. This idea will be incorporated into a business case for a new public website due to the limitations of altering the current site.

Growing the 'Public Panel', targeting groups that are underrepresented in the current membership. First recruitment event will take place on 11/05/21 at Chaand Raat at the The Rotherham Bazaar; part of Ramadan celebrations.

Further promotion of the Trust Staff Networks and engagement with these to benefit other staff and patient care.

*<u>Title</u> - Maximising the potential of Volunteering - recognise, recruit, embed and celebrate*

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

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

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

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

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

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

The aim and objectives including the measures/metrics

We want to see more volunteers across a wider range of services within our hospital and community services. We want to have the necessary infrastructure to enable and support the volunteers to realise their potential here and enjoy every placement they accept within this Trust. We want to become an inspiration for NHS volunteering and for our patients and the staff to know that wherever there are volunteers placed then we are providing an enhanced service with their input.

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

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

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

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

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

A monthly report of volunteering activity features within the Quarterly Patient Experience Report. The following quality indicators will be tracked:

We will adapt or design a Friends & Family Volunteer Survey to understand the experience of our volunteers and we will aim for:

- 90% volunteers feeling that they are valued by this Trust.
- 90% volunteers are feeling prepared and confident to fulfil their roles.
- 90% achieving their goals and personal satisfaction through volunteering.
- 90% would recommend volunteering at TRFT to their peers.
- Case studies and volunteer stories will be collated to demonstrate their contribution to the patients' experience, to staff support and the impact to the volunteers themselves through volunteering.
- Increases to volunteer numbers, and roles; hours will be tracked.
- Demographic information on who is being attracted to join the Trust's Volunteer programme e.g. by age, experience, gender, disability, faith and ethnicity.
- How frequently, and for what duration per week and over time, people volunteer.
- The type of work that volunteers are offered and what they best engage with.

**What did we achieve?**

Due to the current rise in the pandemic R rate and visiting restrictions remaining in place existing Trust volunteers who took a temporary break continue to do so. The Volunteer Co-ordinator remains in contact with them.

Volunteer recruitment also remains temporarily suspended with planned referral routes for potential volunteers into other agencies added for NHS schemes, or local voluntary and community sector partners. Therefore, the priority rolled over to 2021/22 to ensure sufficient opportunity is available to introduce all planned improvements.

However, some of the current Volunteers have been re-deployed to assist in the re-introduction of patient visiting by an interim booking service, based at Rotherham Community Health Centre (RCHC).

**How was progress monitored and reported?**

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

**What further actions need to be undertaken?**

There are no further actions until the service can recommence and recruitment can take place.

### 3.1.3 Additional information about how we provide care

#### Friends and Family Test

There were significant changes introduced to the FFT process last year by NHS England, the main one being that there are no restrictions upon the time scale when people can give their feedback. This was previously required within 48 hours of the care episode, or of discharge and for maternity there were 4 ‘touch points’ when feedback was to be sought. This has all been removed from the national guidance, as well as the percentage target for the response rates giving the freedom to request feedback at any point in the patient’s pathway and focusing on the qualitative nature of the feedback not the quantitate.

On the 30 March 2020 due to the COVID-19 pandemic, NHS England and NHSI advised that in order to reduce the burden upon Trusts and release staff capacity to manage patient care, they were temporarily suspending the requirement to participate and submit FFT data until further notice. Therefore, there is no data to add.

In September 2020 NHS England and NHSI, advised all acute and community providers that they should resume collecting and submitting monthly FFT data from 1 December 2020. The first month for collection will be December’s data, submitted in early January. With the national performance data published in February 2021.

NHS England have not specified how we are to collect the responses i.e. in paper, digital or by other methods. Therefore, within the Trust we have introduced a new in house electronic survey app that all patients can complete online or via mobile phone. This is being developed and introduced by the Data Informatics Team, as well as the paper feedback forms. A new report and performance dashboard has also been created.

This new reporting dashboard will also be used in conjunction with patient demographics to enhance our analysis of the results received; to ensure that we have the best understanding of the findings and make the most use of the completed survey, to change and improve services for future patient experience.

#### Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and continues to have zero occurrences within inpatient wards, despite additional challenges presented by the pandemic. In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit (HDU) level 2 care to base wards. Internal standards require reporting at 4 hours and 6 hours; an external report is made at 8 hours. There have been no instances requiring an external report in the last 12 months.

There is also an internal process for monitoring and reporting ‘pass by’ breaches of mixed sex accommodation. In 2020/21 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 which was paused due to the pandemic.

**Never Events**

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

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

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

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

During 2020/21 the Trust has reported four Never Events within the following categories:

- Retained swab post vaginal delivery- 1 event
- Wrong site surgery- incorrect skin lesion removed- 1 event

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

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

No formal PLACE information is available for reporting/comparisons across all Trusts for the year 2020-2021; the assessments were cancelled by NHSI/England due to the current COVID-19 pandemic.

**The National CQC Patient Experience Surveys for Acute Trusts**

During the year 2020/21, in light of the rapidly escalating COVID-19 pandemic situation, the CQC declared at the beginning of the financial year, April 2020 – March 2021, that all of the four acute Trust Patient Experience surveys due to be conducted, would be significantly deferred or cancelled altogether. The surveys affected were: In-patients, UECC, Children and Young People and Maternity Services, in the case of Maternity the 2020 Survey was completely cancelled.

From the survey activity of the preceding year one set of survey results was still awaited in 2020 and this was for the Inpatient Survey (IP). The Trust’s Inpatient feedback results were published in July 2020. No other survey findings have been reported in this financial year.

The Trust’s Inpatient survey results are drawn from the 12 aspects of a patient’s experience, differentiating emergency admissions from elective patients for some questions. The context of this survey mirrors the 5 key questions which the CQC utilise, for all of their NHS Trust assessments. The most recent Inpatient data is from the survey conducted between

August 2019 and January 2020. CQC surveyed 1250 of the Trust's patients and 491 responded on their experience. Full results are available later in this report.

The CQC published the 2019 patient survey results on 2nd July 2020 and overall the Trust's findings showed that the performance for inpatient experience was average across all 12 sections. The CQC uses the term 'about the same' when reporting these areas, to show that this Trust is '*performing about the same for that particular question as most other trusts that took part in the survey'*. Within each of the 12 aspects of a patient's experience, there are additional sets of questions, which can be further reviewed to see what has led to the final score and any areas of particular note, e.g. where this Trust's patients reported a *better or worse* experience than all other Trusts.

Within the section on The Hospital and The Ward experience, this Trust was about the same for 10 out of 12 questions, but underperformed on *noise from staff at night* and *being able to take own medications in hospital*. In the section on Doctors, this Trust performance was *worse* for doctors answering questions in a way that patients could understand. In the section on Nurses, patients reported a worse experience on *feeling there were enough nurses to care for them.* For Care and Treatment, one question received a worse score, *being given enough information on condition or treatment. For* Operations and Procedure, the question on being told *how the operation/procedure had gone in an understandable way* received a lower score. The Leaving Hospital section highlighted 3 out of 8 areas where patients gave more negative feedback: *advice on discharge, purpose of medications* and *advice on taking medications.*

Overall performance showed that out of the total of 62 questions within the survey, the Trust received a below average result for 9 individual questions. However the action planning resulting from this survey was also based upon the more longitudinal view of the Trust's performance over the 3 prior years, to determine ongoing areas of weakness or new concerns. This resulted in an action plan which also considered all the marginal scores and potential areas for Trust wide improvement across all of the bed-holding Divisions. In turn each Division was also required to produce their own additional actions, where the particular question was likely to be most influenced with their service. The monitoring of the performance against these actions is undertaken at the Patient Experience Group and within the individual Divisions. The Trust's inpatients, who used services in November 2020, have already been surveyed again using almost the same question bank; these results will be published later than usual in November 2021.

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

**UECC**: the patients who received care in September 2020 are still being surveyed on their experiences and the results will be published in September 2021.

**Children and Young People**: the young people and parents of children who used Trust services in December - January 2021, will be surveyed on their experiences over March to May 2021. The findings are expected to be published in November 2021.

**Maternity**: the patients who used the service in January - February 2021 will be surveyed in May to August 2021 and the results published in January 2022.

**Inpatients**: the patients who received Trust care in November 2020 are being currently surveyed on their experience and the findings will be reported in November 2021.

Findings from all of these surveys are triangulated against other sources of patient feedback including concerns and complaints, the FFT, Governors' Surgeries and feedback from local and national advocacy services and other websites. Action plans are created for each of the national surveys following publication and the results are monitored quarterly through the Patient Experience Group. A summary is included in the quarterly Patient Experience report which is shared with the Clinical Governance Committee and Quality Committee.

**Healthcare Associated Infections**

The Chief Nurse is the Director of Infection Prevention and Control (DIPC) and published the annual infection prevention and control report in June 2019. The 2019/20 annual report was not possible due to the impact of COVID management, a combined 19/20 20/21 report will be completed.

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 reported to the Clinical Governance Committee until Jan 2021 and then to Quality Committee from Feb 2021.

The substantive consultant microbiologist left the Trust in July 2019; Locum Consultant Microbiologists have, alongside the Associate Specialist in Microbiology, covered the role from July. There are two posts advertised for substantive Consultant Medical Microbiologists. Cross cover Microbiologist support continues with Barnsley.

Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C-difficile) are both alert organisms subject to annual improvement targets. The MRSA bacteraemia target for 2019/20 was 'zero preventable cases' which was not achieved due to one case in October 2019 in which no lapse in quality of care was identified. There have been zero cases in 20/21

The C-difficile trajectory was 11 cases to year-end which has been breached, with 20 cases to date. An increase in cases of approximately 65% was anticipated across all providers due to a change in the Public Health England (PHE) reporting requirements. Hospital acquired cases were from day 3 onwards prior to April 2019, when it reduced to day 2 onwards with date of admission classed as day 1. Any case where the patient had been in the hospital within the 4 weeks prior to the sample is also classed as hospital acquired.

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

(Source: Trust Winpath System)

| Number of reported cases of C.Diff | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Target not received** | **YTD** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| 2020/21 | 21 | 1 | 1 | 2 | 2 | 1 | 1 | 4 | 3 | 4 | 2 | 0 | 0 |

(Source: Trust Winpath System)

All cases of hospital acquired Clostridium difficile (C. difficile) are under review by the Infection Prevention and Control (IPC) team. Shared ownership of completion of the RCA investigation with the clinical divisions has greatly been challenged due to the impact on COVID-19 management. A comparison with 19/20 needs to be taken with caution as there have been periods of different capacity within the hospital, increased remote GP assessment/prescribing and an increase in antibiotics for respiratory infection.

The post-infection review (PIR) process done jointly with the Clinical Commissioning Group (CCG) Lead IPC Nurse has been on hold due to COVID-19 management and is hoped to be picked up retrospectively as IPC capacity allows.

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 although this had been anticipated for 20/21.

From February 2020 onwards there has been the challenge of COVID-19 pandemic management, which continues with high in-patient capacity, cohorted isolation wards and reduced staffing levels. Point of Care (POC) testing for COVID has now commenced in the UECC and additional units will be used across the hospital as soon as the IPC team can complete staff training as this is live swab training to avoid kit wastage.

Staff vaccination for COVID is in progress by the “Flu crew” team that also completed staff Influenza vaccination for this year’s season under the leadership of the Head of Engagement.

Influenza cases have remained low across the region with no cases in the hospital during the winter months to date.

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

There have been additional challenges during the year of infections with potential public health impact; this has included Serratia marcescens in critical care and TB.

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

## 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** | **2019-20** | **2020-21** | |
|---|---|---|---|---|---|---|
| Falls | 611 | 675 | 668 | 689 | 671 | |
| Bed Days | 144,505 | 145,153 | 132,557 | 158,207 | 118,098 | 🡐 To the end of December |
| **Falls Rate per 1000 Bed Days** | **4.23** | **4.65** | **5.04** | **4.36** | **5.68** | |

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

The Trust continues to participate in the mandatory National Inpatient Falls Survey, the results of which are used to inform the Falls group action plan, which is continually being amended to reflect the most recent falls management initiatives. The Falls Group has also commenced a yearly audit against NICE Quality Standard 86 (Falls in Older People) – (quality statements 4–6) (NICE, 2017) which identify how a patient is managed following a fall and has produced positive results for 2019/20 which has helped identify areas of weakness and improve the care of these vulnerable patients. The Trust has reviewed its current falls assessment documents and released them as electronic forms, which include mandatory fields such as completion of Lying and Standing blood pressure. This will not only improve patient care but facilitate completion of national Commissioning for Quality and Innovation (CQUIN) targets. The Trust's Falls policy has been reviewed to reflect all changes to the way falls are managed and has been uploaded on the Patient Safety Page of the HUB.

## Duty of Candour

'Duty of Candour' requirements are set out in the Health and Social Care Act Regulation 20: Duty of Candour (Health and Social Care Act (2008)). The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust (Report of the Mid Staffordshire NHS Foundation Trust Enquiry, 2013), which recommended that a statutory duty of candour be introduced for

health and care providers, to ensure a more honest and open culture in the NHS. From October 2014 there was a statutory requirement for Trusts to implement the Duty of Candour requirements.

