The Rotherham NHS Foundation Trust

Quality Accounts 2019/20

Ambitious Caring Together

NHS
The Rotherham
NHS Foundation Trust

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Part One: Statement on Quality from the Chief Executive -

The Trust has continued to face a number of challenges during 2019/20, but has also achieved success in other areas.

The 6 week wait diagnostic target, which aims to support patients receiving their diagnostic test within 6 weeks, has traditionally been a standard the Trust has strongly achieved. However, the Trust did not deliver against this performance measure during the year, with smaller specialties, e.g. urology, facing particular challenges. The addition of a dedicated Cancer Improvement Manager mid-year supported the service in being able to decrease the Patient Tracking List from +1,000 patients, to 733 in September 2020, and towards the end of Q3, there were further signs of improvement. Performance against the 31-day cancer treatment target was also strong. However, the onset of the Coronavirus pandemic towards the end of Q4 saw a deterioration, with the Trust achieving only 76.8% against the 85% 6-week wait target for the year. Further work is taking place to improve this position as we move through 2020/21.

Given we have been a field test site for the proposed new A&E standards for 11 of the 12 months of the financial year, 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 particularly focussed on; having twenty-seven 12-hour trolley breaches during the year (2018/19:2) is not satisfactory, and the Trust has taken significant steps to address this position, including a focus on our new assessment pathways to support more timely and effective care for patients.

The new model of care is not yet fully embedded, although improvements have been made, so much so that the CQC recognised progress at their inspection in August 2019 and were able to upgrade our 2018 CQC rating for UECC to 'requires improvement' from 'inadequate'. Clearly there is still some work to be undertaken, and the Trust continues to strive to ensure that the services are rated more positively. The Trust has an improvement plan in place and will continue to further improve the quality and performance of Urgent and Emergency services for patients. The Trust's Hospital Standardised Mortality Ratio (HSMR) stood at 104 at the start of the year, but had deteriorated to 116.9 by the end of January 2020. The issue has received significant attention during the year from the Board and its committees, with quality improvement work undertaken to understand the reasons for the continuous rise; this has included assessment of coding practices, external reviews, and the appointment of the Trust's first Medical Examiner, and Learning from Deaths Specialist Nurse. Work continues in this area and is being led by the Executive
Medical Director.

The Trust's financial challenge remains significant and despite having tackled a number of financial issues in previous years, the Trust did not deliver its financial plan in 2019/20. The financial position deteriorated over the final quarter of the year, and ended the year with a deficit of £4.9M against a break even plan. However, because the South Yorkshire and Bassetlaw Integrated Care System remained in aggregate balance, the Trust qualified for additional Financial Recovery Fund (deficit reduction) monies. As a result, the Trust closed the year with a surplus of £9K. The effective and efficient use of resources remains critical and central to our planning for 2020/21, and the risk to the financial sustainability of the Trust remains; we will need to manage this on a longer term basis, beyond 2020/21.

We have had excellent performance for our Friends & Family Inpatient scores all year, and we have also seen improvements in a number of other areas, including an increase in the percentage of looked after children with assessments reported within 20 days, potential under-reporting of incidents, and non-elective readmissions within 28 days. Improved performance in a number of areas has also been achieved as a result of the ongoing partnership working across the Borough through the Rotherham Integrated Health & Social Care Place Plan, which is bringing partners together across health and social care to improve the health and wellbeing of the population we serve, delivering more joined up integrated services across Rotherham.

We also continue to develop and build upon our Trust 5-year strategy, and have developed a 5-year plan to drive forward delivery of our vision. We continue to implement change across the Trust, we support initiatives across the Rotherham Place and across the South Yorkshire & Bassetlaw Integrated Care System (SYB ICS). This programme of transformation has seen a reconfiguration of our Intermediate Care bed base, the first year of operation of our new Acute Surgical Unit and the full implementation of streaming in our Urgent and Emergency Care Centre. We have equally ambitious plans for 2020/21 which will see us continue our collaboration with partners across health and social care and will include the relocation of our Ophthalmology services to the Rotherham Community Health Centre and implementation of a new model of care for respiratory patients.

Finally, COVID-19. By the time that 'lockdown' had been imposed by the government in late March 2020, the Trust had already been making plans to cope with the expected surge in critically ill patients. 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 inspiring. And whilst the pandemic brought with it a renewed appreciation for the NHS in general, I must say a huge thank you to our incredible colleagues for their on-going dedication in providing safe and effective care for our patients. Their response has been fantastic, and the astonishing outpouring of support from the public, is well-deserved.

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

Dr Richard Jenkins
Chief Executive
26th October 2020

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 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 2020/21, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process including a public 'showcase' where colleagues, governors, patients and members of public were able to comment on the draft proposals and shape how these priorities were delivered, along with using the findings from the recent Care Quality Commission inspection.

Delivering continuous improvement is the responsibility of all colleagues. Clinical Trust services are delivered through our Clinical Divisions, each ultimately accountable to the Board of Directors for its contribution to the performance of the Trust as a whole. Each Division is led by a General Manager with support from a Divisional Director (a Senior Clinician), a Head of Nursing, and Finance and Human Resources Business Partners. However, during the year the leadership transferred from the General Manager to the Divisional Director. 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 2020/21 are:

<u>Patient Safety</u>

- 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 Incident 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 NHS Improvement (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

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 Structured Judgement Reviews.

The planned activity to achieve this

- Provide one-day training for a range of medical/nursing and therapy staff in undertaking structured judgement reviews.
- 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 an 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.

How will progress be monitored and reported?
Progress will be reported and monitored by the Patient Safety Group, Clinical Governance Committee and Quality Committee.

Title - Embed Human Factors & Introduce Schwartz Rounds Within the Organisation

Executive Lead – 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.

The planned activity to achieve this

- 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.
- 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.
- Re-introduction of Schwartz Rounds to the Trust.

How will progress be monitored and reported?

- Number of colleagues completing human factors training.
- Analysis of SI reports quarterly for human factors authorship, content and actions.
- Number of in situ simulation reports completed quarterly. Number of safety actions resulting.
- Staff Survey results (to be published Dec 2020). Questions 4j, 6c, 13b and 13c relate to staff interactions and questions 17a, 17c and 18c relate to the organisational response to incidents and the staff involved.
- Number of, and attendance at, Trust Schwartz Rounds.
- Audit feedback on use of Schwartz rounds
- Monthly reporting of above matrices to Clinical Governance Committee and Quality Committee.

Title - Roll-Out Medical Examiner Office

Executive Lead – 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 Medical Examiner 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 Structured Judgement Review 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 Structured Judgement 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 Serious Untoward Incident 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 mortality review (SJR) and report into the divisional Mortality and Morbidity meeting and Trust wider Mortality meeting and Trust Board.

The planned activity to achieve this
There is currently 1 lead Medical Examiner with plans to appoint 2 more Medical Examiners. The Medical Examiner's office will have a band 6 Medical Examiner Officer, 2 Band 5 Medical Examiner Officers and a band 2 administrator. The other arm of the Medical Examiner will be to have learning from deaths nurse in post to coordinate the outcomes of the reviews and ensure learning from these deaths.

Each division will implement robust, multi-disciplinary SJR reviews, which will be timetabled within the Division.

How will progress be monitored and reported?
Progress will be reported monthly by the Trust Mortality Group, Patient Safety Group, Clinical Governance Committee, Quality Committee and the Board, including through the introduction of a new monthly dashboard with Executive oversight by the Medical Director.

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 – 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.

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 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

The planned activity to achieve this

- Agreement and refinement of areas of focus for first 2 key areas in Quarter 1, including compliance with sepsis bundle
- Audit of standards pertaining to topic agreed
- Analysis of results and Root Cause Analysis of non-compliant areas
- Implement recommendations – ongoing measurement of outcomes (use of Plan, Do, Study, Act (PDSA) and Statistical Process Control (SPC))
- Re-audit at post 6 months' implementation (for first 2 key areas)
- For the 3rd key area, spot audits of ongoing compliance and/or sustained learning from completed action plans relating to significant actions and/or themes will be added to the Trust's Forward Audit Plan.

How will progress be monitored and reported?
Progress will be reported and monitored by the Clinical Effectiveness and Research group and Clinical Governance Committee, with highlight reporting to the Quality Committee.

Title - Reduce HSMR and improve Learning from Deaths

Executive Lead – 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 Hospital Standardised Mortality Ratio (HSMR) and Summary level Hospital Mortality Indicator (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 ReSEPCT or the Gold Standard Framework (GSF) Hospitals Programme

The planned activity to achieve this

The Trust will also 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 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 SJR's 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 Mortality Group meetings within each Division and that the Trust Mortality Group is represented by all Divisions.

How will progress be monitored and reported?
Progress will be monitored and reported monthly by the Trust Mortality Group, Clinical Effectiveness and Research Group, Patient Safety Group, Clinical Governance Committee, Quality Committee and the Board, including through the introduction of a new monthly dashboard with Executive oversight by the Medical Director.

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%

The planned activity to achieve this

- 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 PLD
- Audit the staff groups' 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 LD and Autism)
- Provide access point to staff with LD to discuss issues on urgent basis if necessary.
- Identify those staff who might need more support than others and have a plan how to do so effectively.
- Create culture of confidentiality and trust with the LD staff.
- LD can be one manifestation of complex conditions, therefore address this complexity if it arises by providing the right resources.

- 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 are 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

How will progress be monitored and reported?
To re audit with a questionnaire the level of knowledge of the staff groups that attended the training sessions, to see if this level of knowledge has improved.

To monitor complaints to see if there is a reduction.

Monitored through Clinical Governance Committee and Quality Committee.

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 NHS Improvement 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 1st 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.

<u>The planned activity to achieve this</u>
Individual comments collected through the FFT process can make a significant difference to understanding a patient's lived experience as a service user and in turn lead to actions that improve the quality of care for all patients in a given service. Taken collectively, feedback can also identify themes and issues that need to be investigated. This can be triangulated with other data, resulting in significant insights and changes in how care is provided. Often it is the small improvements that make the biggest difference to patients, such as quieter wards at night, better food, or shorter fasting times before an operation.

Therefore:
- 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 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.

How will progress be monitored and reported?
The FFT numerical data will no longer be comparable across NHS organisations, but it can be used internally to continuously measure user engagement with the process, monitor quality and to inform service or care change decisions. This will include the analysis of time series data such as the FFT generates, to show improvement or a decline in patient experience.

The numerical data has two key uses:

- We can use The Trust’s own data as an informal ‘temperature check’ on satisfaction and engagement, and to look at change over time – e.g. looking at trends and anomalies.
- Commissioners and Regulators can use FFT data alongside other information to get a richer picture of how engaged the provider is with their patients.

The Assistant Chief Nurse for Patient Experience will monitor and report this progress by liaising with the Divisions, to ensure that there is visible evidence in public places to demonstrate what actions have taken place because of feedback (i.e. standardised Quality Boards with “you said, we did” displayed) and that actions are taken and plans are developed, delivered and monitored to address all feedback received in a timely manner. This will be reported to the Clinical Governance Group and Quality Committee within the quarterly Patient Experience Report.