An audit undertaken in 2019 identified 90% compliance regarding the Duty of Candour discussion being undertaken and recorded in the patient's records. Recommendations have now been implemented following the audit, including establishing consistent recording of information within central electronic systems, reviewing letter templates, and ensuring that letters include reference to the TRFT Duty of Candour policy.

To support this, the Duty of Candour policy is now complete and available via the hub.

## 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 Executive 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 remains committed to ensuring Safeguarding is an absolute priority. The Chief Nurse is the Trust's Executive Lead for Safeguarding. The Chief Nurse is supported by the Deputy Chief Nurse and the Head of Safeguarding, who manages the Safeguarding Team.

The Safeguarding Team provide specialist input and advice regarding Adult and Children's Safeguarding. The Team also includes a Lead Nurse for Learning Disabilities and a Lead Nurse (Child Death Review).

In relation to adult vulnerability and adults at risk, the work and support by the team includes the work streams of Domestic Abuse, Multi-agency public protection arrangements (MAPPA), Mental Health Act, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The year has seen a continued increase in activity across all work streams with sustained challenges posed by the embedding of the Care Act 2014, the Mental Capacity Act and the Supreme Court 2013 judgement with regards to the Deprivation of Liberty Safeguards.

The team also includes one Paediatric Liaison Nurse who provides specialist input and support in relation to children's safeguarding within the Emergency Department, the Children's Ward and Community Services, including General Practitioners.

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

- A Trust Safeguarding Nurse Advisor is based in the Multi-Agency Safeguarding Hub (MASH) at Riverside – 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 Safeguarding Children Partnership (RSCP), the Rotherham Safeguarding Adult Board (RSAB) and the Health and Wellbeing Board. In addition, robust governance structures are in place to ensure The Trust has representation on a large number of external Safeguarding strategic and operational groups. This ensures partnership working is embedded across the wider Rotherham Health and Social Care economies.

The Adult Safeguarding Team continues to work in partnership with the Rotherham Metropolitan Borough Council (RMBC) to provide 'health' input for safeguarding investigations. This involves offering support to the RMBC Adult Social Care teams around investigations and preparations for Outcomes Meetings – even where there is no Trust involvement. 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.

Following last year's review of competency levels and Mandatory and Statutory Training (MaST) requirements, there have been regular meetings with the Learning and Development Team to ensure that new starters are allocated the appropriate requirements in line with the Safeguarding Adults and Safeguarding Children's intercollegiate documents. Training compliance is monitored via Safeguarding Key Performance Indicators and reviewed at the Safeguarding Operational Group reporting to the Strategic Safeguarding Group.

The recording of training on ESR is overseen by the Learning and Development Team. A variety of alternative training media has been developed during the last year in response to COVID working arrangements. Face-to-face training has been reduced and is only provided for specific courses, which do not lend themselves to virtual delivery. Other e-Learning has

been developed, with voice-over attached, to support our staff in achieving their MaST requirements. This offers staff a blended approach to learning.

On-going training and supervision is provided to support practice in embedding the implementation of the MCA and DoLS procedures. The MCA has been amended and will introduce the Liberty Protection Safeguards (LPS), which will replace the DoLS. There is a requirement set for this to be fully implemented by March 2022. This is a significant change for The Trust, in that the arrangements for authorisation of LPS for Trust patients will move from the Local Authority to sit with Trust. The Trust is currently working with partner agencies to develop a structure to support this.

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

The Trust's Safeguarding Vulnerable Service Users Strategy, alongside our strategies for working with those with poor mental health and those with a learning disability, are embedded in the organisation. Key performance indicators, against which safeguarding performance is monitored, are in place and reported, via the Strategic Safeguarding Group, to the Clinical Governance Committee. In addition, a number of safeguarding standards are in place and monitored externally via NHS Rotherham Clinical Commissioning Group (CCG).

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

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 Partnership and Local Safeguarding Adult Boards Sub Groups.

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

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

The Care Quality Commission's (CQC) targeted inspection in 2019 resulted in a comprehensive improvement plan. This has been progressed with the engagement of all divisions. The safeguarding safety huddles, now a regular feature within the children's pathway, a new policy for managing 16 and 17 year olds who are cared for on an adult ward, stronger governance arrangements and increased engagement in improving MaST compliance rates are a few of the improvements achieved.

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:

- Work closely with the Cancer Nurse Specialist teams to provide a seamless service for all patients under the care of the hospital.
- 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).
- Achieve the Macmillan Quality Volunteer Standard (MQVS)
- Provide HOPE (Helping People Overcome Problems Effectively) courses to people affected by cancer.

During the 2020 pandemic, we were able to continue to provide online, telephone and occasionally socially distanced face-to-face support to people affected by cancer. Throughout this very difficult year (January 2020-December 2020), we have prevented:

- 51 GP appointments.
- 44 Consultant contacts.
- 332 Nurse Specialist contacts.
- 93 other contacts, such as District Nursing and Social Care.

The cost of the above to the NHS is approximately £48,648 based on 2017-2018 figures from PSSRU and national scheduling costs for 2020.

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.

Prior to COVID 'Drop in Centres' were 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 has recruited and retained 10 volunteers who also 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 outstanding volunteer category in the Trust Proud awards, whilst the Macmillan Information Managers were nominated in the Public Recognition Category. This year the service was also chosen to be included in a Macmillan Advert campaign, which is currently being shown on national TV.

**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;

**Dementia & Delirium Screening**

The Dementia and Delirium screening tool is undertaken electronically by our Meditech system and this utilises the Find, Assess, Investigate and refer tool. This tool is part of the inpatients assessment document across the organisation, this is a mandatory screening tool for all patients and current compliance is 93.5% across the organisation. There continues to be a focus on the screening for our patients.

**Hospital Accreditation and Frailty Service**

Unfortunately due to the impact of COVID-19 we have seen a reduced Frailty Nurse Service, however the team have continued to provide a safe, effective, holistic service to our frail, elderly patients, with a continued reduction in their length of stay, setting an excellent standard from which to improve the service further. As part of the National Getting it Right First Time Programme (GIRFT) the organisation is currently reviewing the Frailty pathway across the organisation, to further develop and enhance the service we provide to our patients in a multi professional way.

**Dementia, Delirium & Person-Centred Training**

Person-Centred Study days' cover end-of-life, mandatory tier 2 dementia training, delirium, falls and person-centred care was delivered in 2019/20, based on feedback from colleagues the newly designed Trust Essential Nursing Training (TENT) introduced in 2021 includes education and training in all aspects of dementia, delirium and frailty.

**Dementia Group**

The dementia, delirium and person-centred care group is currently being reviewed and restructured to encourage attendance and ensure its ongoing effectiveness. Since COVID-19 there have not been any Dementia Café Sessions, when this is safe to do so these will be introduced in the organisation.

## Learning Disability

The Rotherham NHS Foundation Trust is committed to improving the experience for people who have learning disabilities/and or Autism. The Trust has a Lead Nurse in Learning Disabilities and Autism and currently two trainee Nursing Associates specialising in Learning Disabilities. These staff focus on all aspects of the patient care pathway and experience within the Trust, whether people attend as an outpatient, planned inpatient e.g. for surgery, or are admitted through the Emergency Department. The team also has a role to play in the prevention of re-admissions to hospital; visiting patients in the community to assess their needs whilst liaising with Community Services to prevent admission to hospital where possible. The Learning Disability and/or Autism team ensure that the Trust are making reasonable adjustments for people with additional needs by undertaking the following:

- Using an electronic flagging system to identify that a person has a learning disability from their medical records. This information then populates a live database for the Learning Disability team to access.
- Championing the use of the 'Traffic Light System', which is a person-centred assessment tool for people with Learning Disabilities and Autism, which helps staff to learn about how to care appropriately for each individual. The 'Traffic Light System' is also used through magnet symbols on patient headboards, ward boards and medical notes.
- Providing bespoke training regarding learning disabilities and Autism in conjunction with the local advocacy organisation. This is delivered where possible by experts by experience.
- Continuing to build links with established organisations to support learning, such as Speak Up, CHANGE organisation and Health Education England.
- Facilitating a programme of mentorship for Learning Disability Nurse/Generic Social Work Students at Sheffield Hallam University, providing shadowing and training opportunities to the Trust's Trainee Nurse Associates.
- Providing bespoke training for the Undergraduate Adult Branch Nurses at Sheffield University.
- Facilitating a Learning Disability/Autism Patient Experience Sub Group. This has members from Community Learning Disability Teams, care providers for people with Learning Disability, such as Mencap, Voyage and Exemplar Health care, the Local Authority and Healthwatch. This enables the Trust to learn from patient experience in order to improve practice/systems and pathways.
- Working closely with the Volunteer Coordinator to mentor and support volunteers in the Trust who have a Learning Disability/Autism.
- Ongoing work with Equality and Diversity Leads around helping Trust staff members with neuro-diverse needs; helping to have a culture of acceptance and transparency.
- Working closely with colleagues within the Trust's Community Teams, such as Community Matrons, Fast Response and District Nurses, to ensure community care plans are in place for people with a Learning Disability and/or Autism, to minimise frequent admissions to hospital services.
- Working with complex care colleagues around the transition of young people from child to adult services within the Trust. This transition work involves acute colleagues in Sheffield Teaching Hospitals and the Sheffield Children's Hospital.
- Implementing relevant Learning Disability and Autism strategies within the Trust and working in conjunction with partnership organisations borough wide.
- Continued work around the implementation of the Accessible Information Standard with the Trust's Equality and Diversity Leads.

- Championing and using the Learning Disability Mortality Review programme (LeDeR) process, in conjunction with the Clinical Commissioning Group (CCG) leads. This process is across agencies to learn from the deaths of people with a Learning Disability.
- Ensuring that reasonable adjustments are made to Trust care pathways.
- Championing the use of the Mental Capacity Act (MCA), assisting with best interest processes and the use of Deprivation of Liberty Standards (DoLS) where appropriate.
- Helping to reduce the length of stay in hospital by working with Medical Professionals, Allied Health Professionals and Social Care Professionals (on average a person with a learning disability and or Autism, may have a longer than average inpatient stay compared to the general population).

**Future plans:**

- To work with the CCG and Local Authority to look at an electronic flagging system to identify people with Autism with an electronic flag on their medical records (with obtained patient consent). Or, to work around how these reasonable adjustments can be made for people with Autism.
- To expand the use of Nurse Associates within the Learning Disability Team working throughout the Trust.
- Looking at different ways of working and increasing the capacity of the Learning Disability team in order to more effectively meet the needs of people with a Learning Disability and/or Autism within the Trust.
- Explore further Learning Disability specific roles with Health Education England.
- Continue to encourage the role of the Learning Disability Champion on all wards and departments.
- To work with the Trust's Equality and Diversity Steering Group to look at how the Trust can actively encourage people with Learning Disabilities and/or Autism to take on voluntary or paid roles at the Trust.
- Focusing on specific care planning tools for people with Learning disabilities and/or Autism, to help improve individual patient pathways and the responsiveness of the Trust.
- The Lead Learning Disability Nurse will look at reducing unnecessary admissions to hospital for people with Learning Disability utilising their non-medical prescribing qualification and working with local GPs and Trust Community Practitioners.
- To engage the Trust in the Autism accreditation process, through the National Autistic Society.
- Further work around reducing re-admissions to hospital and increased support from the Learning Disability and/or Autism team. Liaising with the Trust's Home First Lead, local GPs and Community Services.
- Continued work around the Learning Disability Mortality Review (LeDeR) programme and how this works within the Trust's Structured judgement review and Death processes.

**Engaging with Colleagues**

The Together We Can© (TWC) programmes have not been driven forward, this was discussed at the Board of Directors as these formed part of the Operational Plan and ceased as part of COVID-19 prioritisation.

| | 2020/21 | | 2019/20 | | 2018/19 | |
|---|---|---|---|---|---|---|
| **Theme** | **Trust** | **Benchmark** | **Trust** | **Benchmark** | **Trust** | **Benchmark** |
| Equality, diversity & inclusion | 9.3 | 9.1 | 9.2 | 9.2 | 9.2 | 9.2 |
| Health & wellbeing | 6.1 | 6.1 | 5.8 | 6.0 | 5.8 | 5.9 |
| Immediate managers † | 7.0 | 6.8 | 6.8 | 6.9 | 6.7 | 6.8 |
| Morale | 6.3 | 6.2 | 6.0 | 6.2 | 5.8 | 6.2 |
| Quality of care | 7.4 | 7.5 | 7.2 | 7.5 | 7.2 | 7.4 |
| Safe environment – bullying & harassment | 8.4 | 8.1 | 8.2 | 8.2 | 8.2 | 8.1 |
| Safe environment - Violence | 9.5 | 9.5 | 9.5 | 9.5 | 9.5 | 9.5 |
| Safety culture | 6.7 | 6.8 | 6.6 | 6.8 | 6.5 | 6.7 |
| Staff engagement | 6.9 | 7.0 | 6.7 | 7.1 | 6.6 | 7.0 |
| Team working | 6.6 | 6.5 | 6.5 | 6.7 | n/a | n/a |

**National Staff Survey 2020**

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The response rate to the 2020/21 survey among trust staff was 52% (2019/20: 48%). Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below.

The results from the NSS 2020 reflect the good progress which the Trust has made during a very challenging period for the whole of the NHS. The Trust returned statistically significant improvements in 8 of the 10 key indicator themes compared to their performance in the previous year; with similar improvements made against benchmark organisations - overall TRFT was the third most improved Trust nationally.