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 Friends and Family 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.

The planned activity to achieve this

- 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.

How will progress be monitored and reported?
Via Diversity and Inclusion Group, Patient Experience Group and Quality Committee.

Title - Maximising the potential of Volunteering - recognise, recruit, embed and celebrate

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

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

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

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

- Promote interesting and diverse volunteering opportunities.
- To engage and retain our volunteers.
- Ensure that there are clear standards of best practice and consistency in supporting volunteers.

- Respond to emerging trends and issues in the volunteer sector.
- Recognise and celebrate all volunteer contributions to this Trust.

The aim and objective(s) (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 developed in 2020/21 and 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.

The planned activity to achieve this

We now have 115 volunteers placed across the Trust, offering their time once or twice per week in the hospital and community, and some individuals offer much more time. A number of the Trust's volunteers also dedicate their time to fundraising and have raised thousands of pounds for the Rotherham Hospital and Community Charity.

As the service continues to grow, the role of the Voluntary Services team has expanded and now includes an administration assistant role, which has been supported by the Patient Experience Group (PEG). This role will be an integral support to assist in key event preparation and at times of data collection and reporting.

- 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

- 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.

Following the appointment of the current Voluntary Services Co-ordinator 16 months ago, who is a lone worker at times, and a part time employee, the service has grown significantly and continues to do so in line with the Voluntary Service strategy in place; therefore, to continue to maximise the potential of volunteering, additional support will be required.

Inpatient Volunteers: In 2020/21 this will be the major focus and priority for new volunteer recruitment and for their role development. We will prioritise the recruitment, training and placement of volunteers in existing and new roles that will have the greatest direct and tangible impact upon the quality of patient experience for inpatients on our wards.

- To deliver this we will:

  - 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.

Outpatient Volunteers: Building on the success of existing outpatient volunteer roles, there is a proven need to increase existing volunteering capacity of the 'Meet & Greet' role, supporting patients, assisting them to check in on arrival and directing and escorting them to their appointments. The majority of 'Meet and Greet' volunteers will be also be trained to push wheelchairs and we will:

- 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.

This Voluntary Services Strategy will also allow for flexibility in introducing and adapting to new and innovative projects and schemes to improve the overall patient experience.

<u>How will progress be monitored and reported?</u>
This will be monitored on a continuous basis and reported via the quarterly Patient Experience Report by the Head of Patient Experience and annually.

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 2019/20 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 2019/20 represented 86% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2019/20.

Clinical Audit

During 2019/20, 52 national clinical audits and 6 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation provides. During that period The Rotherham NHS Foundation Trust participated in 46 (88%) of national clinical audits and 6 (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 2019/20, 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**
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	Yes	100%	NA
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	Yes	100% *	NA
BAUS Urology Audits: Nephrectomy Audit	Yes	100% *	NA
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	Yes	100% *	NA
Care of Children (Care in Emergency Departments): Percutaneous Nephrolithotomy (PCNL)	Yes	100%	NA
Case Mix Programme (CMP)	Yes	100%	NA
Elective Surgery (National PROMs Programme)	Yes	87%	NA
Endocrine and Thyroid National Audit	Yes	0%	Systems for collecting data are in set up as we have not previously participated

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	Yes	100%*	NA
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls	Yes	100%	NA
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Yes	100%	NA
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%	NA
Mental Health (Care in Emergency Departments)	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	100%*	NA
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	100%*	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 Care at the End of Life (NACEL)	Yes	100%	NA
National Audit of Dementia: Dementia care in general hospitals	Yes	100%	NA

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	100% for Cohort 1	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%	Due to COVID unable to collect & submit 19/20 as planned in July 2020
National Diabetes Audit - Adults: National Diabetes Inpatient Audit (NaDIA)	Yes	100%	NA
National Diabetes Audit - Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	100%	NA
National Diabetes Audit - Adults: National Core Diabetes Audit	Yes	100%	NA
National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit	Yes	100%	NA
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%*	NA
National Emergency Laparotomy Audit (NELA)	Yes	70%	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 Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
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
National Smoking Cessation Audit 2019	Yes	100%	NA
Sentinel Stroke National Audit programme (SSNAP)	Yes	Band A 90%	NA
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%	NA
Surgical Site Infection Surveillance Service	Yes	100%	NA
Trauma Audit & Research Network (TARN)	Yes	41% (01/01/2018 - 31/12/2019	NA
UK Parkinson's Audit	Yes	100%	NA

Note - % cases (of those required) are not at 100% for NELA due to data not being available and for TARN due to limited resources.

National Confidential Enquiry	Workstream	Participation yes/no?	% Cases (of those required)	Reason for non-participation
Child Health Clinical Outcome Review Programme	Long-term ventilation in children, young people and young adults	Yes	No cases identified	NA
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance (reports annually)	Yes	100%	NA

Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal morbidity and mortality confidential enquiries (reports alternate years)	Yes	100%	NA
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Yes	100%	NA
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity confidential enquiries (reports annually)	Yes	100%	NA
Medical and Surgical Clinical Outcome Review Programme	Dysphagia in Parkinson's Disease	Yes	100%	NA

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

*Data for projects marked with * require further validation, this may be a result of: final ascertainment results being unavailable from audit providers; final submission dates for 2019/20 data not due or delayed by COVID. 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 at time points throughout the year and therefore final figures may change.*

The reports of 18 national audits were reviewed by the provider in 2019/20 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 32 national audit reports published which are under review.

Title	Published	Report Reviewed	Action(s) to improve quality of care
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	No actions required
Child Health Clinical Outcome Review Programme: Young People's Mental Health	Yes	Yes	Recommendations and appropriate actions are still under review
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	All data submitted and compared with regional and national statistics on Monthly Quarterly and Annual basis. There are no recommendations to adopt
Medical and Surgical Clinical Outcome Review Programme: Cancer in Children, Teens and Young Adults	Yes	Yes	Local audit of the side effects and outcomes of systemic anti-cancer therapy (SACT) to be undertaken
Medical and Surgical Clinical Outcome Review Programme: Perioperative diabetes	Yes	Yes	Discussions are taking place regarding the appointment of a clinical lead for perioperative diabetes care within the Trust
Medical and Surgical Clinical Outcome Review Programme: Pulmonary embolism	Yes	Yes	Standardise CT pulmonary angiogram reporting. Discuss with Imaging Group to consider a region wide CT Pulmonary Angiogram (CTPA) reporting proforma

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	All patients admitted with an acute exacerbation of COPD will be reviewed with spirometry in outpatients/Breathing Space. Ensure that all current smokers are identified, offered, and if they accept, prescribed smoking cessation pharmacotherapy. This is done on admission and will be done on discharge as part of planned discharge bundle. Discharge bundle has now been introduced.
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Action plan in development
National Audit of Dementia: Dementia care in general hospitals	Yes	Yes	Medical clerking document section on cognitive assessment to be re-designed and simplified to include 4AT (rapid clinical test for delirium) as primary delirium screening method and implemented via Meditech in the Urgent and Emergency Care Centre (UECC). Information packs are handed out by the Fragility team to families and carers of people with dementia who they see. Person centred care days are currently scheduled 4 times a year and include tier 2 dementia and delirium training. The frailty team provide feedback forms to patients living with dementia in the information pack given out to patients/significant others. The frailty team are currently working towards the hospital being recognised as dementia friendly by the National Dementia Action Alliance 2018 charter.

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	Improve compliance with entering General Medical Council (GMC) numbers for Implanting doctors by electronically inputting Implanting Doctor GMC numbers to CVIS (Tomcat) – these are then electronically transferred to National Institute for Cardiovascular Outcomes Research (NICOR) as part of the monthly download. Ensure new Implanters are added when starting at the Trust (includes visiting Consultants from regional device service and Specialist Registrars).
National Diabetes Audit - Adults: National Diabetes Foot Care Audit	Yes	Yes	To increase the number of patients audited by liaising with the Podiatry team who undertake the audit to discuss the process.
National Diabetes Audit - Adults: National Diabetes Inpatient Audit (NaDIA) -reporting data on services in England and Wales	Yes	Yes	Work taking place with the Governance Pharmacist to review insulin incidents and liaising with the person/people involved so that learning can be undertaken. Electronic Prescribing is now live at the Trust in both inpatient and outpatient areas and remote blood glucose monitoring is available. Health Care professionals receive regular training from the Diabetes team and there is a Diabetes associate programme running for ward nurses and health care assistants.

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit	Yes	Yes	Discuss with the Clinical Commissioning Group (CCG) re. introduction of Continuous Glucose Monitoring for women with Type I diabetes in pregnancy. Training for staff to introduce Gestational Diabetes Mellitus app for use in Type 2 patients. Introduce diabetes in pregnancy onto Mandatory Training programme and ensure 2 diabetes study days per year. Introduce flags onto GP practice systems for annual reviews for patients with diabetes and flyers to be given with prescriptions to increase preconception folic acid uptake.
National Lung Cancer Audit (NLCA)	Yes	Yes	Optimal lung cancer pathway being introduced. Performance/plans are going to be reviewed as part of Getting it Right First Time (GIRFT) in the new year.
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Recommendations and appropriate actions are still under review
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Improve transitional care and flow including: - Increase transitional care capacity - Consider discharge to young adult clinics earlier - Consider move to transition clinic earlier - Work towards a curriculum- based transition clinic journey - Assess patient experience of transition Local audit of Diabetes Self-Management Education programme
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	Pathology Quality team to organise Human Factor ‘training’ for laboratory staff from TRFT Medical Lead for Human Factors

Title	Published	Report Reviewed	Action(s) to improve quality of care
Surgical Site Infection Surveillance Service	Yes	Yes	There have been no surgical site infections following knee prosthesis in the last 4 years of surveillance. The surveillance is for 1 quarter each year mandatory. No actions are indicated.

Review of Local Clinical Audits

The reports of 94 local clinical audits were reviewed by the provider in 2019-20 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 2019/20 that were recruited to participate in research was 827. A significant number of recruits (548) are the result of participation in the Fast Track study, a gastrointestinal study which closed in December 2019 [data taken from the NIHR Open Data Platform 04 April 2020].

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 2019/20

Study Type	Number of studies
NIHR Portfolio Commercially sponsored	4
NIHR Portfolio Non-commercial	41
NIHR Portfolio Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	6
Non-portfolio The Rotherham NHSFT Sponsored	8
Other Non-portfolio (supporting academic qualifications)	4
Studies undertaken at TRFT which required no Capacity & Capability review	4

(Source: TRFT Research Database)

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

CQUINs (Commissioning for Quality and Innovation)
A proportion of The Rotherham NHS Foundation Trust income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between The Rotherham NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2019/20 £2.09million of Trust income for all applicable Commissioners was conditional upon achieving the quality improvement and innovation goals compared with £3.88 million in 2018/19.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically from the Trust Website at:
http://www.therotherhamft.nhs.uk/CQUINqualityindicatorframework/

CQUIN goals are being reviewed nationally but will continue to form part of the National NHS Standard contract for 2020-21 once finalised. All schemes agreed are national indicators. A high level summary of the indicators applicable in 2019/20 is provided below:

- CCG1a: AMR – Lower urinary tract infections in older people
- CCG1b: AMR – Antibiotic prophylaxis in colorectal surgery
- CCG2: Staff flu vaccinations
- CCG3a: Alcohol and Tobacco – Screening
- CCG3b: Alcohol and tobacco – Tobacco brief advice
- CCG3b: Alcohol and tobacco – Alcohol brief advice
- CCG7: Three high impact actions to prevent falls
- CCG11a: SDEC – Pulmonary embolus
- CCG11b: SDEC – Tachycardia with atrial fibrillation
- CCG11c: SDEC – Community acquired pneumonia

CQC Registration and Periodic Reviews/Specialist Reviews

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

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

The Care Quality Commission has not taken enforcement action against the Rotherham NHS Foundation Trust during 2019/20.

The Trust was fully inspected by the Care Quality Commission in February 2015 with a follow-up re-inspection occurring between 27-30 September 2016 (and a further unannounced inspection on 12 October 2016) and then further unannounced inspections in September and October 2018. Following this the Urgent and Emergency Care Service was inspected in August 2019.

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 26th 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.

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 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 which have been reported to the CQC from 1st April 2019 to 31st March 2020.

	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 wrong name, when date of birth was checked it was shouted through the glass screen to the operator to whom it sounded correct through mask and screen. Process has already been changed so that checklist is positioned in front of glass screen so radiographer in room can read and check directly and give thumbs up to the operator. This is all due to infection control measures and change in work flow. Radiation protection advisors report obtained and reported to Ionising Radiation (Medical Exposure) Regulations (IRMER) CQC. We have had notification on the 21st April 2020 that the CQC has closed this incident and we are awaiting official closure email.

(Source: Datix and Radiation Protection Advisors Report)

We have had no further radiation incidents which are reportable to external agencies from 1st April 2019 to 31st March 2020; 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.

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

The Trust have had no radiation incidents which are reportable to external agencies. 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.

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

Data Quality
The Rotherham NHS Foundation Trust submitted records during 2019/20 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 2018/19) for admitted patient care
100.0% (100.00% for 2018/19) for outpatient care, and
99.6% (99.5% for 2018/19) 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 2018/19) for admitted patient care
100% (100% for 2018/19) for outpatient care, and
100% (100% for 2018/19) for accident and emergency care.

Please note: 2019/20 data in this section is based on a refreshed data position from NHS Digital submissions. The 2018/19 data is based on the published data April 2018 – October 2018 from the same source.

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

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

Organisations are expected to achieve the 'standards met' assessment on the DSPT by 31 March each year but due to COVID-19, organisations now had until 30th September 2020 to submit this year.

The Rotherham NHS Foundation Trust's DSPT current status for 2019/20, is "standards fully met".

The Trust will submit again by September 30th 2020 and is aiming for full compliance.

The Rotherham NHS Foundation Trust Information Governance Assessment Report overall score for 2019/20 was Standards Fully Met.

Payment by Results
The Rotherham NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission. (Note: NHS Improvement (NHSI) Comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone '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 Rotherham NHS Foundation 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 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 Rotherham NHS Foundation Trust was subject to the mandatory Clinical Coding Information Governance (IG) audit in December 2019, during the 19/20 reporting period as required by NHS Digital. The Trust again achieved an IG rating of level three (Advisory), for the third year running, which is the highest possible rating that can be achieved. An aggregate percentage score of 98.1% was achieved across the four domains audited.

No additional audits were performed in this financial year as it was necessary for the department to focus on ensuring that all staff attended their three yearly refresher courses, which is a requirement for all NHS clinical coders to attend to ensure that they are up to date with all national standards – all staff that were required to attend, attended and passed their exams with strong grades.

Data Quality Index (HRG4+ based)
CHKS continues to be the source of information for the Data Quality Index and at the time of reporting data for the period April 2019 to December 2019 is available. The Trust has again managed to continue to outperform peer averages with an index of 96.11% compared to a peer average of 94.33%. Although there was a decrease in our overall index score, as it was with our peers, this was down to a new data submission which always takes time to stabilise the quality of the data submitted therein.

The Rotherham NHS Foundation Trust will be 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 next year to improve the quality of the data submitted from systems thus ensuring that additional data quality activities can be performed prior to submission.

As a team the Data Quality Indicators are reviewed monthly both from a CHKS 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.

Blank, invalid or unacceptable primary diagnosis rates (HRG 4 based)
The Trust position for unaccepted diagnosis codes in the period up to March 2020 has improved, achieving 0.00% against a previous measurement of 0.02% for 2018/19. The depth of coding (average number of diagnoses per coded episode) has been slightly improved at circa 7.51 for this financial year, which is 25% higher than the peer average of 6.1.

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%	97.8%	98.3%	98.7%

(Source: The Rotherham NHS FT Information Governance Audit Report 2019/2020)

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

In 2018/19 the Trust continued with the following actions to improve clinical coding and data quality and these continued throughout 2019/20:

- Using data analysis to flag up potential coding and data quality errors and generate regular reports to monitor coding and data quality, using the ever expanding locally designed clinical coding indicators
- Engaged clinicians across specialties, creating coder/clinician two way communications through coding/documentation review sessions
- Provided in-house coding training sessions for consultants.
- Sample checking of coding activity performed by staff and internal feedback sessions provided to individuals
- Annual coding training sessions included on the F1 junior doctor's induction.

Improvements and actions to further improve clinical coding during 2019/20 included:

- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable.
- Implement and review coding performance indicators.
- The Trust 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.

Table – areas selected for focussed improvement activity

Data Quality - April 2019 to Oct 2019

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2019-20	Qtr 2 2019-20	Qtr 3 2019-20	Qtr 4 2018-19	YTD Apr to Oct	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	97.53%	97.33%	TBC end of May/June 2020	TBC end of May/June 2020	97.34%	
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	0.00%	0.00%	TBC end of May/June 2020	TBC end of May/June 2020	0.00%	
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)**	2015 -16	8.84%	Decrease	9.53%	10.74%	TBC end of May/June 2020	TBC end of May/June 2020	10.26%	
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)**	2015 -16	11.99%	Decrease	11.63%	13.86%	TBC end of May/June 2020	TBC end of May/June 2020	12.76%	
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 -16	99.80%	Increase	99.90%	99.90%	99.90%		99.90%	
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 -16	100.00%	Maintain	100.00%	100.00%	100.00%		100.00%	
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	100.00%	100.00%		100.00%	
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Maintain	100.00%	100.00%	100.00%		100.00%	
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	99.50%	99.60%	99.60%		99.50%	
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	100.00%	100.00%	100.00%		100.00%	

* Data from external sources only available up to Dec 2018 in a complete state
** Due to clinical coding team coding from EMR and not notes due to lack of access to notes there is always a tendency to have signs and symptoms as this is usually only the data that the patient had recorded on admission
(Source: NHS Digital and CHKS Live)

Note: Qtr 4 Data will be available late May / early June 2020

Data Quality - April 2018 to Mar 2019

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2018-19	Qtr 2 2018-19	Qtr 3 2018-19	Qtr 4 2018-19	YTD 18 – 19	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 - 16	96	Increase	97.86%	97.88%	97.34%	97.68%	97.70%	
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 - 16	0.46 %	Decrease	0.28%	0.20%	0.48%	0.41%	0.32%	
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)**	2015 - 16	8.84 %	Decrease	9.53%	9.98%	10.68%	9.64%	9.82%	
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)**	2015 - 16	11.99 %	Decrease	11.51%	12.41%	15.50%	15.51%	12.35%	
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 - 16	99.80 %	Increase	99.90%	99.90%	99.90%	99.90%	99.90%	
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 - 16	100.00%	Maintain	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 - 16	99.90 %	Increase	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 - 16	99.90 %	Maintain	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 - 16	86.60 %	Increase	99.40%	99.50%	99.50%	99.60%	99.60%	
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 - 16	99.10 %	Increase	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	

* Data from external sources only available up to Dec 2018 in a complete state

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

(Source: NHS Digital and CHKS Live)

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

Learning from Deaths
During 2019/2020, 957 of TRFT patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period.

- 228 in Q1
- 205 in Q2
- 231 in Q3
- 293 in Q4

By 29th April 2020, 715 case record reviews and 14 investigations have been carried out in relation to the 957 deaths included in the above. In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 218 in Q1
- 172 in Q2
- 112 in Q3
- 180 in Q4

14 representing 0.1% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in care provided to the patient. In relation to each quarter, this consisted of

- 2 representing 0.3% for Q1
- 1 representing 0.14% for Q2
- 3 representing 0.4% for Q3
- 5 representing 0.1% for Q4

These numbers have used the Preventable Incidents Survival and Mortality scoring methodology (PRISM)

What the provider has learnt from case record reviews.
The Trust has been conducting case record reviews on patients within the separate divisions. It has been a specific aim to complete 100% of case record reviews within the divisions prior to the scrutiny by the Medical Examiner service. From April 2020 the Medical Examiner service will scrutinise the cases within 1 week of the death and determine whether the record should be scrutinised in more depth by a multidisciplinary team from the individual divisions.

The Trust also responds to alerts from the data provider on specific diagnosis codes with the aim to determine any themes and trends and use these to drive improved quality.

The Trust welcomed an external expert team in learning from deaths to review cases from 2016-2018 with the diagnosis of respiratory disease and community heart failure where the patient had been admitted to the hospital.

The review showed areas of excellent care when the palliative care team had been involved. It highlighted the great care that the physiotherapy department gives to the in patient population, and it highlighted good care in the first 24 hours of admission to the Trust. Areas for improvement were also highlighted such as improving documentation around nutrition, documentation and the filling in of the case notes. It specifically highlighted fluid balance as an issue.

Description and assessment (including actions)
The Trust launched the new initiative of Safe and Sound with multiple quality improvement work streams. 2 of the work streams are from learning from deaths and alerts received into the hospital, these are care of the deteriorating patient and sepsis which will feed into the mortality reduction programme.

The mortality data had shown that the Trust had an issue with sepsis and a working party sepsis group was set up with monthly meetings and discussions as a multidisciplinary team. The CQUIN target is also being used to triangulate improvements.

Work in the sepsis group has led to improved compliance with taking blood cultures. The Vascular Access Team have been educating clinicians to aim to reduce the number of false positives due to contamination.

The antimicrobial policy is constantly being updated with updates in September 2019 to aim to improve the stewardship of antibiotics and aid clinicians in prescribing.

The use of procalcitonin in sepsis has been rolled out to the Trust which helps with sepsis diagnosis but also directs the clinician when antibiotics can be safely stopped. This may improve hospital discharges which should reduce patients' risk of hospital acquired infections due to longer lengths of stay.

The sepsis group reports to the Patient Safety Team and is chaired by the AMD for patient safety.

To reduce the incidents in medication errors, the Trust has implemented electronic prescribing throughout the divisions. This is being embedded and is already seeing reduction in medication omissions.