**NHS Response Rate**

The Trust changed its approach for the distribution of staff survey during 2020 and achieved its highest response rate in the last 5 years (52.2%).

| | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Best | 76.3% | 72.6% | 71.6% | 76.0% | 79.8% |
| TRFT | 40.2% | 41.5% | 38.5% | 48.0% | 52.2% |
| Median | 42.3% | 43.9% | 43.6% | 46.9% | 45.4% |
| Worst | 28.8% | 27.3% | 24.6% | 27.2% | 28.1% |

**Areas of improvement**

Our staff have rated the Trust as good as, or better than, most Trusts for:
- Morale
- Team working
- Equality Diversity and Inclusion
- Immediate managers
- Safe environment from bullying and harassment
- Safe environment from violence
- Health and wellbeing

**Key areas for improvement and future priorities**

The key areas where we aspire to do better and which will be a focus for all our colleagues during 2021/22 will be:

- Care of patients is our top priority
- Reporting experiences of physical violence
- Staffing levels
- Avoid coming to work when unwell

**Performance against priority areas**

The Trust improved against the key priority areas they identified last year, with key improvements being made in relation to:

- Staff would recommend the Trust as a place to work
- If a friend or relative needed treatment, staff would be happy with the standard of care we provide
- Staff have adequate materials, supplies and equipment to do their job
- There has been a decrease in the number of staff planning to leave or likely to look for a job at another organisation

**Monitoring arrangements - future priorities and how they will be measured**

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

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

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

**Staff Friends and Family Test**

Due to the coronavirus pandemic, Trusts were asked to temporarily suspend the Staff Friends and Family Test therefore there was no data submission or publication of results. There has been no indication as to when the Staff Friends and Family Test will be re-launched.

**Freedom to Speak up (FTSU) Guardians**

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

Since the appointment of the National Guardian, Dr Henrietta Hughes, there has been increased direction from the National Office regarding the role of FTSUG. As a result of COVID the regional network now meets virtually every two months and the annually national event was also held virtually; our FTSUG has been supported to attend. The FTSUG month In October 2020 aimed to raise the profile of FTSUGs across the Trust and saw several events including the lighting up of the UECC with the new national Guardian logo and the #speakuptome. The Rotherham Foundation Trust were also the only trust in the country that provided their guardians with facemasks sporting the logos. The Rotherham Foundation Trust remains one of the only trusts in the region to have completed the new FTSU self –assessment tool and adopt the new FTSU training as a Mast subject with a 97.93 % compliance rating.

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

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

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

To date in 2020/21, the FTSUGs have received 34 concerns. The concerns have related to attitudes and behaviour (18), with colleagues being directed to HR or union support for further advice.  Of the remainder, 6 to policy and procedures, 5 to Patient safety, 2 to performance and capability and 3 to staffing levels. It is anticipated that the number of concerns will show a year on year increase which may be linked to the increased time dedicated to the role and staff experience from those who have accessed the service. It may also be due to Rotherham Foundation Trust being one of the only Trusts nationally to have FTSU as a mandatory training subject; this training ensures staff are aware of FTSU and what to do if they suffer a detriment and how to escalate it, if it does indeed occur. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors.

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

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

On 27 November 2020, The Trust's annual Proud Awards took place to celebrate dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

More than 420 nominations were received for the 2020 Proud Awards. Usually held at Magna, the 2020 ceremony was held virtually due to the COVID-19 pandemic. The event, hosted live by Heart Yorkshire's Dixie and streamed on YouTube, consisted of pre-recorded 'Thank You' messages and entertainment alongside the awards. The award categories were announced by members of the Executive Team, Chairman, Lead Governor and local

health reporter in pre-recorded segments. More than 2,700 people have watched the awards, with around 400 colleagues and partner organisations watching it live.

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

The 2020 winners are:

**Values Award**
Ward A2 – Medicine

**Outstanding Volunteer Award**
Patient Communication and Property Facilitators

**Apprentice of the Year Award**
Samantha Horton – Medical Physics

**Inspiring Leader Award**
Talhat Mughal – Chaplaincy

**Diversity and Inclusion Award**
Jennifer Turedi – Learning Disabilities

**Safe and Sound Award**
Integrated Sexual Health

**Unsung Hero Award**
Damian Staples – Communications

**Innovation and Improvement Award**
Speech and Language Therapy

**Team of the Year Award**
Critical Care and Anaesthetics

**Public Recognition Award**
Midwifery

**Governors' Award for Outstanding Colleagues**
Ann Kerrane – Infection Prevention and Control

**Interim Chief Executive's Award**
Community Nursing Team

**Chairman's Award**
Infection Prevention and Control

### Implementing the priority clinical standards for 7-day hospital services

The 7-day assessment was paused nationally. The last audit was completed in 2019. There is no intention to continue with the BAF returns in the format previously used.

### 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 9%; the equivalent of 12 posts out of an establishment of 152 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 Advanced Nurse Practitioner (ANP) for an F1 gap. Rota design also plays an important part to ensure optimum cover is provided; any change to rotas fully involves the junior doctors in the design of the rota and their agreement to undertake the revised work pattern. The Trust has also adopted Good Rostering Guidance, produced jointly by NHS Employers and the BMA in May 2018, along with adherence with contractual requirements of the 2016 Doctors in Training contract.

### External Agency Visits, Inspections or Accreditations

During 2020/21 there have been 11 external agency visits. Details of these visits are included in Appendix 3 (page 128). Action plans are developed, where required, and monitored through the Clinical Governance Committee.

### 3.2: Performance against relevant indicators

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

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

For the purposes of this Report, only the indicators that appear on both the lists above, are required. For The Rotherham NHS Foundation Trust therefore, the six 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 - Incomplete | YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target >=92% | | | | | | | | | | | | | |
| 2019/20 | 91.60% | 92.6% | 92.6% | 92.9% | 92.6% | 92.0% | 92.2% | 92.1% | 92.2% | 91.6% | 91.0% | 91.0% | 86.4% |
| 2020/21 | 65.20% | 77.1% | 67.1% | 53.4% | 46.8% | 53.3% | 61.5% | 66.4% | 68.8% | 69.2% | 70.2% | 72.4% | 76.6% |

(Source: Meditech and SystmOne)

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.

Given the COVID-19 pandemic and significant reduction in activity within the NHS throughout this period, performance against the Referral to Treatment time standard declined dramatically nationally in 2020/21, and the Trust experienced a similar trend, with the end of year performance at 76.6%. This was, however, an almost 30 percentage point improvement on the position recorded in July, which reflected a more than 57% reduction in the number of patients waiting more than 18 weeks for treatment.

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

When the four-hour target was introduced in 2004 it helped to significantly reduce the lengthy waits faced by many patients in emergency departments. At that time the four-hour

standard was the right measure, to drive and support improvement in patient flow within acute hospitals. Since the introduction of the A&E access standard 15 years ago, there has been major improvements embedded in the system, and changes in how urgent and emergency care is delivered meant that, increasingly, this single standard is no longer on its own driving the right improvement.

As a result, the NHS National Medical Director was asked by the Prime Minister in June 2018 to review the core set of NHS access standards which included the four hour standard, and recommend any required updates and improvements to ensure that NHS standards, promote safety and outcomes, drive improvements in patients' experience, are clinically meaningful, accurate and practically achievable, ensure the sickest and most urgent patients are given priority, ensure patients get the right service in the right place, are simple and easy to understand for patients and the public and will not worsen inequalities.

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

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

The new urgent and emergency care standards aim to measure:

- Time to Initial Assessment in A&E
- Time to be seen by a Clinician
- Mean Total Wait in A&E
- Mean time in department for admitted patients
- Mean time in department for non-admitted patients

ED New Indicators - Time to Initial Assessment in A+E

| Target | YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | **16** | 12 | 12 | 15 | 14 | 15 | 15 | 15 | 21 | 24 | 18 | 18 | 17 |
| 2020/21 | **16** | 14 | 12 | 12 | 13 | 15 | 16 | 18 | 16 | 20 | 20 | 17 | 20 |

ED New Indicators- Time to be seen by a Clinician

| Target | YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | **96** | 100 | 87 | 96 | 104 | 87 | 87 | 83 | 106 | 118 | 100 | 98 | 89 |
| 2020/21 | **87** | 38 | 42 | 56 | 65 | 93 | 102 | 95 | 87 | 115 | 92 | 89 | 116 |

ED New Indicators - Mean Total Wait in A+E

| Target | YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | **221** | 197 | 189 | 205 | 218 | 207 | 206 | 211 | 236 | 258 | 250 | 252 | 230 |
| 2020/21 | **205** | 159 | 130 | 148 | 157 | 194 | 208 | 231 | 241 | 259 | 259 | 228 | 243 |

ED New Indicators - Mean Total Wait in A+E - Admitted

| Target | YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | **391** | 289 | 317 | 351 | 382 | 369 | 363 | 366 | 419 | 470 | 477 | 476 | 373 |
| 2020/21 | **343** | 234 | 248 | 269 | 263 | 307 | 318 | 379 | 417 | 441 | 439 | 351 | 376 |

ED New Indicators - Mean Total Wait in A+E Non-Admitted

| Target | YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | **178** | 170 | 158 | 171 | 182 | 165 | 169 | 173 | 192 | 201 | 186 | 189 | 186 |
| 2020/21 | **180** | 147 | 125 | 142 | 149 | 181 | 191 | 192 | 187 | 207 | 197 | 199 | 212 |

April 2021 has seen the introduction of a new standard ‘Clinically Ready to Proceed’ to the pilot sites. The Clinically Ready to Proceed is when the Emergency Department (ED) Clinician has completed all necessary clinical patient treatment and all investigations have been initiated (not necessarily complete), the patient is therefore deemed to be clinically stable for Discharge/Admit/Transfer from the emergency department.

## Cancer National Waiting Times

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

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

(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 days classic.'

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

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

Performance Against Targets

| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| 62 day | No | No | No | No |
| Screening | No | No | No | No |

Screening:

Achieving screening targets can be challenging due to the small numbers of patients within the screening programme. We are striving to improve year on year, however due to low numbers this can be challenging. We have introduced working to 7 days for first seen appointment, to try and achieve this target additional clinics have been put on to reduce waiting times.

62 Day Cancer Waiting times:

The overall size of the 62 day Patient Tracking List (PTL) was significantly high in relation to the referrals received into the Trust. The piece of work cleansing the PTL was undertaken by cancer services and the divisions in the first quarter of the year. Performance deterioration was expected as a result of this cleansing exercise. The cleansing process identified a large cohort of patients who had remained on the PTL longer into their pathways and who had already breached. Working closely with our clinical colleagues, patients were treated in date order. During the cleansing process, pathways with avoidable delays were

highlighted. Working with the Divisions and our clinical colleagues, clear clinical pathways were agreed and signed off to ensure early diagnosis and treatment within shorter timeframes was achievable.

Performance as we expected deteriorated, which has been attributed to the following reasons:

- PTL numbers over 1000 patients.
- Lack of understanding throughout the Trust on Cancer Targets.
- A significant number of patients already breached.
- A significant number of patients inappropriately left on the pathway.

Changes implemented so far, to try to improve performance:

- Manageable PTL Size against referrals received.
- Standardized training for Cancer Services staff to allow for resilience and cross cover.
- Clinical specific pathways developed and signed off.
- First Appointment to 7 days, including creating additional capacity.
- Engagement with the divisions.
- Introduction of new PTL meetings which were patient focused.
- Twice weekly PTL meetings established with divisional representation for each speciality.
- Cancer Recovery meetings established bi-weekly to monitor improvements and escalate delays in pathways.
- Working on MDT Professional standards to standardise processes.

**Delayed Transfer of Care**

National reporting against Delayed Transfers of Care (DTOCs) was suspended in March 2020 as part of the COVID-19 response. National guidance indicates there are no plans to return to this reporting arrangement at present, and systems should not be counting, recording or charging local authorities under the DTOC regime.

As part of the pandemic response, new situation reporting processes were put in place in March 2020, which incorporated reporting on the discharge status of all patients in hospital. These arrangements identify the numbers of people leaving hospital and where they are discharged to, and the reasons why people continue to remain in hospital.

Further discharge guidance was published nationally in February 2021 in the form of ‘Hospital discharge service: policy and operating model”. This asked providers to continue to report through the daily Situation Reporting arrangements. The guidance states that nationally they are working on improving situation reporting and will notify providers of new requirements as and when appropriate. They are also exploring an automated system of collection of this data and, subject to further engagement with providers and other stakeholders, they hope to roll this out in 2021.

### 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** |
| 2019/20 | **36** | 0 | 2 | 3 | 1 | 3 | 3 | 4 | 3 | 2 | 8 | 5 | 2 |
| 2020/21 | **22** | 1 | 1 | 2 | 2 | 1 | 1 | 4 | 3 | 4 | 2 | 0 | 1 |

(Source: Trust Winpath System)

Due to the changes in the Public Health England (PHE) reporting system for C.Difficile, the data is not comparable with the numbers pre 2019/20.

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

No National trajectory was received for 2020/21 and to date has not been received for 2021/22

All cases of C.difficile in 2020/21 have been reviewed in terms of ribotype and time/place and no cross infection occurred.