The Medical Director has submitted business plans to develop an Acute Response Team which will incorporate the Hospital at Night team and the Critical Care Outreach Team. So that deteriorating patients are managed quickly and effectively thereby reducing the number of unplanned admissions to critical care. The introduction of the electronic observations has improved compliance with the NEWS 2 early warning score

The number of case record reviews/investigations finished in the reporting period related to deaths during previous reporting period.

The Trust has undergone a significant number of reviews of patients in 2019 who had died in 2018 to catch up with the backlog of reviews not undertaken.

471 reviews completed after April 2019 related to deaths which took place before the start of the reporting period.

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 Dec 18 - Nov 19	TRFT previous value Sept 18 - Aug 19	Acute Trust average Dec 18 - Nov 19	Acute Trust previous average Sept 18 - Aug 19	Acute Trust highest value Dec 18 - Nov 19	Acute Trust previous highest value Sept 18 - Aug 19	Acute Trust lowest value Dec 18 - Nov 19	Acute Trust previous lowest value Sept 18 - Aug 19
Summary Hospital Mortality Indicator – Value	Sept 18 - Aug 19 Dec 18 - Nov 19	118	117	*	*	119	119	69	69
Summary Hospital Mortality Indicator – Banding	Sept 18 - Aug 19 Dec 18 - Nov 19	1	1	*	*	1	1	3	3
SHMI: Percentage of patient deaths with palliative care coding at *diagnosis* level	Sept 18 - Aug 19 Dec 18 - Nov 19	37.0	35.0	36	36	58	59	11	13

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

Patient Related Outcome Measures (PROMS)

DOMAIN	Indicator Title	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Domain 3 - Helping people to recover from episodes of ill health or following injury	**Primary hip replacement surgery (EQ-5D Index) - health gain**							
	1st April 2017 - 28th March 2018	111	0.21	0.79	0.58	103 (92.8%)	2 (1.8%)	6 (5.4%)
	1st April 2018 – 31st March 2019	127	0.232	0.745	0.514	115 (90.6%)	5 (3.9%)	7 (5.5%)
	Groin hernia surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	*	*	*	*	*	*	*
	1st April 2018 - September 2018	*	*	*	*	*	*	*
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	126	0.37	0.78	0.41	112 (88.9%)	8 (6.3%)	6 (4.8%)
	1st April 2018 – 31st March 2019	135	0.405	0.761	0.356	115 (85.2%)	12 (8.9%)	8 (5.9%)
	Varicose vein surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	*	*	*	*	*	*	*
	1st April 2018 - September 2018	*	*	*	*	*	*	*
	* *No Data - On the 1st October 2017, PROMs data for varicose veins and groin hernia surgery ceased collection, following on from the NHS England Consultation on the future of PROMs*							

Please note: Results in this document are provisional for April 18 – March 19 and subject to change until the publication of finalised data.

Re admissions within 28 days of discharge from Hospital:

	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain4: Ensuring that people have a positive experience of care.	*CQUIN: Responsiveness to patients personal needs	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%

	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain5: Treating and Caring for people in a safe place.	*Percentage of patients admitted to hospital and risk assessed for 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 17-Mar 18	30.5	23.9	156.4	0
		Apr 18-Mar 19	16.4	22.1	168	0
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison	Oct 17 - March 18	37.3	21.8	124	24.2
		Oct 18 - March 19	46.7	Awaiting data - national not yet available		
	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison	Oct 17 - March 18	0.38%	0.34%	no data	no data
		Oct 18 - March 19	0.18%	0.15%	0.5%	0.0%

(Source: NHS Digital)

*** C Diff figures 18/19 published July 2019 (which is after the deadline date of the report and so is not included)**

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. See page 41 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 Divisions within the Trust hold regular mortality meetings which feed into the Mortality Review Group which currently reports to the Clinical Governance Committee. Data (SHMI and HSMR) and incidents are reviewed to help identify trends and areas of concern. A summary of the Trust's performance and mitigating actions taken is shared in Board reports. Deaths are reviewed and reported quarterly in the Learning from Deaths Report to the Board.
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only patients receiving care from the team are included in the data. See page 41	To improve the percentage score the Trust's Consultant-led Specialist Palliative care Team continue to identify and assess all patients receiving palliative care.
18. Patient Reported Outcome Measures scores for (i) groin hernia surgery; (ii) varicose vein surgery;	The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital. The latest reporting periods vary between the type of surgery performed.	PROMS are measures recorded pre- and post-operatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision. (i) No longer collected. (ii) No longer collected.

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:
(iii) primary hip replacement surgery (iv) primary knee replacement surgery during the reporting period.	Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement. See page 42.	(iii) 93% 14/15 patients stated they noticed an improvement post surgery. (iv) 72.72% 8/11 patients stated they noticed an improvement post surgery.
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 28 days of discharge from the Trust	This indicator is not presently being updated by NHS Digital; as yet there is no date available for the next data release. The latest update available from NHS Digital is for the period 2011/12. Therefore, the internal TRFT data Warehouse is used for all reporting of re admissions for the performance reports for the Board, the Divisions, the clinical support units (CSU) and for the Service Line Monitoring (SLMs) reports	The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data. The Transfer of Care Team works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission of Care Home Patients and works with the sector to improve effectiveness.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's position is drawn from 5 key questions asked in the national in-patient survey (administered by the CQC). The most recent data is from the survey conducted between August 2018 and January 2019. Full results are available later in this report.	CQC will publish 2019 patient survey results in July 2020.
21. The percentage of staff employed by, or under contract to, the Trust	Department of Health conduct an annual	For staff survey data and staff Friends and Family data see page 90.

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:
during the reporting period who would recommend the Trust as a provider of care to their family or friends.	independent survey of staff opinion.	
21.1 Friends and Family Test – " How likely are you to recommend our hospital to friends and family if they need similar care or treatment" Services covered: - Inpatients - Day Cases - Accident and Emergency - Outpatients - Maternity - Community	The data is considered to be accurate based on the number of forms inputted into the system received for each area. The data is submitted to NHS Digital monthly for publication. The published data relates to the positive and negative scores for each area derived from the number of patients who would or would not recommend our services. Since March 2017 the Trust has run the Friends and Family test in house, previously it was out sourced to an external contractor.	The target for the positive score is 95% for all areas except Accident and Emergency where it is 85%. The Trust will continue to collect FFT data to help to improve the experiences of our patients and to triangulate the data with the national patient survey results. The majority of the data collection was to remain in paper form with a SMS messaging service being piloted in UECC. However, due to the pandemic the Trust are considering alternative ways of working including the SMS service being implemented Trust wide. The data informatics team are also looking at other ways for people to give feedback if they are only having appointments by phone or video. Under the new guidance there will be no restrictions/time scale on when people can give feedback so as a Trust

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:
	Due to the large number of outpatient clinics there is a rota system in operation which ensures all clinics are captured at certain months throughout the year.	we do not need to try to catch them at discharge. Data will also not be comparable across organisations but it can be used to continuously monitor quality and inform decisions, including analysis of time series data such as the FFT generates, to show improvement or a decline in patient experience, you said we did.
23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Data is validated and published by NHS DIGITAL See page 43.	The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the Clinical Governance Committee.
24. The rate per 100,000 bed days of cases of C.Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	Data is validated and published by NHS DIGITAL See page 43.	The Trust will continue to monitor rates through root cause analysis and audits and report through local clinical governance structures to the Clinical Governance Committee; for further actions to reduce rate of C-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 October 2019 to March 2020 This was the latest reporting period where TRFT has submitted its data and it has been validated by the NRLS Team. Number of NRLS reportable incidents occurring in this period was 4,426. The percentage of severe harm or death was 0.29%.	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 2019/20

The number of Inquests held involving the Trust has risen sharply over the last 3 years, with a 66% increase from FY 2017/18 to FY 2018/19. The increase continued into 2019/20 with 69 Inquests opened. It is anticipated that with the introduction of the Medical Examiner role in 2020, there will be a further increase in the number of matters the Coroner will consider opening as Inquests. The Trust has responded to this by increasing capacity within the Legal Affairs Team.

Learning from Inquests continues to be a priority for our organisation. During 2018/19 the Trust received one “Report to Prevent Future Deaths”; the power that comes from regulation 28 of the Coroners (Investigations) Regulations 2013. This is currently being addressed. Learning has also been identified in a number of Inquest cases, and this has been widely shared within the organisation through the Patient Safety Group, Clinical Governance Committee and Divisional Governance Meetings in order to avoid repeat of harm events and improve the quality of patient care and experiences of our patients and their families.

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2019/20

A summary of the Trust’s quality priorities for 2019/20 is provided below with an indication as to whether the priority was achieved or not by the year end.

Patient Safety

- Increase Medication Safety
- Improve the Treatment of the Deteriorating Patient
- Improve Mandatory Training Compliance for Medical Staff

Patient Experience

- Improve End of Life Recognition
- Improve Patient Discharge
- Enhance Patient Feedback and Public Engagement

Clinical Effectiveness

- Improving the Experience of Patients Transitioning from Children to Adult Services
- Improve Mortality Reviews
- Improve Policy and National Institute for Health and Care Excellence (NICE) Guidance Compliance

Reference	Aim	Metric	RAG Rating
Increase Medication Safety	To increase the proportion of medication signed for and documented and increase the proportion of patients who receive medication in a timely and appropriate manner on discharge. This is a continued priority from 2018/19.	1) Reduce inappropriate medication omissions by 10% (9% in 2018/19)	
		2) Reduce critical medication omissions by 20% (11% in 2018/19)	
		3) Increase the appropriate prescribing and administration of antibiotics within the first hour by 10% (59.7% for the Emergency Department and 70.10% for Acute Inpatients in Quarter Four for the treatment of patients that have been identified as having sepsis)	
Improve the Treatment of the Deteriorating Patient	To improve the identification and treatment of deteriorating patients.	1) Reduce the number of Serious Incidents relating to deteriorating patients (19 in 2018/19)	
		2) Reduce the Trust's Hospital Standardised Mortality Ratio (HSMR) to below 100	
Improve Mandatory Training Compliance for Medical Staff	Improve clinical practice and maintain statutory requirements for completion of Mandatory and Statutory Training (MAST).	Increase mandatory training compliance for medical staff to 85% (with 95% for Information Governance)	
Improve End of Life Recognition	Improve the recognition of patients at the end of life. To increase the number of nurses trained in the use of End of Life Care plans and to increase the number of care plans in place for patients receiving End of Life Care.	Increase positive feedback with regards to Patient Experience In End of Life Care	
		Reduce the number of cardiac arrest calls made for patients at the End of Life Care who have a DNACPR in place	
Improve Patient Discharge	To improve the percentage of patients safely discharged from the Trust by midday on the day of discharge. This is a	Reduce 0-1 day length of stays from 21% to 20% for 2019/20 (2019/20 target to be 20% a reduction from 21%)	
		Increase activity through ACC by 20% from 2382 in 2018/19 to 2858 (2019/20 increase activity by 50	

	continued priority from 2018/19.	patients per month, 10 patients per week)	
		Increase number of patients discharged before 12 noon, reported at 2018/19 – 10% (2019/20 - 20% and 2020/21 - 30%)	
Enhance patient feedback and public engagement		Achieve the Friends and Family Test Trust agreed response rate of 40% for all inpatient areas (48% in March but with 6 individual areas falling below the baseline)	
		Achieve the Friends and Family Test Trust agreed response rate of 10% for UECC (0.4% in March)	
		To increase the number and range of opportunities for patients, carers and members of the public to be consulted with and have an opportunity to inform the decision making process within the Trust	
		To liaise with local partners to ensure that Trust patient and public involvement engagement utilises existing best practice and can reach wider target audiences	
Improving the experience of patients transitioning from children to adult services	The aim is to ensure that as many children as possible can be seamlessly transitioned from child to adult services. The proposed activity to achieve this and anticipated success measurements will vary depending upon the pathway.	a) Where national recommendations are available, a baseline position should be established and the Trust should aim to meet the national recommendations. It is recognised that this may not be possible within one year but a measure of progress made against available recommendations should be recorded.	
		b) The Trust to develop a similar model to the 'Ready Steady Go' transition programme used in other organisations, which routinely commences for all children with long term conditions at 14 years.	
		c) The Trust should plan to offer a staged approach to transition at different ages, dependent on wishes and feelings of the young person, appropriate to the underlying healthcare requirement.	