### National and local priorities and regulatory requirements:

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

| Measure | Department of Health | NHS Improvement | 2018/19 | | 2019/20 | | 2020/21 | |
|---|---|---|---|---|---|---|---|---|
| | | | *Year-end position | National Target | *Year-end position | National Target | end of Jan-21 | National Target |
| Number of cases - clostridium Difficile infection (C-difficile) | x | x | 8 | >26 | 35 | >26 | 21 | >26 |
| Number of cases - MRSA | x | x | 1 | 0 | 1 | 0 | 0 | 0 |
| Delayed transfers of care | x | x | 1.90% | 3.50% | 4.16% | 3.50% | not reported | 3.50% |
| Infant health & inequalities: breastfeeding initiation | x | x | 66.50% | 66% | 67.90% | 66% | 67.00% | 66% |
| Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool | x | x | 96.10% | 95% | 80.63% up to end Feb-20 | 95% | 90.20% | 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 | 84.40% | 90% | 72.70% | 90% | 63.60% | 90% |
| Non - Admitted | x | x | 95.40% | 95% | 93.60% | 95% | 83.10% | 95% |
| Incomplete | x | x | 95.01% | 92% | 91.60% | 92% | 63.40% | 92% |
| Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test | x | x | 0.49% | Less than 1% | 0.67% | Less than 1% | 49.70% | Less than 1% |
| Patients waiting less than 4 hours A&E | x | x | 85.65% | 95% | not reported | 95% | not reported | 95% |
| Cancelled operations for non-medical reasons | x | | 0.80% | 0.80% | 1.11% | 0.80% | 0.60% | 0.80% |
| Women who have seen a midwife by 12 weeks and 6 days of pregnancy | x | | 93.60% | 90% | 93.10% | 90% | 92.80% | 90% |
| Patients who spend at least 90% of their time on a stroke unit | x | | 81% | 80% | 59.3% | 80% | 25.61% (end Oct) | 80% |
| Higher risk TIA cases who are scanned and treated within 24 hours | x | | 70% | 60% | 63.5% | 60% | 75% (end Oct) | 60% |
| Elective Adult patients 18years and over readmitted to hospital within 28 days of discharge from hospital | x | | 1.53% | 6% | 1.96% | 6% | Require guidance on whether can change to 30 days? | 6% |
| Non Elective Adult patients 18 years and over readmitted to hospital within 28 days of discharge from hospital | x | | 12.45% | 12.50% | 10.52% | 12.50% | Require guidance on whether can change to 30 days? | 12.50% |
| Elective patients 0-17 years readmitted to hospital within 28 days of discharge from hospital | x | | 0.29% | 3% | 1.34% | 3% | Require guidance on whether can change to 30 days? | 3% |
| Non-Elective 0-17 years patients readmitted to hospital within 28 days of discharge from hospital | x | | 8.33% | 10.40% | 6.04% | 10.40% | Require guidance on whether can change to 30 days? | 10.40% |
| Ensuring patients have a positive experience of care (Pt survey overall score) | **CQC** | | 2019 Inpatient Survey CQC score – 87.3/120 | CQC Results descriptor against other Trusts 'About the Same' for all sections | Published 2 July 2020 | -- | 2020 Survey results to be published November 2021 | Awaited |
| **Patients waiting no more than 31 days for second or subsequent cancer treatment** | | | | | FINAL FIGURES | | Cancer data April to Nov 2020 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anti-Cancer Drug Treatments - Chemotherapy | x | | 100% | 98%* | 100% | 98%* | 100% | 98%* |
| Surgery | x | | 98.50% | 94%* | 95.50% | 94%* | 92.60% | 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 | | 94.90% | 90%* | 92.50% | 90%* | 75.00% | 90%* |
| Urgent GP Referral | x | | 81.30% | 85%* | 76.90% | 85%* | 62.70% | 85%* |
| **31-Day Wait For First Treatment (Diagnosis To Treatment)** | | | | | | | | |
| All cancers | x | | 97.60% | 96%* | 97.50% | 96%* | 94.80% | 96%* |
| **Two week wait from referral to date first seen** | | | | | | | | |
| All cancers (%) | x | | 93.80% | 93%* | 93.20% | 93%* | 92.20% | 93%* |
| For symptomatic breast patients (cancer not initially suspected) | x | | 85.70% | 93%* | 87.10% | 93%* | 72.80% | 93%* |
| SHMI | x | | 112.42 | 100 | | 100 | | 100 |

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

**Statement on behalf of the Council of Governors**

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

We believe that the report is an accurate and true reflection in terms of actions taken by the Trust during the year 2020/21 and indicates both the significance and the emphasis placed on safety, quality, patient experience and the clinical effectiveness by the Trust.

During the year, the Trust once again welcomed the Care Quality Commission who carried out inspections at the Trust. The Governors were concerned that enforcement action was taken against the Trust during the year. In July 2020, concerns were raised about the safeguarding children pathway and in November in relation to quality of health in the Acute Medical Unit and learning throughout the organisation.

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 give assurance that the concerns were and are being addressed.

The Governors have noted that the above inspections during 20/21 have not changed the ratings for the Trust from requires improvement.

The NHS year 2020/21 has been inextricably linked, in large part, to the COVID-19 pandemic. It was a very demanding year for the NHS and for this Trust in particular. As last year, the Council of Governors want to take this opportunity to again thank the NHS staff within the trust and the community, for their dedication, hard work, compassion and diligence in fighting this pandemic.

Colleagues have worked against immense pressure in what have occasionally been life threatening circumstances, to help patients in their battle against and recovery from COVID-19. The Governors salute all of the frontline staff and other key worker colleagues for their efforts in this unprecedented year.

The pandemic also had a detrimental effect on progress in elective surgery waiting times and also diagnostic testing.

As Governors stated last year, we have monitored closely the levels for mortality during 2020/21. There was improvement in both of the standard measures of mortality and we know that a great deal of effort is being made by the Medical Director and Medical Examiner, together with their teams, to bring the figures down to the target of 108.

The end of year financial position of the trust was much better than end of 2019/20. The two interim finance directors have both worked very hard, together with the Board and the Chairman, to ensure that the Trust is on a former financial footing. The Governors have been informed appropriately of the issues and the solutions put in place to remedy them.
The ICS are moving toward statutory status from April 2022. The Governors are assured that executive colleagues will collaborate effectively and do everything in their power to

ensure that Rotherham patients are well served in their healthcare provision as the system becomes operational.

Gavin Rimmer
Lead Governor, The Rotherham Foundation Trust.

**Statement from NHS Rotherham Clinical Commissioning Group**

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Rotherham
Clinical Commissioning Group

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Date: 7 May 2021

Anne Rolfe
Quality Governance, Compliance and Risk Manager
The Rotherham NHS Foundation Trust

Dear Anne

**TRFT Quality Account**

2020/21 has been an unprecedented year for the NHS and NHS Rotherham Clinical Commissioning Group commend The Rotherham NHS Foundation Trust (TRFT) for the continuous commitment that they have shown in delivering safe and effective care to patients throughout the year.

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

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

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. In November 2020, concerns were raised in relation to quality of health in the Acute Medical Unit and learning throughout the organisation. As a result, a Section 29A of the Health and Social Care Act warning notice was issued. Comprehensive action plans have been developed to address the inspection findings and TRFT provide robust updates through the joint Contract Quality meetings with RCCG. TRFT are currently under Enhanced Surveillance with the NHS England and Improvement expectation that they receive a higher level of support and oversight. RCCG recognises the hard work that has been put into not only developing the

plans but addressing the immediate concerns raised by the CQC and will continue to work in a supportive manner with TRFT as well as seeking assurance on delivery of the plan and identifying notable improvements.

During 2020/21 the Trust received two inspections/reviews by the Care Quality Commission. In July 2020, concerns were raised about the safeguarding children pathway. Immediate actions were undertaken in response to these concerns and an ongoing action plan was developed for each issue. It is evident that Safeguarding is an absolute priority for the Trust, and this has been evidenced by the level of focus in this area during 2020/21. The CCG's Deputy Chief Nurse/Designated Nurse Safeguarding and Looked After Children has been fully engaged in the review of the safeguarding action plans and has been impressed with their commitment to continually develop and learn. The level of transparency and commitment that TRFT has demonstrated has been well received by the Rotherham Safeguarding Adults Board (RSAB) and the Rotherham Safeguarding Children Partnership (RSCP). It is particularly noteworthy that TRFT now have a Non-Executive Director with safeguarding firmly within their portfolio further enhancing their level of scrutiny and commitment to safeguarding.

TRFT regularly monitor their safeguarding training to ensure that the Royal Colleges Intercollegiate competency framework is embedded into all areas of the Trust. TRFT can quickly identify areas that need additional support or enhanced surveillance to assure themselves and the inspectorate that safeguarding training is at the anticipated level. The recent publication of an Intercollegiate Document specifically to raise staff competency in supporting Looked After Children is being incorporated into the trusts training programme. The development of a bespoke Looked After Children team is proving to be an asset to the Trust with the quality and level of care delivered to this cohort of vulnerable children being well recognised locally and across the South Yorkshire and Bassetlaw network.

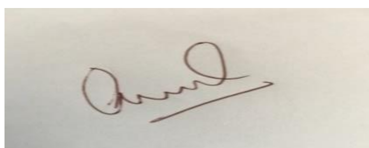
The reputation of the Trusts safeguarding team as an outward facing team looking to continually mature and improve working relationships is according to the CCGs Designated Nurse Safeguarding and Looked After Children an asset. The Trust exhibits their commitment to safeguarding being everyone's responsibility and continue to deliver on that expectation.

Despite one of the Trusts key quality priorities being to reduce HSMR and improve learning from deaths, in accordance with this Quality Account, the Trust's HSMR and SHMI are both currently high at 116 and 118 respectively (December 2019 data). This has been a concern for RCCG and the CQC during 2020/21 and RCCG continues to utilise the Contract Quality Meetings to gain assurance on the actions that the Trust are taking to reduce these levels. There is a clear focus on mortality within the Trust including the implementation of a monthly Trust Safe and Sound Mortality Group chaired by the Executive Medical Director which ensures that the relevant themes and trends from the mortality reviews are discussed, and decisions on corrective actions required are made. It is also positive to note that 100% of Stage 1 reviews were completed by the Medical Examiner within 30 days of death in January 2021.

The Safe and Sound Framework developed by the Chief Nurse and Medical Director to deliver the Quality Improvement Strategy and Quality Improvement Plan continues to be a significant achievement. Coupled with the introduction of the Organisation Learning Action Forum, these elements show the Trust's commitment to quality improvement, shared learning and implementation of consistent, good practice across the hospital. The Safe and Sound Quality Scorecard Report is shared with the CCG on a monthly basis through the

joint Contract Quality Meeting and highlights key areas of focus with regards to quality improvement both on an exceptions basis and by emerging themes. The report is concise and specific and provides the CCG with assurance that the key quality issues are being identified and improvement actions are being put in place to address them both on a short- and long-term basis.
RCCG is supportive of the way in which the Trust's key quality priorities for 2021/22 have been developed through a consultation process involving colleagues, governors, patient and members of the public. It is also positive to note the inclusion of 'Engagement with seldom heard groups with the aim of addressing any health inequalities' as one of the Patient Experience quality priorites.

Yours sincerely



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|---|---|
| Dr Anand Barmade | Sue Cassin |
| GP Executive Lead – TRFT Contract | Chief Nurse |
| NHS Rotherham CCG | NHS Rotherham CCG |

**Statement from Healthwatch Rotherham**

**The Rotherham Foundation Trust (TRFT) Quality Report 2020/21**

These comments are on behalf of Healthwatch Rotherham

Healthwatch Rotherham has welcomed the opportunity to be involved in The Rotherham Foundation Trust Quality Report again this year. We recognise the response to issues raised in the Quality Report have been compromised due to the need to respond to the national COVID-19 pandemic.

Healthwatch Rotherham would like to congratulate the Trust on all areas of their Quality Report where actions have been achieved and rated green, and we acknowledge the work carried out to ensure quality and safety are paramount within the Trust. We recognise that some work is still to be completed and appreciate the Trust's open and honest responses.

It is pleasing to see the work being undertaken around patient feedback/experience despite the "Stop reporting requirement" being in place for FFT between March 2020 - December 2020. The Quality Nursing/Patient Experience Information Boards are a welcome addition, as are the online survey and QR code for mobile phones.

We have had the pleasure of working alongside the Engagement and Inclusion Officer and hope to build on this relationship as restrictions ease and we are able to connect with some of the seldom heard communities in Rotherham to ensure that the patient voice is heard and no community feels excluded.

Healthwatch Rotherham are also grateful for the opportunity to be part of the Patient Experience Group and Patient Information Group. It is really good to see the improvements which have and continue to be made with the discharge process and Healthwatch Rotherham welcome the opportunity to continue our quarterly stakeholder meetings where we can identify trends and issues which may arise.

We know it has been an extremely challenging year for colleagues working in the health and care sectors and we want to give thanks for the way that they have adapted over the year and for keeping us safe.

Lesley Cooper
Service Manager
Healthwatch Rotherham

**Statement from Rotherham Health Select Commission**

TRFT Draft Quality Account 2020-21 Statement from Health Select Commission

The subgroup has met to review the draft Quality Account and appreciates the opportunity to provide feedback on the draft in progress. Members noted the effort and attention that has been dedicated to several positive areas of improvement. They also identified some areas they hope to see become the focus of improvements in the coming year. Members very much look forward to seeing the completed Quality Account and all its accompanying data.

Members were pleased to note several positive accomplishments reflected in the Quality Account. For example, recent CQC inspections have once again rated many service areas as highly Caring and Responsive. Members are also pleased to see the investment that has been made to improve clinical coding, and the good measures taken to enhance the review process to maximise learning from deaths. Positive steps have also been taken in sepsis diagnosis and management, and to reduce hospital acquired infection. Members noted that electronic prescribing continues to be a success.

It is also a positive step that the hospital is proactively complying with the new requirement that staff be trained to give care to patients with learning disabilities or autism. Members hope that the coming year brings additional opportunities to consult with local community groups such as Rotherham Speak Up who can infuse a wealth of knowledge around patient experience. Members hope that the stated rationale for doing this might be reconsidered, however: “If we get it right for people with a learning disability, we get it right for everyone.” Whilst we applaud the goal to provide safe and effective care for everyone including those most vulnerable, patients with learning disabilities should not serve as the barometer by which we measure our ability to care for the able bodied. Rather, the rationale for improving care for these vulnerable patients is that they themselves have a right to safe and effective care. So often, the experiences of people with disabilities improve only when the improvements can be shown to benefit able-bodied people as well.

Members also noted areas for improvement. The CQC reviews suggest Urgent and Emergency Services and Children and Young People’s Services are still in need of overall improvement in several domains. More specifically, Members are eager to see further description of a strategy for improving patients’ nutrition and fluid balance. Members agree that patients would also benefit from thorough completion of case notes.

Members were pleased to see the reinvigoration of efforts to embed human factors, particularly as this framework supports staff wellbeing. Members are especially keen to observe the trends reflected in staff feedback regarding wellbeing, engagement and morale. Members believe that staff experience would be improved if a human factors emphasis on safety culture were successfully implemented. Members hope to see human factors also relieve time pressures on staff, help ensure sufficient materials, supplies and equipment are available, and ultimately help return to working contracted hours and less overtime. Timely and high-quality staff appraisals would also benefit staff. As plans are in place to collect feedback in a new way that de-emphasizes the quantitative in favour of free-text responses, Members will be observing how thoroughly feedback is represented in future Quality Accounts.

Members wish to extend a sincere thanks to all the staff who have worked so hard during the pandemic and have gone above and beyond expectations during this time of exceptional need.

Sincerely,

Cllr Rob Elliott
Vice-Chair of Health Select Commission

**Annex 2:**
**Statement of Directors' Responsibilities for the Quality Account**

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

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

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

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

    - Board minutes and papers for the period April 2020 to 31 March 2021.
    - papers relating to quality reported to the board over the period April 2020 to 31 March 2021.
    - feedback from commissioners dated 7 May 2021.
    - feedback from governors dated 16 May 2021.
    - feedback from local Healthwatch organisation dated 14 May 2021.
    - feedback from Overview and Scrutiny Committee received 7 May 2021.
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2021.
    - the national patient survey published July 2020.
    - the national staff survey 2020, published 11 March 2021.
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 28 May 2021.
    - CQC inspection report dated 22 September 2020.

- 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 controls are subject to review to confirm that they are working effectively in practice.

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

- the Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality Account.

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

By order of the Board

**Chairman**
**June 2021**

**Interim Chief Executive**
**June 2021**

**Appendix 1: Review of Local Clinical Audits**

The reports of 125 clinical audits were reviewed by the provider in 2020-2021 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

| CSU | Title | Actions to improve care | Project No |
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| A&E | Procedural Sedation | The procedural sedation proforma will be emailed to Middle Grades and results discussed in staff huddles. | R1158 |
| A&E | Re-audit of the management of paediatric burns presenting to the ED | An email has been circulated to all clinicians involved in the management of paediatric burns patients highlighting the Standard Operating Procedure (SOP). | R1228 |
| A&E | Medical Documentation Audit 2020 | Presentation to colleagues highlighting oxygen is a drug and needs to be prescribed and vital signs, abnormal observations document and recognise it. | S1978 |
| A&E, CYP, Safeguarding | Survey of staff understanding of Safeguarding procedures - Acute ("Survey Monkey") | To develop and distribute dates for bespoke training for The Rotherham Foundation Trust (TRFT) colleagues to support areas identified from the survey. To raise the awareness of practice resolution protocol and guidance document and to develop a PowerPoint presentation for delivering the audit, outcome and recommendations. | R1145 |
| A&E, Safeguarding | Monthly Audit of body maps in the Urgent and Emergency Care Centre (UECC) | Discussion needed with IT to address how non-accidental injury (NAI) and major trauma diagnosis can be added to the coding system, in order to identify the appropriate patient sample. | R1200 |
| A&E, General Surgery | The Practice of Urinalysis in Patients on Admission to Acute Surgical Unit | To increase the awareness among doctors and nurses regarding the importance of urinalysis in assessment of patients and the need for clear documentation under the 'Patient Care' on Meditech by putting Posters at Doctors' office in Acute Surgical Unit (ASU), Nurse main reception desk in ASU and Doctors & Nurse main reception/ workplace in the red zone Emergency Department | R1229 |

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| | | (ED). Emails as gentle reminders to increase the awareness among Doctors, Nurses and Advanced Nurse Practitioners (ANPs) regarding the importance of urinalysis in assessment of patients, and the need for clear documentation under the 'Patient Care' on Meditech. Join the ED huddle with Nurses and Doctors present to explain about this audit and to increase the awareness among the staff. Join the ASU nursing handover and present the audit with its core message. | |
| Anaesthetics | Compliance with NICE Guideline 65 Inadvertent Perioperative Hypothermia | Raise awareness of the NICE guideline by circulating to the department and produce a poster for use in theatre. Carry out ongoing quality improvement work to ensure reduction in hypothermia and adherence to the guidance. Improve pre-warming of high risk patients pre operation by carrying out ongoing service evaluations of pre-warming options for major joint surgery and fractured neck of femur patients. Look at the content of the pre-op advice letter to ensure includes advice about keeping warm and if this is suitable. | R1166 |
| Anaesthetics | Emergency Equipment Audit | A plan to improve compliance will be requested from Ward Managers where a score of 90% or below has been achieved. A re-audit will be undertaken in October 2020. | R1170 |
| Anaesthetics | The impact of Chronic pain on Inpatient Pain Services | None required. | S1676 |
| Anaesthetics | Audit and Service Evaluation of Super Morbidly Obese (BMI>50) Patients on the Labour Ward | Aim for starting induction of labour (IOL) before 9 a.m. Aim to perform artificial rupture of membranes (ARM) around 6:00 a.m. Aim for Booking only 1 person belonging to this category of BMI >/= 50 at 36 weeks. Add manual handling risk assessments to 36 week check-up template on Meditech. Dietician referral and request phone call by dietician mandated early in pregnancy. | S1938 |

| Community Adult Services | Quality of Radiographs in Barnsley, Doncaster and Rotherham Community Dental Service 2019 | To ensure the correct completion of the Radiography Custom Screen on Software of Excellence, an email will be sent to all Ionising Radiation Medical Exposure Regulator (IR(ME)R) Practitioners advising them of the required standards. Each operator will be informed of their individual quality grades, reasons for less than excellent quality and rectangular collimator usage. To ensure consistency in the beam aiming devices service wide, consult with colleagues in other areas to ascertain what beam aiming devices are used. Contact all IR(ME)R Practitioners to advise to record the use of the rectangular collimator when they take an OPT (panoramic radiograph). | R1154 |
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| Community Adult Services | Top referring Dental Practices (DP) and their ability to successfully take dental radiographs for behavioural management paediatric patients. | Advice to be given to the General Dental Practitioners (GDPs) regarding how the number of referrals to the Community Dental Service can be reduced and how to improve patients' compliance. The results of the audit will be shared with the GDPs, along with a link to a pre-visit video regarding radiographs which can be shared with patients prior to their appointment. | R1107 |
| Community Adult Services | Re-audit of Auditory brainstem response (ABR) | There is a robust process in place for the peer review and management of the outcomes of local ABR testing results, waveforms and the test procedures. | R1178 |
| Community Adult Services | Audit of Compliance with Extraction Checklist in Barnsley, Doncaster and Rotherham 2019/2020 | A standardised patient data sticker to be produced for new patients referred to the service, which will be applied to the extraction checklist. Patient detail stickers to be introduced on an as/when basis for existing patients. Individual results to be fed back to clinicians and a re-audit to be undertaken at a later date. | R1153 |
| Community Adult Services | Record keeping audit of new patient examinations and compliance with | Review both methods of recording, text box and custom screen, to ensure all criteria required are | R1102 |

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|  | National Institute for Health and Care Excellence (NICE) recall guidelines | present as headings/boxes. Circulate Faculty of General Dental Practitioner (FGDP) guidelines and new NHS dental record keeping guidelines via email to clinicians |  |
| CYP Community | Re-Audit of paperwork provided at Looked After Children (LAC) clinic | The Looked After Children Nurse to continue on-going liaison with Social Care to raise awareness of information required to complete health assessments, the importance of completing the forms at the first point of contact with the family and its relevance to the wellbeing of the child. | R1173 |
| CYP Community | Re-audit of Midwife to Health Visitor (HV) handover template | To consider the handover template be restricted to Mothers requiring post-natal care that is outside of normal parameters | R1162 |
| CYP Community | Audit of Record keeping in 0-19s | Present feedback at team meetings and to clinical governance meetings.<br>Team Leaders to provide 1 to 1 support to practitioners during individual supervision an identify areas for improvement | R1167 |
| CYP Community | Children's Community Nursing Team- Record Keeping Audi | To ensure that all staff have training around the input of care plans and ensuring they are completed. Look at devising additional care plans for procedures such as gastrostomy changes/review. Look at documentation at team meetings to ensure the information documented on System 1 (S1) is clear enough to allow for another professional to provide follow up care. Give examples of good documentation. Ensure staff are aware of S1 procedures for marking electronic records in error. | S1993 |
| CYP Community, Safeguarding | Monthly Audit of body maps in CYP | To arrange a teaching session on child protection for all new paediatric registrars. To put the injury table on the same page as the body map to make it easier for both to be completed together. To introduce a checklist on the proforma so the clinician completing it can ensure they have completed necessary sections. To | S1984 |

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| | | add a tick box on the front of document 'nothing to declare' to use in the absence of a lesion or mark. Re-audit to be undertaken. | |
| CYP Community, Safeguarding | Audit of Midwife to Health Visitor (HV) handover template | To share the audit findings with Midwifery Team Leaders so they can disseminate the information to their staff. Re-audit to be undertaken. | R1217 |
| CYP Service | Audit of resuscitation facilities for community paediatrics | Escalate to all paediatric community line managers that the resuscitation policy states that Basic Life Support training renewal is mandatory for all staff. Confirm with Trust resuscitation team responsibilities and content for resuscitation equipment kits in the various types of outreach settings and implement. | S1793 |
| CYP Service | Documentation Audit 2019/20 | No actions required. | S1854 |
| CYP Service | United Nations Children's Fund (UNICEF) Baby Friendly Initiative Audit of Staff Education | To develop an annual update training package and establish regular meetings for clinical staff to increase knowledge and skills in the areas not meeting the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Standards.<br>To recruit at least one Breastfeeding Champion for each 0-19 Team<br>Monitor progress towards UNICEF BFI standards by conducting a further audit of staff skills using UNICEF BFI Audit Tool. | R1148 |
| CYP Service | Paediatric Acute Rapid Response Outreach Team referrals (Parrot) Referral Form | Review the referral form at a multidisciplinary (MDT) meeting to ensure design is user friendly and implement training on how to correctly complete Paediatric Acute Rapid Response Outreach Team referral form | S1918 |
| CYP Service | Audit of Antimicrobial Stewardship in Paediatric | Update the Junior Doctors' Induction to include how to access the Antimicrobial Guidelines on the intranet.<br>A summary of antimicrobials used for common infections to be made available on the Children's | S1961 |