		d) Metrics/Audit to be developed to monitor the progress for all services that transition into the adult service.	
Improve Mortality Reviews	Improve the mortality review process undertaken within the Trust.	1) Increase the mortality reviews undertaken by the Medicine Division by 50% (10 in 2018/19)	
		2) Increase mortality reviews undertaken within two months of death by 50% (3 (30%) in 2018/19)	
Improve policy and National Institute for Health and Care Excellence (NICE) guidance compliance	Improve clinical practice and effectiveness through using up to date polices and complying with relevant NICE Guidance.	1) Increase the number of in date policies by 30% (baseline is 54% of policies in date at 31 March 2019)	
		2) Increase the number of NICE guidance compliance reviews undertaken in line with agreed timescales by 20% (baseline is 38% responses received in 28 days)	

3.1.2 Performance against the 2019/20 Priorities

There were nine quality priorities for 2019/20, as follows;

<u>Patient Safety</u>

- Increase Medication Safety
- Improve the Treatment of the Deteriorating Patient
- Improve Mandatory Training Compliance for Medical Staff

<u>Patient Experience</u>

- Improve End of Life Recognition
- Improve Patient Discharge
- Enhance Patient Feedback and Public Engagement

<u>Clinical Effectiveness</u>

- Improving the Experience of Patients Transitioning from Children to Adult Services
- Improve Mortality Reviews
- Improve Policy and National Institute for Health and Care Excellence (NICE) Guidance Compliance

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

Domain: Patient Safety

Increase Medication Safety

Executive Lead - Medical Director
Operational Lead - Chief Pharmacist

Rationale
Medicines optimisation is a strategic issue fundamental to the way that hospitals work and to the quality of patient care provided. The consequences of failing to deliver an effective system are significant and include: exposure of patients to unnecessary risk and harm; failure of patients to get the benefits from the medicines they are prescribed; whole system inefficiency; unnecessary expenditure and other avoidable costs; poor patient experience; and loss of reputation.

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

Medication Incidents	**2017**	**2018**
Medication	1,133	1,106

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

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

1) Reduce inappropriate medication omissions by 10% (9% in 2018/19)
2) Reduce critical medication omissions by 20% (11% in 2018/19)
3) Increase the appropriate prescribing and administration of antibiotics within the first hour by 10% (59.7% for the Emergency Department and 70.10% for Acute Inpatients in Q4 for the treatment of patients that have been identified as having sepsis)

What did we achieve?
Monthly omissions data from September 2019 onwards showed a reduction in omission rate to approximately 5% and a reduction in critical medication omission rate to under 4% with the introduction of EPMA in inpatient areas. There are no “blanks” for administration and reasons are entered for missed doses.

100 case notes were audited from the year April 2019-Feb 2020. These cases were combined from the UECC and in-patients. Approximately 68% of severe sepsis and septic shock cases received antibiotics within an hour; this is therefore above the 64.9% aggregate from combining the 59.7% ED and 70.10% acute inpatient targets. 11/11=100% septic shock cases received antibiotics within an hour. Some data was unobtainable due to poor documentation as we collected 50% data from the old paper Kardex. We are hoping this figure to improve as Electronic Prescribing and Medicines Administration (EPMA) is fully used by the prescribers now.

We are trying to improve the awareness and knowledge of our staff in the recognition of sepsis and the timely implementation of the sepsis 6 tool.

How was progress monitored and reported?
Progress was monitored and updates provided through the year at various Trust forurms, most significantly, Medication Safety Group (monthly), Patient Safety Group (monthly) and Clinical Governance Committee (quarterly).

What further actions need to be undertaken?
Further work is required in the EPMA system to refine the "reason codes" list for missed doses to make it easier to select the correct code should a medication not be given at the prescribed time. There is some work going on nationally to produce consistency in EPMA systems in regards to reason codes and TRFT will look to align with any recommended codes list.

Improve the treatment of the Deteriorating patient
Executive Lead - Medical Director
Operational Lead - Associate Medical Director for Patient Safety

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

HSMR (Hospital Standardised Mortality Ratio) Target less than 100

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

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

This was a continued priority from 2018/19.

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

What did we achieve?
Trust HSMR sat at 116.8 against a national baseline of 100 (November 2019 data). The Trust has received the report of the external mortality review which identified areas for improvement around quality of care and case mix, whilst focus remains ongoing with coding and clinical documentation. The Trust is in the process of looking to recruit an additional 2 Medical Examiners, in addition to the Medical Examiner Officers.

How was progress monitored and reported?
The progress was monitored by reviewing all incident reporting. Any incident reported or mortality reviews with a rating harm of moderate or above was reviewed at the Serious Incident panel and where there were significant concerns, an internal red incident or serious incident called. The Investigation of these incidents leads to a SMART action plan in order to ensure that these incidents are not repeated. Any incidents involving the deteriorating patient were reviewed in light of the agenda for the deteriorating patient and sepsis group.

What further actions need to be undertaken?
The Trust needs to establish a robust mechanism for monitoring the action plans from all internal red incidents and serious incidents and this will be monitored through the new "learning from incidents" Quality Improvement measure. This is now termed the operational learning action forum (OLAF).

The Trust needs to further improve the quality of patient care with regards to the deteriorating or septic patient. This includes publishing a revised sepsis policy, introducing mandatory sepsis training, and improving the measurement of fluid balance and management of acute kidney Injury.

Improve mandatory training compliance for medical staff

Executive Lead - Medical Director
Operational Lead – Head of Medical Workforce

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

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

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

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

This was a new priority for 2019/20.

What did we achieve?
As at 29 February 2020, Medical & Dental Core MaST was 79.73% and Information Governance was 80.77%

How was progress monitored and reported?
Monthly reports provided by Workforce Information and distributed to Divisions by the Deputy HRD with support from Divisional HRBPs.

What further actions need to be undertaken?
Continue to monitor monthly progress and provide support where necessary from each HRBP plus additional input from Medical Workforce.

Domain: Patient Experience

Improve End of Life Recognition

Executive Lead – Chief Nurse
Operational Lead – Assistant Chief Nurse (Patient Experience)

Current position and why is it important?
The quality priority implemented in 2018/19 and sustained for 2019/20, has continued to focus on a limited number of ward areas. It was very challenging at the end of the financial year due to the Covid 19 pandemic, leading to unprecedented demand for specialist input, guidance and support from the End of Life specialist team with the new and diverse presentations of patients experiencing Covid 19 infections and sadly the number of patients for whom recovery was not possible.

The Palliative Care team remains committed to their intention to deliver additional support and training, in relation to the recognition of the end of life and the care required, to clinical teams and through this approach to reinforce, sustain and advance leadership skills in this area across the Trust. Staff empowerment is a significant part of this work also. The work during the pandemic on Ward A2 has shown excellent progress this year and it is intended to take the achievements from this work and roll this out when restrictions are lifted.

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

This is a continued priority from 2018/19.

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

What did we achieve?
Objective 1 -

Although the Trust participates in the national Care of the Dying Audit annually, it has not undertaken the sections for 'The needs of families and others' and 'Families and others experiences of Care' at the end of life to canvas user experience feedback. It is intended to participate fully in 2020/21 and then be able to benchmark our performance with the national and also the ICS SY&B positions.

The work to canvas families and carers' experiences in end of life care continues to be progressed. This is led by the Patient Experience Team, working collaboratively with the Trust Bereavement Service, under the leadership and guidance of the Medical Examiner and with the Consultant Lead for Palliative Care. During the year, families received a bereavement pack which contained a feedback card requesting their experience of their relative's care and also of the Bereavement Service although altered practices during Covid 19 have impacted upon this process.

Objective 2 -

There was a 50% reduction in the number of inappropriate cardiac arrest calls made for patients at the End of Life Care who had a Do Not Attempt Cardio-pulmonary resuscitation (DNACPR) in place. Whilst this improvement is welcomed, work continues to eradicate these occurrences.

Trust performance 2019 - 2020

Quarter	**Date**	**No of DNACPR patients where an arrest call was made**
Q4	Jan to March 20	1
Q3	Sept to Dec 19	1
Q2	July to Sept.19	1
Q1	April to June 19	0
		Total 3

Trust performance 2018 - 2019

Q4	Jan to March 19	5
Q3	Oct to Dec 18	1
Q2	July to Sept 18	0
Q1	April to June 18	0
		Total 6

How was progress monitored and reported?
End of Life operational and strategic groups were reinstated during the year although further action is required to increase the influence of these groups. The Assistant Chief Nurse for Patient Experience is providing leadership for the Quality Priority now and progress is monitored through the Patient Experience Group and Clinical Governance Committee.

What further actions need to be undertaken?
A new Bereavement information leaflet has been developed with the Medical Examiner and the service also intends to develop a telephone line for families to leave their enquiries and feedback for a later response. These developments will continue to be embedded over the coming year.

It was intended to hold a Cross-Divisional and Commissioning End of Life Care Summit led by the Chief Nurse on 1 April 2020; sadly this had to be cancelled and the potential for a new autumn or winter date is still uncertain. One particular area for the participants to consider was to address readmissions to an acute hospital setting at the end of life. Alternatives will continue to be explored to ensure this key area of concern can be addressed.

It was recognised that the provision of a dedicated End of Life ward in Spring 2020 provided an excellent opportunity to deliver high quality end of life care. Learning from this model will continue to be disseminated across the organisation.

Improve Patient Discharge

Executive Lead - Chief Operating Officer
Operational Lead – Director of Operations

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

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

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

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

What did we achieve?
In 2020 we have heavily focused on the key to Exit Strategy which is Estimated Discharge Dates (EDD). We are still increasing and maintaining EDD compliance across the organisation at ward level, we are reviewing EDDs daily in most inpatient areas, in line with best practice and keeping the patient journey as contemporary as possible.