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| | | Assessment Unit and intranet. To provide access to prescribing guidance via link on Meditech and/or alongside paediatric guidance | |
| CYP Service | United Nations Children's Fund (UNICEF) Baby Friendly Initiative Audit of Formula Feeding Mothers | To develop a template within the Electronic Patient Record to record consent for telephone interviews and ensure all health visitors are aware of the new method of recording this. Lead auditors to access UNICEF Baby Friendly Initiative Audit Workshop for training and to meet regularly to discuss ongoing audits and uniform standards. Re-audit to monitor progress towards UNICEF Baby Friendly Initiative standards. | R1146 |
| CYP Service | United Nations Children's Fund (UNICEF) Baby Friendly Initiative audit of Health Visitor (HV) Services - Premises | The Infant Feeding Co-ordinator to visit premises where health visiting services are provided to ensure they meet World Health Organisation Baby Friendly Initiative standards, where issues are identified to explore solutions with the relevant staff or building managers. | R1147 |
| CYP Service | United Nations Children's Fund (UNICEF) Baby friendly initiative audit of Breastfeeding Mothers | To develop a template within the Electronic Patient Record to record consent for telephone interviews and ensure all health visitors are aware of the new method of recording this. Lead auditors to access UNICEF Baby Friendly Initiative Audit Workshop for training and to meet regularly to discuss ongoing audits and uniform standards. Re-audit to monitor progress towards UNICEF Baby Friendly Initiative standards. | R1149 |
| CYP Service | United Nations Children's Fund (UNICEF) Baby friendly breastfeeding policy audit | Annual review of Infant Feeding Policy against UNICEF UK Baby Friendly Initiative (BFI) criteria using UNICEF BFI checklist to be included in Audit Programme. | R1151 |
| CYP Service | Looked after Children’s Clinic: Reaudit of paperwork | To design a leaflet to improve Social Worker's understanding of the relevance of required forms and how to complete them. To circulate the leaflet to all doctors who do a Looked After Children's | R1221 |

| | | clinic for comment. To present the audit and leaflet to Social Care. | |
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| CYP Service | Quality of records on CAU and Children's ward | To present the audit findings to both nursing and medical staff including a list of expectations of a good standard of documentation. Use posters, newsletters and the stop shift method to educate staff around how to correctly address errors, deletions and alterations in hand written care records. | S1940 |
| CYP Service, Safeguarding | Re-audit of Safe Sleep Assessment 0-19s - 2020 | To develop further safe sleep training packages online for all professionals working with babies 0-1 years. To include the risk assessment framework into the safe sleep assessment. To undertake further assessments and hold discussions on a regular basis with individual practitioners to ensure improvement in standards. To explore using SMS links to parents, grandparents and carers phones to ensure family member are provided with the safe sleep message. | R1203 |
| CYP Service, Safeguarding | Records audit reviewing the 5-19 safeguarding pathway following 12 months of implementation | Develop a caseload management Standard Operating Procedure (SOP) to support practitioners across the 0-19 service. To liaise with Social Care regarding the sharing of core group minutes with practitioners. To update the 5-19 safeguarding pathway into a SOP, including safeguarding supervision. Ensure a health assessment is included on the appropriate health assessment template within SystmOne. | R1204 |
| CYP Service, Safeguarding | Safeguarding Documentation Audit on the children's ward (voice of the child & evidence of practitioner thinking check and Think Families approach) | To ensure all non-English speaking families have access to interpreting service to ensure robust assessments and consideration to safeguarding risk and voice of children. Re-audit to be undertaken. | S1992 |
| CYP Service, Safeguarding, Trust wide | Re-Audit of Child Protection Medical Report | To set up a spreadsheet to track progress and identify delays in Child Protection Medical Reports. Ensure agreement on delegation of responsibility to a deputy if the | S1939 |

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| | | registrar is not available within 48 hours to approve with Consultant to ensure that the Child Protection Medical Reports are within deadline. | |
| CYP Service, Therapy Services & Dietetics | Audit of Children and Young People meeting The Royal College of Paediatrics and Child Health (RCPCH) Quality Programme Measure M21 - Diabetes Self-Management Education programme | The Paediatric Diabetes Team to participate in The Royal College of Paediatrics and Child Health (RCPCH) quality improvement project for the newly diagnosed type 1 diabetes pathway, for children and young people, which includes carbohydrate counting from diagnosis. Meet with the Matron, Ward Manager and Ward Link Nurses to discuss improving the skills of ward nurses to support carbohydrate counting. To liaise with the catering department to obtain required nutritional information for new ward menus. | R1108 |
| CYP Service, O&G, O&G - Maternity, Safeguarding | Audit of Infant Safe Sleep in Hospital Based Paediatric and Maternity Services | Email communication to be sent to all nursing and medical team with lullaby trust safer sleep guidance and reminder about key point identified in audit. All staff to give verbal information on admission and discharge, with particular reference to management of temperature when coming from outdoors to inside departments. New staff to be given training from safer sleep champion. | R1187 |
| Dermatology | Audit of Compliance with a Patient Group Direction (PGD) (Lidocaine 1% and Adrenaline 1:200 000) | Results showed 100% compliance, no actions required. | R1152 |
| Dermatology | Serum PC3NP Monitoring in Patients Treated with Methotrexate for Psoriasis | To schedule an educational session for staff involved in monitoring patients on methotrexate for psoriasis to highlight current guidelines, clinical recommendations and rationale. Modify the methotrexate proforma to include 3 monthly PIIINP monitoring on Meditech. Display guidelines in clinic rooms and on Meditech. Liaise with the gastroenterology department to agree which investigations should be ordered prior to referral for | S1943 |

| | | patients with a persistently raised serum PIIINP. | |
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| Endoscopy | Percutaneous Endoscopic Gastrostomy (PEG) Audit - July to December 2018 | No actions required. | S1721 |
| Endoscopy | Percutaneous Endoscopic Gastrostomy (PEG) Audit - January to June 2018 | No actions required. | S1722 |
| Endoscopy | Number of endoscopic procedures performed by operator - July to December 2018 | No actions required. | S1723 |
| Endoscopy | Gastrointestinal (GI) Bleeding/ therapeutic Gastroscopy - July to December 2018 | No actions required. | S1725 |
| Endoscopy | Gastrointestinal (GI) Bleeding/ Therapeutic Gastroscopy - January to June 2018 | No actions required. | S1726 |
| Endoscopy | Gastroscopy audit - July to December 2018 | No actions required. | S1728 |
| Endoscopy | Gastroscopy audit - January to June 2018 | No actions required. | S1729 |
| Endoscopy | Endoscopic Retrograde Cholangiopancreatography (ERCP) Audit - January to June 2018 | No actions required. | S1732 |
| Endoscopy | Colonoscopy Completion Rates - April to September 2018 | No actions required. | S1734 |
| Endoscopy | Endoscopic Retrograde Cholangiopancreatography (ERCP) Audit - July to December 2018 | No actions required. | S1792 |
| Endoscopy | Audit of Outcomes of Endoscopic Retrograde Cholangiopancreatography (ERCP) July 19 – July 20 | To input results of audit in Joint Advisory Group on Gastrointestinal Endoscopy (JAG) format. Re-audit to be undertaken. | R1193 |
| Endoscopy | Audit of Haemostasis after Endoscopic therapy and Timing for Upper Gastrointestinal (GI) bleed July 2019 – July 2020 | Improve vetting of all urgent requests for suspected upper gastrointestinal tract (UGI) bleed by establishing a protocol of all urgent request for gastroscopy and revising the Rockall referral form | R1195 |
| Endoscopy | Audit of Outcomes of Percutaneous Endoscopic Gastrostomy (PEG) Feb18 - July20 | No actions required. | R1194 |

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| Endoscopy | Audit of Repeat endoscopy within 12 weeks for gastric ulcer | Feedback results to Upper Gastrointestinal (UGI) Endoscopists and establish tighter controls on re-biopsy. | S1989 |
| Endoscopy | Colonoscopy Outcomes - October 2019 to March 2020 | Circulate individual Key Performance Indicators (KPIs) and educate at appraisal of all Endoscopists, the British Society of Gastroenterology (BSG) guidelines for gastroscopy and colonoscopy and Endoscopic Retrograde Cholangiopancreatography (ERCP). Introduce National Endoscopy Database (NED) compliant version of Infoflex for reporting. | S1988 |
| Endoscopy, General Surgery | Perioperative factors affecting post-ERCP pancreatitis at Rotherham General Hospital | To review post Endoscopic Retrograde Cholangiopancreatography (ERCP) discharge criteria. To discuss case selection and the use of rectal non-steroidal anti-inflammatory drugs at planned multidisciplinary team (MDT) meeting with Barnsley. | R1219 |
| General Surgery | Re-audit of the Practice of Urinalysis in patients on admission to Acute Surgical Unit | To ensure the clear documentation of the urinalysis result by increasing awareness amongst nurses. To remind Foundation Year 1 doctors and Advanced Nurse Practitioners. | R1235 |
| General Surgery | Retrospective audit on the blood and blood product transfusions carried out in the General surgery Department in one year | Disseminate guideline to trainees and invite Hospital Transfusion Manager to speak to new trainees on induction. Discuss documentation with the Hospital Transfusion Committee to consider reducing duplication and possibly to go paperless using Meditech. Discuss possibility of Integrated Care Pathway (ICP) going paperless using Meditech. | S1813 |
| General Surgery | General Surgery readmissions (2019/20) | No actions required. | S1878 |
| General Surgery | The Surgical Management of Patients with Suspected Appendicitis at Rotherham General Hospital | No actions required. | S1812 |

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| General Surgery | Effectiveness of weekend handover in General surgery Department | Improve documentation of handover at the weekend by creating an electronic document on Electronic Patient Record. | S1885 |
| General Surgery | Review of Hot Laparascopic cholecystectomy operation at Rotherham General Hospital (RGH) | Discuss attaching the scoring sheet electronically to the Gall bladder theatre booking to encourage the use of hot laparascopic cholecystectomy scoring sheet electronically. Re-audit, to include total v subtotal cholecystectomy data. | S1903 |
| General Surgery | Re-audit of General Surgery Operative notes | To discuss with Breast Surgeons the requirement to document operation notes on Meditech. | S2010 |
| GU Med | Vasectomy audit | To set up task lists within the Electronic Patient Record to co-ordinate the follow up and return of samples by the administration team. To review the Standard Operating Procedure and communicate to issues at team meetings to improve standards of record keeping. Make changes to the post operation leaflet and advise patients to contact Integrated Sexual Health Service if problems occur in the first 4 weeks to improve the accuracy of data in relation to post operation problems. Re-audit in 12 months. | R1182 |
| GU Med | BASHH 2020 National Audit: management of gonorrhoea | Investigate possible treatment failures. Send a SMS text with a link to the gonorrhoea patient information leaflet to patients with a positive gonorrhoea culture result. | R1157 |
| Lab Med | Rotherham NHS Foundation Trust ability to meet National Guidelines for laboratory communication of abnormal potassium results; Re-Audit | Update Standard Operating Procedures (SOPs) and communicate with staff escalation procedures where clinical teams are non-contactable and rejection criteria for haemolysed samples | R1131 |
| Lab Med | Compliance with the transfusion Integrated Care Pathway (annual audit) | None required | R1242 |

| Lab Med, O&G | 2018 National Comparative Audit of the Management of Maternal Anaemia | To review and update local guidelines for the detection and management of anaemia in pregnancy to align local guidance with the latest British Society for Haematology (BSH) and National Institute for Health and Care Excellence (NICE) guidelines. | R1090 |
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| Medicine | Acute Coronary Syndrome (ACS) follow up time audit - follow up | Increase the number of inpatient angiography slots to two per session (up to 10 slots per week). Consider direct referral to Northern General Hospital (NGH) for left heart catheterization (LHC)/percutaneous coronary intervention (PCI) in selected cases. Continue to refer patients for revascularisation promptly. Develop treat and discharge policy with NGH. | S1826 |
| Medicine | Tuberculosis Contact tracing re-audit | Undertake the audit again once the National Institute for Health and Care Excellence (NICE) Tuberculosis (TB) guidelines have been updated to assess practice against the standards. Discuss with the Paediatric Clinical Effectiveness Lead the idea of a contact tracing audit being undertaken within their service. | S1841 |
| Medicine | Screening and management of 'suspected sepsis' adhering to Trust's 'sepsis screening tool'. | To improve knowledge on sepsis detection and timely application of the sepsis 6 tool, by taking this forward as a Quality Improvement Project, led by the Sepsis Nurse. Access to the national sepsis training tool to be provided on the electronic staff record (ESR) for all relevant medical and nursing staff. | S1912 |
| Medicine | Compliance with weekend escalation plan on medical wards at Rotherham General Hospital | A weekend escalation plan proforma to be created electronically so data can be completed electronically | S1933 |
| Medicine | Audit of Referral Pathway for Patients Admitted with Syncope | The development of a rapid access syncope clinic to be discussed with and data/costings to be presented to the Operational Performance Manager. | S1925 |
| Medicine | DNA CPR and escalation plans in COVID patients | None required | R1185 |

| Neuro-rehabilitation, Safeguarding | Rotherham Integrated Neurological Conditions Service (INCS) Multidisciplinary (MDT) documentation audit | All patients should have clearly documented discharge plans and choices of 24 hour care recorded in their medical notes. The Multi-disciplinary team (MDT) will continue to complete this information in the medical notes and use the MDT documentation. | S1979 |
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| O&G | Audit of Sequential and Abandoned Instrumental deliveries | Work towards electronic documentation of the operative deliveries in Meditech, to reduce omissions in the midwifery record of birth. | S1595 |
| O&G | Re-Audit on Category 1 AND 2 caesarean sections | To arrange a meeting with the Anaesthetic department to discuss the high rate of general anaesthetics in caesarean sections. To discuss increasing documentation of Antacids, cord bloods and World Health Organisation checklists at the labour ward forum. To include Lower Segment Caesarean Section audit findings in the induction. Display World Health Organisation posters in the relevant areas and discuss with infection control ways to reduce wound infections. | S1949 |
| O&G | Re-audit of Obstetric Anal Sphincter Injuries (OASIs) 2018 | Remind staff the importance of completing a Datix at the time of incident. Add blood loss to the Datix review form. Service Evaluation to be undertaken to compare overall episiotomy rate with and without epi-scissors. Re-audit to be undertaken. | S1837 |
| O&G | Spot Audit of Compliance with Postnatal Thromboprophylaxis in the Community on SystmOne | Create a new template that streamlines the way postnatal thromboprophylaxis is documented in the community to be aligned with the previous 'Stop the Clot' action plan. Re-audit to be undertaken. | R1138 |
| O&G | Audit of intrapartum and immediate postpartum (12 hours) management of diabetes Type 1, 2 and Gestational Diabetes Mellitus (GDM). | Develop a proforma for use via online partogram on Meditech to standardise the patient assessment, to ensure all observations are recorded. Develop short educational summary of guideline and audit focussing on successes and | S1911 |