Snapshot:

- 100% for COVID positive areas.
- Surgery 93%
- Medicine circa 70%
- Family Health 50%. This is a significant achievement as this time last year EDD was not utilised.

The above EDD figures are now recorded centrally on Electronic Patient Record (EPR), this is a move to digital from 12-18 months ago when EDDs remained siloed on white boards (or not set at all) on individual ward areas, the change is significant and using EPR allows the organisation a whole overview of our business of discharge.

We are still working on Red to Green across all areas but with a clear focus on discharge. The turnaround for Red to Green is now so rapid that the visual system of 'Red and Green' is not always needed as the 'wasted time' element in patient journeys [that the red and green highlight] is now very minimal. Currently the focus has shifted from Red to Green to a 'Home First' approach, which is reaching far and wide and we have a more urgent response in general.

We have a once daily Medical review in all areas to support timely review and discharge planning. As part of the national discharge guidance a medical and nursing lead is being appointed to review ward discharge practice including the frequency and timing of reviews.

Same day discharge is happening more frequently. Health and social care wrap around support is in place to facilitate this with assessments taking place in the community in line with national guidance. However, planning in Golden Patient Discharge has benefited from same day and rapid discharge as the morning focus is clearer.

The Integrated Discharge Team (IDT) are seeing the quality of referrals increase, this is in line with the Mentoring and Support we have had in place throughout the year, including a successful 'Where Best Next Week'.

Prior to the suspension of reporting, Delayed Transfers of Care (DToC) had been significantly reduced.

Covid19 Response, impact on SAFER

New government guidance on discharge was a clear part of the national response to free up hospital beds in response to Covid-19. The Trust has aligned its discharge practice with the national guidelines.

One of the most important tasks we have done is to ensure we have the capacity to support people who have acute healthcare needs in our hospitals. To do this we have a safe and rapid discharge process in place for people who no longer need to be in a hospital. The new default is home today. Below are our new pathways with predicted percentages.

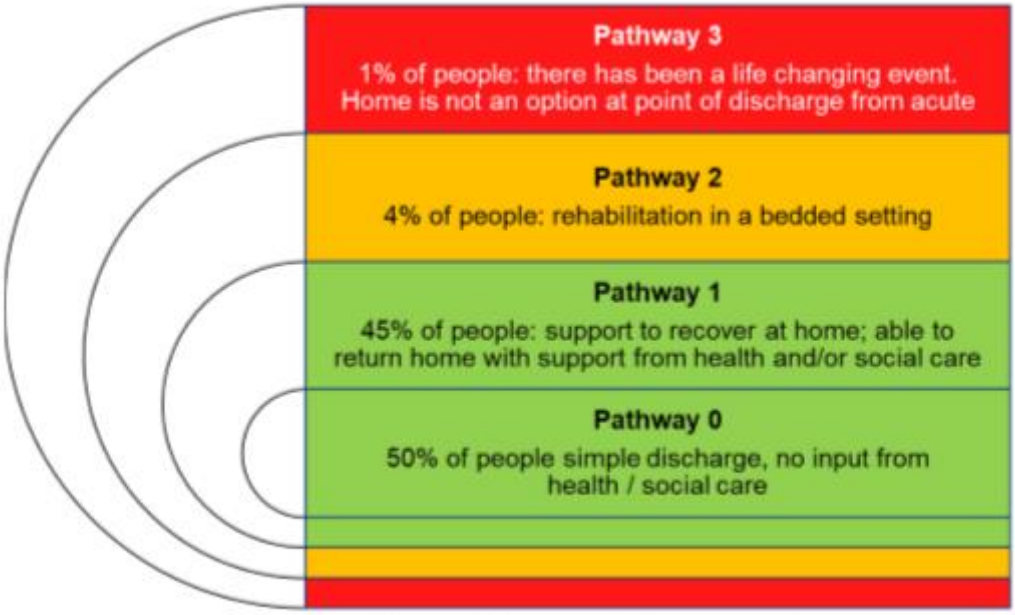


Figure 1: Discharge to Assess model

As part of the National Discharge Guidance all patients are reviewed daily in relation to their 'right to reside' within the Acute Trust. This detail is used to support same day discharge and has been built within the patients EPR, and is used to support the patient journey and avoid any unnecessary delays.

As an acute and community provider we must discharge all patients as soon as they are clinically safe to do so and ensure barriers have been removed in regards to funding and waiting times to transfer to their discharge destination.

Once a patient has been identified for discharge they should be transferred to a suitable discharge area within one hour of that decision being made. Discharge from hospital will occur soon after, with anticipation that discharges will occur within 3 hours. We are finding some challenge to this speed, but are achieving a high proportion of same day discharges. Since the implementation of the New Discharge Guidance 85-90% of discharges are supported the same day with some delays seen whilst supporting the more complex

discharges, however these have significantly reduced following the introduction of the new guidance.

The Government has agreed the NHS will fund the cost of new or extended out-of-hospital Health and Social Care support packages for up to 6 weeks as part of the recovery and rehabilitation pathway; this means no delay in accessing funds. This applies to people being discharged from hospital or who would otherwise be admitted into it, although for a limited time. This is to enable quick and safe discharge and avoid unnecessary admissions to hospital.

Staffing Support/ Process Changes

We have removed much of the delays in discharge by pushing the "Home First" model, whereby funding is agreed outside of the organisation. Currently 95% of all Adult Discharges from the Acute Hospital return 'Home First'. The IDT have extended their hours of work to 8-6pm 7 days per week in response to the National Discharge Guidance which supports the same day Discharge pathways.

Discharge letters that are sent to GPs have been amended to incorporate information related to COVID-19.

We have developed and implemented a Discharge Checklist. This will ensure that once a patient has been identified for discharge all steps have been taken to make a discharge Safe and Sound, including making discharge information clearer and relevant to the individual, more so than the current auto generated letters.

At ward level, we are implementing, in summary:

- Clinically-led review of all patients at an early morning Board round. Any patient meeting the revised clinical criteria, 'no right to reside' will be deemed suitable for discharge.
- Once daily review of all patients in acute beds to agree who is not required to be in hospital and will therefore be discharged. This requires increasing to twice daily.
- Ensuring a full MDT of professionals and clinical leadership between nursing, medicine and allied health professions for managing decisions.
- Reviewing Long Stay Patients Daily.

Capacity Tracker:
The Trust is able to access live information from a national community bed tracker system. The existing North of England Commissioning Support (NECS) can see capacity across our Commissioned bed base and private sector beds, making procurement of beds and discharge easier.

Actions still need to be taken

- We still need to push SAFER at ward based and senior level, for both digital quality and a move away from silo working e.g. on whiteboards or processes that are now outdated. We need the support at a Nursing/AHP/Social Care leadership level to make sure the

data quality from our wards feeding our discharge understanding is real time and accurate, and not seen as a tick box. The message is becoming clearer across the staffing range, but we still need to continue the momentum.

- The quality of Discharge prediction still needs to improve, uptake of EDD needs to move to a mandate stance, every patient with an EDD no later than first post-take ward round, this way we will achieve 100% of EDD from the SAFER bundle.

- We need to review the time of ward rounds and timing, frequency and attendance at Board rounds, strengthening the links with wards and the community. This has some staffing challenges and is a part of a wider recruitment conversation.

- 'Tomorrows TTOs today' still needs work as the late writing of TTOs and sending to pharmacy is still contributing to some delays, however it is improving.

- We have ward based, and substantive discharge coordinators working to SAFER principles in the Trust; on the wards that they work the quality of discharges remains good. Areas without this support still have delays and quality issues. As a Trust, a decision to model on discharge coordination support needs to be made. The Covid response has meant that we have 2 more (redeployed) discharge coordinators who are improving flow to areas without this usual support.

1) Reduce 0-1 day length of stays from 21% to 20% for 2019/20 (2019/20 target to be 20% a reduction from 21%)

NE Admissions from ED	Q1	Q2	Q3	Q4	2019/20
% 0 LOS	28.28%	25.23%	27.97%	27.64%	27.31%

2) Increase activity through ACC by 20% from 2382 in 2018/19 to 2858 (2019/20 increase activity by 50 patients per month, 10 patients per week)

Ambulatory Care (ACC) is now referred to nationally as Same Day Emergency Care (SDEC). The Trust continues to see good utilisation of the SDEC unit, with activity delivering well above the planned 20% increase at 37.32% for the year overall.

	Q1	Q2	Q3	Q4	2019/20
Actual 2019/20	667	831	901	872	3271
Target 2019/20 – 2858	714	714	714	714	2858
Percentage Inc/Dec on 18/19	12.10%	39.70%	51.20%	46.55%	37.32%

3) Increase number of patients discharged before 12 noon, reported at 2018/19 – 10% (2019/20 - 20% and 2020/21 - 30%)

Work continues with the SAFER care principles to facilitate earlier flow in the day. The number of patients using the discharge lounge has increased. Pre-noon discharges, including transfers to discharge lounge, increased to over 16% compliance by year end.

	Pre-Noon Discharges	Transfers	Total Discharges	Pre Noon %	Pre-Noon % inc Transfers
Q1	697	195	5884	11.85%	15.16%
Q2	639	249	5787	11.04%	15.34%
Q3	567	395	5865	9.67%	16.40%
Q4	567	294	5359	10.58%	16.07%
2019/20	2470	1133	22895	10.79%	15.74%
2019/20 Target					20%
2018/19 Baseline					10.10%

How was progress monitored and reported?
Cross system reviews of the discharge guidance have been carried out and an action plan developed to implement the August discharge guidelines and address barriers to timely discharge. Successful implementation has been embedded as a priority in the Urgent and Community Place Plan.

Progress against the quality priority was monitored through the Clinical Governance Committee and Quality Committee.

What further actions need to be undertaken?
A cross system discharge task and finish group has been agreed as part of Trust and Place governance arrangement to oversee timely implementation of the action plan. Key actions include:

- Reviewing the 7-day service.
- Review of ward procedures including timely decision making, quality of discharge information and dispatch of TTO.
- The interface between acute and community roles and responsibilities including domiciliary care and VCS.
- Review of Nomad policy.

Enhance Patient Feedback and Public Engagement

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

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

2018-19 In Patient Response Rate Friends and Family												
	Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Target 40%	50%	50%	48%	54%	49%	54%	48%	47%	44%	43%	42%	48%

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

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

This is a continued priority from 2018/19.

What did we achieve?

2019-20 In Patient Response Rate Friends and Family												
	Apr-19	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**
Target 40%	54%	52%	47%	54%	46%	44%	50%	42%	36%	43%	52%	*

***March not available due to non-collection/reporting as a result of Covid-19**

The Trust achieved over 40% response rate during 2019/20 apart from December 2019.

2019-20 UECC Patient Response Rate Friends and Family												
	Apr -19	**May -19**	**Jun -19**	**Jul-19**	**Aug -19**	**Sep -19**	**Oct -19**	**Nov -19**	**Dec -19**	**Jan -20**	**Feb -20**	**Mar-20**
Target 15%	0.7 %	0.9 %	0.8 %	1.1 %	0.8 %	1.5 %	0.3 %	0.3 %	0.2 %	0.0 %	0.7 %	No data collected during March 2020 due to Covid-19

The Trust did not achieve over 10% response rate during 2019/20 for UECC. It was acknowledged that achievement of this was adversely affected by the inability to introduce alternative methods of data collection during the year.

At the end of March 2020 NHS England and NHS Improvement issued the “Stop reporting requirement” for FFT. The measures were intended to allow for staff resources to be diverted towards more immediate priorities during the COVID-19 pandemic.

To support those measures NHS England and NHS Improvement advised they were temporarily suspending the submission of FFT data to NHS England and NHS Improvement from all settings until further notice.

The Trust were also advised to stop using methods of feedback collection that posed an increased risk of infection to either staff or patients (e.g. feedback cards).

How was progress monitored and reported?
The quality priority is reported through the Clinical Governance Committee.
Friends and Family data is reported through the Friends and Family Group, Patient Experience Group and into divisions through their Divisional Governance Meetings.

What further actions need to be undertaken?
FFT data submissions will restart from December 2020. NHS England are not specifying how to collect the responses – that is for the organisation to decide based on what works best locally and for our patients.

Discussions are currently being held to ascertain if paper data collection can recommence given Covid-19 concerns or if we need to solely use electronic solutions, in particular an App service that is due to be piloted in UECC. This will potentially adversely affect data collection in some areas in the short term.

The national changes to FFT data collection mean that there will be no restrictions/time scale on when people can give feedback so this can be undertaken following discharge.

When NHS England recommence publication of the monthly numbers again they highlight that during the pandemic some Trusts may have lower numbers than usual because of their circumstances.

The data informatics team are also looking at other ways for people to give feedback if they are only having appointments by phone or video; for example, have a simple questionnaire on a web page/survey monkey that they could be directed to in appointment letters or during appointments etc.

FFT numerical data will not be comparable across organisations but it can be used to continuously monitor quality and inform decisions, including analysis of time series data such as the FFT generates, to show improvement or a decline in patient experience. By making the new FFT data count Patients:

• Should be able to provide feedback at any point during their care and treatment.

• Should be able to use the published FFT data alongside other publicly available data sets to inform their choices.

• Should be able to challenge healthcare organisations if they are not provided with the opportunity to provide feedback.

• Should be able to see visible evidence in public places to demonstrate what actions have been taken because of people's feedback.

• Should be able to ask healthcare organisations to explain what improvements have been made as a result of feedback if this information is not transparent.

Domain: Patient Clinical Effectiveness

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

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

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

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

There are three main areas to consider:

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

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

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

- Where national recommendations are available, a baseline position should be established and The Rotherham NHS Foundation Trust (TRFT) should aim to meet the national recommendations. It is recognised that this may not be possible within one year but a measure of progress made against available recommendations should be recorded.
- TRFT to develop a similar model to the 'Ready Steady Go' transition programme used in other organisations, which routinely commences for all children with long term conditions at 14 years.
- The Trust should plan to offer a staged approach to transition at different ages, dependent on the wishes and feelings of the young person, appropriate to the underlying healthcare requirement.
- Metrics/Audit to be developed to monitor the progress for all services that transition into the adult service.

This is a new priority for 2019/20.

What did we achieve?
Current focus is on improving transition of young people with Diabetes. On 12 February 2020, the Trust had a visit from NHS Improvement (NHSI) to talk about the work we have done so far on the project.

The celebration event due to be held on the 18 March 2020 in London was postponed and will be held later in the year.

Ready, Steady, Go model is being trialled in Diabetes in February. Based on our experience with Diabetes, we will be looking to expand this to other areas that have young people transitioning into adult service.

Possibilities for moving the age of transition clinic from 17 to 16 are being explored. Based on the feedback on how the staged approach for Diabetes, it will be adapted for the remaining long term conditions as applicable.

How was progress monitored and reported?

Progress was monitored throughout the year through a weekly project group and through bi-monthly reporting to the Children's Trustwide Steering Group and monthly Clinical Governance Committee and Quality Committee. NHS Improvement were kept informed of all progress made towards meeting our agreed objectives.

What further actions need to be undertaken?

The team will participate in the national celebration event for improving transition care later in 2020. Progress within the Diabetes specialty needs to be maintained but this then needs to be replicated within other specialties. Plans are in place for this to develop within Respiratory Medicine next. The business case to employ a transitional care nurse within a corporate role needs to be progressed to ensure Trustwide support for this essential quality priority for young service users.

Improve Mortality Reviews

Executive Lead – Medical Director
Operational Lead – Medical Examiner

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

There were 81 mortality reviews in 2017/18

The aim and objective(s) (including the measures/metrics)
Improve the mortality review process undertaken within the Trust.

1) Increase the mortality reviews undertaken by the Medicine Division by 50% (10 in 2018/19)
2) Increase mortality reviews undertaken within two months of death by 50% (3 (30%) in 2018/19)

This is a new priority for 2019/20.

What did we achieve?

The Medical Examiner has started to review all deaths from March 2nd 2020. Cases that required an SJR have been identified and the divisional teams will be reviewing these within the specified timescales. There have been 27 % of cases felt to require an SJR which is in line with national experience.

The medical examiner service discusses the cases with the family members and any concerns are picked up immediately and relayed to the specific division. This has been successful in reducing the work for the coroner in some cases.

The medical examiner has reviewed 75% of the deaths from March 2020 with an aim to increase this in the following quarter. There has been 100% of discussions with families and clinicians regarding the cause of deaths and ensuring that the Medical Certificate of Cause of Death (MCCD) is accurate.

The learning from deaths' nurse has been appointed and started within the Trust March 2020. The aim is to consolidate the learning from mortality reviews and from investigations and inquests to ensure improvement in quality of care.

How was progress monitored and reported?
Progress was monitored monthly by the publication of the Mortality Insights dashboard which is interrogated by the Informatics team. This is a live dashboard which allows the Divisions/Executives to monitor the number of completed reviews and the themes and trends coming out of them. The dashboard is discussed at both the Clinical Governance Committee and the Quality Committee monthly. The Medical Examiner currently reports on the review process and highlights significant issues to the Executive teams. The Organisational Learning Action Forum (OLAF) has been set up to ensure that learning from reviews/inquests is widely discussed and actions taken to prevent the same trends from future review. This forum reports to the above committees.
The Trust internal audit committee undertook an audit reviewing the outcomes of mortality reviews for quality assurance. It found 88% correlation with the outcome of the reviews and the bench mark.

What further actions need to be undertaken?
Further capacity within the Medical Examiners service is underway to ensure that there are 100% of reviews undertaken as a first stage. The themes and trends from reviews require further highlighting Trust wide to ensure the learning is taken and used for improved quality. This will be in the form of a regular newsletter, which will be published from the Medical Examiner's office.

The further strengthening of the capacity to undertake Structured Judgement reviews will be undertaken in the Divisions and a rolling programme of mortality review training is in the pipeline in conjunction with the Learning and development team.

Improve Policy and NICE Guidance Compliance

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

Current position and why is it important?
The 2017 Care Quality Commission (CQC) inspection identified a concern around staff working to out of date policies. This was confirmed as an issue as part of the preparation for the 2018 CQC Inspection. Whilst improvements have been made with the use of a new intranet site where documents can be located easier, there are still 46% of policies which are out of date. There is therefore a risk that staff could be following out of date processes.

Policies	
2017/18	51.1%
2018/19	54%

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

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

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

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

The aim and objective(s) (including the measures/metrics)
Improve clinical practice and effectiveness through using up to date polices and complying with relevant NICE Guidance.

1) Increase the number of in date policies by 30% (baseline is 54% of policies in date at 31 March 2019)
2) Increase the number of NICE guidance compliance reviews undertaken in line with agreed timescales by 20% (baseline is 38% responses received in 28 days)

This is a new priority for 2019/20.

What did we achieve?
As at 13 March 2020 there are 30% of policies in date. A significant amount of work has been undertaken and continues to be undertaken.

Progress has been made with response rate to compliance review requests with 51% responses from the 2019/20 FY being returned within agreed Trust timelines as at end of February 2019 (range per month 38-77%). Further review of effectiveness and efficiency of escalation processes will be undertaken to plan for further refinements.

The total number of compliance reviews requested in 2019/20 is 482 with 379 (79%) returned.

The overall percentage of reviews completed within the target of one month for 20/21 is 50% (range of 38 to 77%) which does not meet target however by working on the priority we have reversed the downward trend and have been engaging with Divisional Governance to support compliance review.

How was progress monitored and reported?
Progress was monitored and reported to the Clinical Effectiveness and Research Group and Clinical Governance Committee using standard reports showing 1) A dashboard of the number of outstanding responses by Division and Clinical Service unit (CSU) showing the number that were within and outside of timelines (at periods of 1-2 months; 3-5 months and more than 6 months) and 2) A graphical report showing the number of NICE guidance published and circulated for review by month and the percentage where a compliance response was received in the agreed timeline of 28 days.

What further actions need to be undertaken?
Further actions will be taken to review the months where compliance was better, firstly, to identify whether there are lessons to be learned and secondly, to focus on the number of compliance review responses that are outstanding for more than 6 months, to reduce the risk of working to out of date policies.

3.1.3 Additional information about how we provide care

Friends and Family Test
The Trust continues to use the Friends and Family Test as one method of gaining feedback from patients and their families. The data is anonymised and reported to NHS England who publish the data each month. The latest data is for November 2019 and shows the Trust has approval ratings comparable to acute Trusts across England. The 40% target for the response rate for inpatient areas is not being achieved in some areas, however the Trust continues to explore ways for increasing the completion rate. Whilst A&E response rates nationally are significantly lower than inpatient areas, the Trust remains an outlier. This is being addressed as a quality priority for 2019/2020.