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| | | concerns. Review separating Gestational Diabetes Mellitus off from pre-existing diabetes within intrapartum element in local guideline. | |
| O&G | Audit of Induction of Labour using Balloon Catheter | To increase the number of assessors for completion of the training programme in order to facilitate quicker sign off of midwives at completion of training, and re-do the patient satisfaction survey once the service has appropriate staffing. To convert the documentation to electronic format for Meditech entry. Review the benefits and risks of Dilapan (an osmotic dilator of the cervix) into the induction to evaluate whether it would be a suitable option for the unit. | R1109 |
| O&G | Audit on Elective Caesarean Section | To update the caesarean section guideline to include previous caesarean section and previous 3/4th degree tear as indications for caesarean delivery. Caesarean section leaflets to be included in consenting packs to give to patients upon consenting in outpatients. | S1991 |
| O&G | Audit of Antenatal Smoking Status | To ensure smoking in pregnancy training remains part of new staff induction training and annual Mandatory and Statutory Training (MAST) updates. To maintain communications with data analysts by attending meetings as required to ensure all data required can be provided. Re-audit to be undertaken. | R1247 |
| O&G | Uptake and provision of postnatal contraception and contraception post termination of pregnancy | Arrange Faculty of Sexual and Reproductive Healthcare (FSRH) training for Pregnancy Advisory Service nurses. To educate midwives in contraception using the FSRH course. To arrange a pilot with one consultant to discuss coils at c-section fitting. | S1969 |
| O&G - Maternity, Safeguarding | Audit of completion of the Digital Body Mapping fields on Meditech for the Day 0 neonatal examination | Remove the paper Body Maps from the red books and repeat audit to ensure all staff are documenting Body Maps electronically | S1986 |

| O&G - Maternity, Safeguarding | Safe Sleep Assessment Re-audit in Community Midwifery 2020 | Communicate at the next community midwifery meeting that The Safe Sleep assessment must be completed on all babies discharged home. It must be completed in the infant's record not the mothers. If a repeat is needed then the safe sleep questionnaire must be used. At discharge from the community midwifery service the 0-19 hand over template must be used in all women's records. Where an issue had been identified on the safe sleep assessment or a repeat is needed, add to the learning sheet for community midwifery service along with other recent audits. | R1189 |
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| O&G - Maternity, Safeguarding | Re-Audit of child sexual exploitation assessments for any woman aged under 18 in Maternity | Inclusion reminder on Matrons Roundup to all staff regarding their responsibilities around Child Sexual Exploitation screening and teenage pregnancy, and present the audit and discuss at the community midwifery meeting. Email all Safeguarding Supervisors and community midwives to remind them that all teenagers need to be discussed in their 1:1 supervision sessions to ensure all screening and a holistic overview has been undertaken to reduce negative outcomes. To develop a criteria list to aid consideration of cases to be discussed at 1:1 supervision to ensure all teenagers are captured on safeguarding caseloads for practitioners regardless of whether they have specific safeguarding concerns identified or not. To develop and disseminate a 'how to' guide to ensure community midwives know how to complete the screening tool. | R1207 |
| O&G - Maternity, Safeguarding | Re-audit of Perinatal Domestic Abuse Screening 2020 | Communicate at the next community midwifery meeting and add to the learning sheet for community midwifery service, that the SystmOne record for recording routine enquiry questions must be used in conjunction to the hand | R1202 |

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| | | held records, that women must be seen alone to ask routine enquiry questions. The importance of screening for domestic abuse in pregnancy to be circulated to all areas and added to the newsletter. Communication on the use of Meditech for documentation of routine enquiry for domestic abuse screening. | |
| O&G - Maternity, Safeguarding | Audit of child sexual exploitation assessments for women aged under 18 in Maternity - October 2020 | Remind all staff regarding their responsibilities around Child Sexual Exploitation (CSE) screening and teenage pregnancy by presenting the audit findings at the community midwifery meeting and include on Matrons Roundup newsletter.<br>To develop a how to guide on completing the screening tool and disseminate to all community midwives. | R1233 |
| O&G - Maternity, Safeguarding | Audit of child sexual exploitation assessments for women aged under 18 in Maternity - December 2020 | To present audit findings and discuss at the Community Midwifery meeting and Maternity Governance. To appoint a Young Parent Midwife who will complete all bookings, safeguarding assessments and Child Sexual Exploitation screening for 19 year olds and under. | R1234 |
| O&G - Maternity, Safeguarding, Trust wide | Re-audit of Midwife to Health Visitor Handover (Maternity) 2020 | Communicate to the community midwifery service that the hand over template must be used in the mother's record at 15 weeks and discharge from the service and babies who are Looked after must be done on the infant record.<br>Re-audit quarterly until handover improved. | R1199 |
| O&G, O&G - Maternity, Safeguarding | Audit of the effectiveness of discharge planning meetings (by reviewing Huddle documentation) - Maternity | Update and circulate discharge planning policy once ratified and 7 minute briefing. Stop the shift work direct with staff to raise the awareness of Discharge Planning Meeting for any new emerging concerns when subject to Child Protection Plan or Looked After Children. Raise the awareness of importance of 0-19 service undertaking any concerns from admission and ensuring | R1186 |

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| | | contribution to the discharge plan. Ward manager to be notified to ensure consistent process for records to be scanned into Meditech. Summary on a page developed and circulated to key staff on maternity and children's ward | |
| OMFS | Audit of the World Health Organisation (WHO) surgery checklist in the Oral and Maxillofacial outpatient's department Minor Oral Surgery (MOS) | Ensure that one member of staff per clinic is responsible for completing the World Health Organisation surgery checklist for each patient and that Minor Oral Surgery staff engage with the questions they are being asked pre and post operatively. | R1141 |
| OMFS | The Diagnostic Quality of Radiographs Received from General Dental Practitioners | Test a sample of 10 referrals to identify possible causes of scanning errors to identify areas for improvement.<br>Contact Bradford University to identify what systems they use to achieve digital transfer. | R1130 |
| OMFS | New Referrals for Skin Cancer: Do We See and Treat Them Quick Enough? | Contact cancer services for breach reasons and resolve causes. Discuss biopsy speed with Dermatology and find out if adequate staffing. Discuss referral straight to Oral and Maxillofacial Service (OMFS) after biopsy whilst waiting for results if surgery will be required regardless of histopathology. | R1132 |
| OMFS | General Dental Practitioner (GDP) referrals received by RGH OMFS department | Create a standardised General Dental Practitioners (GDP) referral proforma to avoid important information being omitted. Disseminate the referral forms to GDPs via NHS mail. Contact the Local Dental Committee to help raise awareness of using NHS email with digital radiographs attached. Re-audit to be undertaken. | R1213 |
| OMFS | Documentation Audit 2019/20 | To remind all staff comply with Trust documentation standards set by the trust. | S1856 |
| OMFS | Re-audit of Quality of pathology request forms | Create a new pathology form in collaboration with Pathology with a larger information area for more detail. | S1945 |

| OMFS | Consent in Third Molar Extractions | To present the audit findings to the Oral and Maxi facial Surgery team to highlight the gold standard required compared to current practice. To Ensure patients are provided with information leaflets at their initial outpatient visit. Standardise the documented risks on consent forms involving third molar removal to ensure all risks are covered. Re-audit to be undertaken. | S1995 |
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| OMFS | The Acute Management of Traumatic Dental Injuries in A&E - A Clinical Audit | Update the 'OMFS DCT induction booklet'. Update the Meditech OMFS A&E proforma to include a 'General Dental Practitioner (GDP) follow-up' section. Advise Dental Core Trainees (DCTs) to download 'ToothSOS' app which details the recommended special investigations. | R1201 |
| OMFS | Are impacted canine being referred appropriately | To improve the referral process by liaising with Picture Archiving and Communication System (PACS) and the online referral portal to allow direct radiographic referrals. Re-audit to be undertaken. | R1214 |
| OMFS | Are all A&E patients with maxillofacial fractures receiving a timely follow up in the outpatient departments at Rotherham and Doncaster Hospitals? | To arrange additional A&E slots on the Rotherham consultant clinics. To amend the Dental Core Trainee (DCT) induction booklet to ensure all members of the DCT team are aware of the importance of 5 day window. Re-audit to be undertaken. | R1218 |
| Ophthalmology | Follow up against Discharge guidelines Re-audit | Email to be sent to all middle grade doctors to advise them to document the time period for the follow up in the notes and when in doubt to seek advice from the consultant. Make copies of the departmental guidelines for discharge available in all consultation rooms in outpatients. | R1239 |
| Ophthalmology | Gonioscopy post Yttrium Aluminium Garnet (YAG) laser Peripheral Iridectomy Re-audit | To educate staff on using the gonioscopy section on Meditech. To add the option to choose 0 on the gonioscopy section on Meditech. Re-audit to be undertaken. | R1241 |

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| Ophthalmology | Gonioscopy post Yttrium Aluminium Garnet (YAG) laser Peripheral Iridectomy | Email the audit findings to all doctors to ensure that Gonioscopy forms are completed on Meditech. | S1974 |
| Ophthalmology | Audit of Monitoring and Management of Ocular Hypertension and Glaucoma | Ensure the glaucoma document on Meditech pulls through Central Corneal Thickness and Gonioscopy. Email clinical staff the glaucoma follow up guidelines and remind them to update the diagnosis on Meditech as appropriate. | R1248 |
| Orthopaedics | Getting it Right First Time (GIRFT) Best Practice for knee and hip arthroplasty surgery documentation | A re-audit to be undertaken within 12 months to assess current practice. | S1917 |
| Orthopaedics | Orthopaedic Readmissions | No actions required. | S1875 |
| Orthopaedics | ATILLA: Administration of Tranexamic Acid in Lower Limb Athroplasty | No actions required. | R1057 |
| Orthopaedics | Orthopaedic readmissions (2018/19) | No actions required. | S1790 |
| Orthopaedics | Distal Radius Acute Fracture Fixation Trial (DRAFFT) Impact Study Protocol | No actions required. | R1046 |
| Orthopaedics | Audit on the Management of stable ankle fractures | The standards of practice will be circulated to A&E and Orthopaedic staff via e-mail. Poster outlining British Orthopaedic Association Standards for Trauma (BOAST) standards to be displayed in the Urgent and Emergency Care Centre (UECC) and the Orthopaedic Department. Teaching sessions on ankle fracture management to be arranged. | S1996 |
| Orthopaedics | An Audit on Consent 4 in Trauma and Orthopaedic patients | Completion of all required areas and second signature, if required, on consent form 4 discussed with colleagues. | S1971 |
| Orthopaedics | Project to improve compliance with VTE assessment in Orthopaedic inpatients | VTE assessment is now online and more visually prominent. | R1209 |
| Palliative Care | Re-audit of preferred location of care for end of life patients | A re-audit to be undertaken at a later date to assess current practice and to review patients that are sent home or to the hospice for end of life care. | S1882 |

| Radiology | A&E computerised tomography (CT) head timings audit (2019) | Remind staff of importance of reporting A&E computerised tomography (CT) heads in a timely manner and to inform off site radiologist as soon as an Emergency CT head has been performed. | R972 |
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| Safeguarding | Mental Capacity Application 16/17 year olds: Audit of Case Records of Complex Care Nurse Team | Review the SystmOne Mental Capacity Act (MCA) template to ensure it includes all relevant children's units so they are recorded accurately. Develop and deliver training for all staff working with young people (16/17 Year olds)<br>Develop a parent leaflet based on local and national resources to support best decision-making. | R1180 |
| Safeguarding | Female Genital Mutilation (FGM) Multi Agency re-audit DIP sample | The Rotherham Foundation Trust (TRFT) to attempt to gather specific ethnicity details and other demographics at midwifery booking appointment when Female Genital Mutilation is identified as a risk.<br>National Female Genital Mutilation Good referral Guide to be sent out again across the Partnership, to be shared internally as appropriate within organisations. Workshop on FGM to be held during safeguarding awareness week. | R1206 |
| Safeguarding | Documentation of who accompanies women during labour Re-audit | To add information on Midwifery Mandatory and Statutory Training (MaST) and to send a briefing out to all Maternity staff to remind them to record the name and relationship of the people accompanying women in labour/birth. To add the routine questioning at the point of birth to Meditech. Re-audit to be undertaken. | R1208 |
| Safeguarding | Evaluating the use of the Hospital Passport for people with Learning Disabilities | To formulate a business case regarding the capacity and working hours of the current Learning Disability Team. Re-audit to be undertaken. | S1799 |
| Safeguarding | Audit of compliance with the Mental Capacity Act (MCA) & Deprivation of Liberty Standards (DoLS) | The safeguarding team to create a Powerpoint training resource to deliver Mental Capacity Act (MCA) training to ward managers, area | S1985 |

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| | requirements - Ward based audit. | managers and qualified staff within the Trust to promote understanding. | |
| Safeguarding, Trust wide | A comparative audit of Deprivation of Liberty Safeguards (DoLS) requests made by The Rotherham Foundation Trust (TRFT) staff in Quarter 2 of 2019-20 | The team administrative support to continue to visit the wards 1 – 2 times a week to check that the relevant paperwork is in the patient record i.e. DoLS, Mental Capacity Act (MCA) form. The Adult Safeguarding Practitioner will also go around the wards to identify the patients that need a DoLS and give the list to the Administrators to make a request to the Ward Managers. Launch The MCA Champions and continue the support of this staff group and further develop the role. Present audit at the Operational Safeguarding Group and DoLS Operational Group to give operational leads for departments the opportunity to assess the progress and compliance of their respective areas. MCA and DoLS to remain on the agenda for the Operational Safeguarding meeting and the quarterly MCA/DoLS lead meetings will continue to review the individual department. | R1086 |
| Therapy Services & Dietetics | To review the appropriateness and effectiveness of dietetic care at time from hospital to community follow up | The handover policy will be updated and made more specific so everyone is aware of the standards they should be working to, which will speed up time between handover and review. Additional community clinics will be added to help reduce waiting times. | R1093 |
| Therapy Services & Dietetics | Therapies and Dietetics documentation audit | The areas where improvements are required are in relation to risk assessments and the need to document that one has been undertaken. Ensure that documentation of patient consent for each intervention in the patient record is completed within 24 hours of the appointment time and to include who accompanied the patient to their appointment and the relationship to them. | S1736 |

| Urology | Surveillance Cystoscopy Following Resection of Trans Urethral Bladder Tumor (TURBT) in Bladder Cancer Patients | Follow up criteria and risk stratifications to be displayed in all cystoscopy suites for clinicians to use as reference. Size and number of lesions to be estimated and recorded during initial flexible cystoscopy/on Transurethral Resection of Bladder Tumor (TURBT) to allow accurate risk stratification. | S1927 |
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**Appendix 2: Readmissions within 28 days**

| Emergency Re admissions within 28 days of discharge from Hospital | | |
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| Age Bands | 1st April 2019 - 31st March 2020 | 1st April 2020 - 31st December 2021 |
| Age 0- 15 years | 9.74% | 9.97% |
| Age 16 years and above | 10.55% | 14.65% |

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 CSUs and for the Service Line Monitoring (SLMs) reports.

The internal TRFT data has been aligned to the National Benchmarking reports, in this case Model Hospital. Model Hospital is an NHSI tool that uses HES (Hospital Episode Statistics) Data and contains some additional methodology on how they report readmissions. Previously we followed the DoH methodology and also implemented some local exclusions; we also excluded all INOs, same day readmissions and reported re-admissions within 28 days. We have now rewritten our reports to align to this data. The NHSI methodology is very similar to the old methodology, with some slight variances, we are now including INO, same day readmissions and reporting within 30 days. We are also picking up if a patient has had multiple readmissions in the reporting period if within the time frame. This is all as per the National Methodology.

## Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2020/21

| Detail of Visits | Date of Visit |
| --- | --- |
| British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices | 16 April 2020 |
| CQC unannounced inspection of children's pathways | 07 – 09 July 2020 |
| Health and Safety Executive visit to Microbiology, Pathology | 29 – 30 July 2020 |
| GIRFT[1] Pathology Deep Dive (virtual) meeting for South Yorkshire and Bassetlaw Pathology Network | 11 September 2020 |
| Yorkshire & Humber Paediatric Critical Care Operational Delivery Network Service Evaluation visit to Emergency Department and Anaesthetics | 14 October 2020 |
| British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices | 12 November 2020 |
| UKAS[2] 3rd Surveillance Visit to Laboratory Medicine | 8 - 12 February 2021 and 26 February 2021 |
| GIRFT Gastroenterology Deep Dive (virtual) | 16 February 2021 |
| GIRFT Acute & General Medicine Deep Dive (virtual) | 26 February 2021 |
| Interim external screening quality assurance review Rotherham Breast screening service | 8 March 2021 |
| GIRFT Paediatric Trauma & Orthopaedic Deep Dive (virtual) | 15 March 2021 |

[1] GIRFT stands for 'Getting It Right First Time'

[2] United Kingdom Accreditation Service (UKAS) is the national accreditation body for the United Kingdom, appointed by government, to assess organisations that provide certification, testing, inspection and calibration services.

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**Acronyms**

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|---|---|
| A&E | Accident & Emergency Department |
| ABS | Auditory Brainstem Response |
| ACS | Acute Coronary Syndrome |
| AMD | Associate Medical Director |
| AMU | Acute Medical Unit |
| ANP | Advanced Nurse Practitioner |
| APC | Admitted Patient Care |
| ARM | Artificial Rupture of Membranes |
| ART | Acute Response Team |
| ASU | Acute Surgical Unit |
| ATILLA | Administration of Tranexamic Acid in Lower Limb Athroplasy |
| BAUS | The British Association of Urological Surgeons |
| BFI | Baby Friendly Initiative |
| BI | Business Intelligence |
| BMA | British Medical Association |
| BMI | Body Mass Index |
| BOAST | British Orthopaedic Association Standards for Trauma |
| BSG | British Society of Gastroenterology |
| BSI | British Standard Institute |
| BSL | British Sign Language |
| CAP | Community Acquired Pneumonia |
| CCG | Clinical Commissioning Group |
| C-DIFF | Clostridium Difficile |
| CHKS | Comparative Health Knowledge System |
| CMP | Case Mix Programme |
| CNST | Clinical Negligence Scheme for Trusts |
| COPD | Chronic Obstructive Pulmonary Disease |
| CRM | National Audit of Cardiac Rhythm Management |
| CSDS | Community Services Data Set |
| CSE | Child Sexual Exploitation |
| CSU | Clinical Support Unit |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| CT | Computed Tomography |
| CYP | Children and Young People |
| DFI | Dr Foster Intelligence |
| DIPC | Director of Infection Prevention and Control |
| DNACPR | Do not attempt cardio-pulmonary resuscitation |
| DoH | Department of Health |
| DoLS | Deprivation of Liberty Safeguards |
| DP | Dental Practice |
| DQMI | Data Quality Maturity Index |
| DRAFFT | Distal Radium Acute Fracture Fixation Trial |
| DRG | Document Ratification Group |
| DSPT | Data Security and Protection Toolkit |
| DTOC | Delayed Transfers of Care |
| ECDS | Emergency Care Data Set |
| ED | Emergency Department |
| EPR | Electronic Patient Record |

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| ERCP | Endoscopic Retrograde Cholangiopancreatography |
| ESR | Electronic Staff Record |
| FFFAP | Falls and Fragility Fractures Audit Programme |
| FFT | Friends and Family Test |
| FGDP | Faculty of General Dental Practice |
| FGM | Female Genital Mutilation |
| FTSU | Freedom to Speak Up |
| FTSUG | Freedom to Speak Up Guardian |
| GAfREC | Governance Arrangements for Research Ethics Committee |
| GDM | Gestational Diabetes Mellitus |
| GDP | General Dental Practice |
| GI | Gastro Intestinal |
| GIRFT | Getting it Right First Time |
| GP | General Practitioner |
| GSF | Gold Standard Framework |
| HCAI | Healthcare Associated Infection |
| HDU | High Dependency Unit |
| HES | Hospital Episode Statistics |
| HOPE | Helping People to Overcome Problems Effectively |
| HSE | Health and Safety Executive |
| HSMR | Hospital Standardised Mortality Ratio |
| HV | Health Visitor |
| ICP | Integrated Care Pathway |
| IDQ | Improving Data Quality |
| IG | Information Governance |
| INCS | Integrated Neurological Conditions Service |
| IPC | Infection Prevention and Control |
| IRMER | Ionising Radiation (Medical Exposure) Regulations |
| ITU | Intensive Treatment Unit |
| JAG | Joint Advisory Group |
| KPI | Key Performance Indicator |
| Lab Med | Laboratory Medicine |
| LAC | Looked After Children |
| LD | Learning Disability |
| LeDeR | Learning Disabilities Mortality Review |
| LHC | Left Heart Catheterization |
| LPS | Liberty Protection Safeguards |
| MAPPA | Multi-agency Public Protection Arrangements |
| MARAC | Multi Agency Risk Assessment Conference |
| MASH | Multi-agency Safeguarding Hub |
| MaST | Mandatory and Statutory Training |
| MCA | Mental Capacity Act 2005 |
| MCISS | Macmillan Cancer Information Support Base |
| MDT | Multi-Disciplinary Team |
| ME | Medical Examiner |
| MHRA | Medicine and Healthcare Products Regulatory Agency |
| MIG | Mortality Improvement Group |
| MINAP | Myocardial Ischaemia National audit Project |
| MOS | Minor Oral Surgery |
| MQEM | Macmillan Cancer Support Quality Environment Mark |
| MQUISS | Macmillan Quality in Information and Support Services Standard |
| MQVS | Macmillan Quality Volunteer Standard |

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| MRSA | Methicillin-Resistant Staphylococcus Aureus |
| MSDS | Maternity Services Data Set |
| mSv | Millisievert |
| NABCOP | National Audit of Breast Cancer in Older People |
| NACAP | National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme |
| NaDIA | National Diabetes Inpatient Audit |
| NBOCA | National Bowel Cancer Audit |
| NCAP | National Cardiac Audit Programme |
| NCAA | National Cardiac Arrest Audit |
| NED | National Endoscopy Database |
| NEIAA | National Early Inflammatory Arthritis Audit |
| NELA | National Emergency Laparotomy Audit |
| NEWS | National Early Warning Score |
| NGH | Northern General Hospital |
| NGO | National Guardian Office |
| NHS | National Health Service |
| NHSD | National Health Service Digital |
| NHSE | NHS England |
| NHSFT | National Health Service Foundation Trust |
| NHSI | NHS Improvement |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health Research |
| NJR | National Joint Registry |
| NLCA | National Lung Cancer Audit |
| NMPA | National Maternity and Perinatal Audit |
| NNAP | National Neonatal Audit Programme |
| NOGCA | National Osophago-Gastro Cancer Audit |
| NPDA | National Paediatric Diabetes Audit |
| NRLS | National Reporting and Learning System |
| OASIs | Obstetric Anal Sphincter Injuries |
| O&G | Obstetrics and Gynaecology |
| OLAF | Organisation Learning Action Forum |
| OMFS | Oral and Maxillofacial Surgery |
| OP | Out Patient |
| OPT | Optical Projection Tomogrophy |
| PCI | Percutaneous Coronary Intervention |
| PDSA | Plan, Do, Study, Act |
| PEG | Percutaneous Endoscopic Gastrostomy |
| PGD | Patient Group Direction |
| PGME | Post Graduate Medical Education |
| PHE | Public Health England |
| PIR | Post Infection Review |
| PLACE | Patient-led Assessment of the Care Environment |
| PLD | Patients with a Learning Disability |
| POCF | Point of Care Foundation |
| POCT | Point of Care Testing |
| PPE | Personal Protective Equipment |
| PRISM | Preventable Incidents Survival and Mortality Scoring Methodology |
| PROMs | Patient Reported Outcome Measures |
| PSIRF | Patient Safety Incident Response Framework |
| PSSRU | Personal Social Services Research Unit |

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| PTL | Patient Tracking List |
| QIP | Quality Improvement Programme |
| QR | Quick Response |
| R&D | Research and Development |
| RCA | Root Cause Analysis |
| RCCG | NHS Rotherham Care Commissioning Group |
| RCHC | Rotherham Community Health Centre |
| RCPCH | Royal College of Paediatrics and Child Health |
| RGH | Rotherham General Hospital |
| RMBC | Rotherham Metropolitan Borough Council |
| RPA | Radiation Protection Advisor |
| RSAB | Rotherham Safeguarding Adult Board |
| RSCP | Rotherham Safeguarding Children Partnership |
| RTT | Referral to Treatment |
| S1 | SystemOne |
| SHMI | Summary level Hospital Mortality Indicator |
| SHOT | Serious Hazards of Transfusion |
| SI | Serious Incident |
| SJR | Structured Judgement Review |
| SLM | Service Line Monitoring |
| SOP | Standard Operating Procedure |
| SQL | Structured Query Language |
| SSNAP | Sentinel Stroke National Audit Programme |
| SUI | Serious Untoward Incident |
| SUS | Secondary Uses Service |
| TARN | Trauma Audit and Research Network |
| TB | Tuberculosis |
| TENT | Trust Essential Nursing Training |
| TIA | Transient Ischaemic Attack |
| TNA | Trainee Nursing Associate |
| TRFT | The Rotherham NHS Foundation Trust |
| TURBT | Trans Urethral Bladder Tumor |
| UGI | Upper Gastrointestinal |
| UECC | Urgent and Emergency Care Centre |
| UNICEF | United Nations Children’s Fund |
| WHO | World Health Organisation |
| YTD | Year To Date |
| VDI | Virtual Desktop Infrastructure |
| VTE | Venous Thromboembolism |
| YAG | Yttrium Aluminium Garnet |

Glossary

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

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| Schwartz Round | Group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare |
| Secondary Uses Service | A collection of health care data required by hospitals and used for planning health care, supporting payments, commissioning policy development and research. |
| Structured Judgement Review | Usually undertaken by an individual reviewing a patient's death and mainly comprises two specific aspects: explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received. |
| Summary level Hospital Mortality Indicator | The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there |
| SystmOne | Clinical Software System |