TRFT- FFT results compared to England November 2019*

Service	Rate of return	% recommending	% not recommending
A&E			
TRFT	0.2%	66.7%	33.3%
England	12%	84%	10%
INPATIENTS			
TRFT	36.0%	96.5%	1.6%
England	24.8%	96%	2%
OUTPATIENTS			
TRFT	n/a	96.1%	2,1%
England	n/a	94%	3%
MATERNITY SERVICES			
ANTENATAL			
TRFT	19%	96.8%	3%
England	1.16%	95%	2%
BIRTH			

TRFT	20%	100%	0%
England	20.9%	96%	1%
POSTNATAL WARD			
TRFT	83%	94.3%	5.7%
England	1.25%	94%	2%
POSTNATAL COMMUNITY			
TRFT	18%	100%	0%
England	1.03%	98%	1%
OVERALL COMMUNITY SERVICES			
TRFT	n/a	98.3%	0%
England	n/a	96%	2%

**Please note February is the latest published data by NHS England.*
Data Source NHS ENGLAND Friends and Family Test data – November 2019

TRFT- FFT results compared to England February 2020*			
Service	**Rate of return**	**% recommending**	**% not recommending**
A&E			
TRFT	1.00%	83.00%	14.00%
England	12%	85%	9%
INPATIENTS			
TRFT	52.00%	97.00%	1.50%
England	24.40%	96%	2%
OUTPATIENTS			
TRFT	n/a	96.80%	2,1%
England	n/a	94%	3%
MATERNITY SERVICES			
ANTENATAL			
TRFT	27%	100.00%	0%
England	n/a	95%	2%
BIRTH			
TRFT	43%	100%	0%
England	n/a	97%	1%
POSTNATAL WARD			
TRFT	94%	100.00%	0.00%
England	n/a	95%	2%
POSTNATAL COMMUNITY			
TRFT	18%	100%	0%
England	n/a	98%	1%
OVERALL COMMUNITY SERVICES			
TRFT	n/a	98.60%	0%
England	n/a	96%	1%

**Please note February is the latest published data by NHS England.*
Data Source NHS ENGLAND Friends and Family Test data – February 2020

Friends and family Test Positive scores 2018 / 2019 (1st April 18 - 31st March 2019)													
	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Inpatients	**95%**	**98.4%**	**98.0%**	**97.5%**	**97.0%**	**97.0%**	**95.3%**	**97.3%**	**98.2%**	**97.6%**	**97.5%**	**96.8%**	**97.4%**
Day Cases	**95%**	**99.4%**	**99.5%**	**98.6%**	**99.2%**	**98.4%**	**99.5%**	**99.0%**	**99.3%**	**99.7%**	**99.8%**	**99.4%**	**98.7%**
Urgent & Emergency Care Centre	**85%**	**97.5%**	**94.3%**	**97.8%**	**94.5%**	**94.1%**	**88.5%**	**93.1%**	**93.9%**	**95.8%**	**82.7%**	**71.4%**	**95.8%**
Maternity Service	**95%**	**99.7%**	**99.3%**	**98.1%**	**98.1%**	**99.0%**	**99.0%**	**98.4%**	**100.0%**	**99.6%**	**100.0%**	**99.6%**	**100.0%**
Outpatients	**95%**	**97.1%**	**97.8%**	**98.3%**	**96.2%**	**97.6%**	**97.3%**	**96.7%**	**97.4%**	**97.0%**	**97.8%**	**98.2%**	**97.3%**
Community Services	**95%**	**95.2%**	**96.8%**	**95.9%**	**97.8%**	**99.1%**	**97.8%**	**92.8%**	**97.6%**	**97.0%**	**99.8%**	**94.6%**	**96.7%**

Data Source TRFT data capture system.

Friends and family Test Positive scores 2019 / 2020 (1st April 19 - 31st March 2020)													
	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Inpatients	**95%**	98.7%	97.7%	97.9%	97.8%	98%	95.7%	96.6%	96.1%	96.5%	97%	97.0%	
Day Cases	**95%**	99.2%	99.1%	99.7%	99.7%	99.7%	100%	98.4%	99.6%	99.4%	100%	100.0%	
Urgent & Emergency Care Centre	**85%**	90.9%	89.5%	89.4%	95.8%	98%	94.5%	90%	84.2%	66.7%	100%	83.0%	
Maternity Service	**95%**	99.3%	99.4%	100%	100%	99.5%	100%	100%	99.5%	97.9%	99.1%	99.6%	
Outpatients	**95%**	98.7%	97.9%	97.3%	97.5%	97.8%	98%	98%	96.5%	96.1%	98.2%	96.8%	
Community Services	**95%**	96.0%	97.3%	97.1%	99.2%	99.6%	86.6%	97.7%	98.3%	98.3%	99.1%	98.6%	

Data Source TRFT data capture system.

Data Source TRFT data capture system.

2017-18 In Patient Response Rate Friends and Family												
	Apr-17	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**
Target 40%	56%	63%	60%	70%	60%	51%	58%	46%	**43%**	**51%**	49%	47%

2018-19 In Patient Response Rate Friends and Family												
	Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Target 40%	50%	50%	48%	54%	49%	54%	48%	47%	**44%**	**43%**	42%	48%

2019-20 In Patient Response Rate Friends and Family												
	Apr-19	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**
Target 40%	54%	52%	47%	54%	46%	44%	50 %	42%	36%	43%	52%	

Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and since CQC inspection in 2015 and 2018 there have been zero occurrences within inpatient wards. In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit (HDU) level 2 care to base wards. Internal standards require reporting at 4 hours and 6 hours; an external report is made at 8 hours. There have been no instances requiring an external report in the last 12 months.

Additionally, there is also an internal process for monitoring and reporting 'pass by' breaches of mixed sex accommodation. In 2019/20 there were no reported breaches for pass-by of toilet facilities. When a bed area is reallocated to a different gender, the associated toilet facility and side room are also reallocated. This is monitored at ward and department level. The Trust is part way through a programme of refurbishment of wards and development of more toilet facilities within bays.

Never Events

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

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

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

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

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

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

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

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

Patient-led assessments of the care environment (PLACE)
The 2019 PLACE assessment was conducted in October 2019. Visits were made to 18 clinical areas at Rotherham Hospital, (Breathing Space no longer receives inpatients so is excluded from this year's assessment). The 2019 visits involved Governors, Healthwatch and Trust colleagues. The 2019 Assessment returns have been delayed until September 2019 as there is a current review of the process taking place nationally.

Trust results 2018 and 2019	**Cleanliness**		**Food**		**Food (Organisational)**		**Ward Food**	
	2018	**2019**	2018	2019	**2018**	**2019**	**2018**	**2019**
Breathing Space	**94.91 %**	**N/A**	88.22 %	**N/A**	**86.94 %**	**N/A**	**89.50 %**	**N/A**
Hospital	97.13 %	97.73 %	**85.36 %**	**94.04 %**	**88.27 %**	**96.59 %**	**84.56 %**	**93.39 %**

(Source: NHS Digital)

Trust results 2018 and 2019	**Privacy Dignity and Wellbeing**		**Condition Appearance and Maintenance**		**Dementia**		**Disability**	
	2018	**2019**	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**
Breathing Space	**100%**	**N/A**	**86.48 %**	**N/A**	**70.99 %**	**N/A**	**76.36 %**	**N/A**

Hospital	**80.13 %**	**85.66 %**	**92.11 %**	**92.89 %**	**66.47 %**	**71.49 %**	**74.52 %**	**77.38 %**

(Source: NHS Digital)

Whilst all category scores have increased from 2018, there is scope for improvement in the dementia & disability metrics in particular and further improvements can be made around privacy, dignity & wellbeing.

The PLACE assessment questions are constantly evolving so a comparison year on year must take account of this.

Inpatient Survey Findings

During the year 2019/20 the Care Quality Commission has published results from four national patient surveys; In-patients, Urgent and Emergency Care, Children's and Young People and Maternity services.

The CQC compare the Trust results with other organisations and classify whether Trusts are performing about the same as other Trusts, better than other Trusts or worse than other Trusts. For all surveys where national comparisons are available, the Trust scored 'about the same' as similar organisations.

Within the national In-patient survey, the Trust scored worse than other Trusts for delayed discharges, doctors talking in front of patients as though they were not there and options to take own medications. Actions are in place to improve performance in these areas. The Trust scored better than other Trusts for the provision of post-operative information.

Findings from all surveys are triangulated against other sources of patient feedback including concerns and complaints, Friends and Family Test, Governors' Surgeries and feedback from advocates and other websites. Action plans are created for each survey 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 Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in June 2019. The 2019/20 annual report will be published in June 2020.

Throughout the year detailed updates on the incidence of healthcare associated infections have been provided to the Infection Prevention and Control and Decontamination Committee which reports to the Clinical Governance Committee. The Chief Nurse is the Director of Infection Prevention and Control.

The substantive consultant microbiologist left the Trust in July 201; 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.

The C-difficile trajectory was 11 cases to year-end which has been breached with 20 cases to date. An increase in cases of approx. 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**
2019/20	1	0	0	0	0	0	0	1	0	0	0	0	0

(Source: Trust Winpath System)

Number of reported cases of C.Diff													
Target = <11	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2019/20	35	0	2	3	1	3	3	4	2	2	8	5	2

(Source: Trust Winpath System)

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

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

In 2019/20 ten cases have been classed as unavoidable with no lapse in quality of care identified; one case from November and one case from December 2019 are still under investigation but eight cases did have an identified lapse in quality of care although it has been considered that these lapses did not contribute to the C-difficile occurrence. The lapses identified were:

- Delay in time to take blood culture.
- MRSA screens missed.

- BMI and MUST scores missed.
- Treatment and communication delay
- Delay in treatment and isolation.
- Lack of samples for blood culture, urine and stool.
- Delay in stool sample being obtained and lack of stool chart completion.
- Delay in referral to MDT.
- Missed opportunities to escalate type 6&7 stool.

All samples of C-difficile are sent for Ribotyping at the Leeds reference laboratory in order to determine the exact identity type of the organism. In the event that any samples have the same Ribotype, the epidemiology is examined further to determine if there could be any link in time and place between the cases. If such a link is possible enhanced DNA fingerprinting is requested via the Leeds reference laboratory, which identifies if the cases are indeed linked and thus caused by cross infection or not. There has been no link between any of the cases to date.

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

The winter of 2019/20 has been challenging with an early onset of influenza cases identified, which was in line with the national picture. A second point of care (POC) machine was purchased for the season and has helped to support the rapid identification of influenza results, which assists the emergency department team to discharge with diagnosis and advice and for those admitted a more accurate use of individual rooms that support flow through the hospital. The hospital has continued to be a voluntary sentinel reporting site for influenza to PHE.

Staff influenza vaccination has been provided via the peer vaccinator model which has again been a successful campaign with 78% front line staff vaccinated to date.

A number of schools and care homes in the region experienced influenza outbreaks as reported via PHE

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

A number of schools in the region experienced Norovirus outbreaks as reported via PHE

There have been additional challenges during the year of infections with potential public health impact; this has included an increase in cases of Measles in the UK, with outbreaks reported in parts of Yorkshire and some cases diagnosed in Rotherham.

Post-operative surgical site infection (SSI) surveillance is mandatory for one quarter per year of Orthopaedic lower limb procedures (either hip or knee replacement) to PHE. This surveillance has covered knee replacement for the 2019/20 return. The results of the surveillance are provided to the Orthopaedic Governance Group but results are provided to the Trust approximately 6- 9 months after the surgery. The Consultant for Podiatric Surgery completes continual SSI surveillance via the speciality national database and has had zero post-operative infection.

In summary, whilst the Trust was disappointed that a case of MRSA bacteraemia occurred, Norovirus, Rotavirus and Influenza infections have been well managed. More patients are being treated in the community with I/V antimicrobials which means that patients are prevented from hospital admissions or discharged earlier.

Reducing the incidence of Falls with Harm

A fall in hospital can be devastating. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also affects the family members and carers of people who fall, and has an impact on quality of life, health and social care costs. Falls represent significant cost to Trusts and the wider healthcare system, with annual total costs to the NHS alone from falls among older people estimated by the National Institute for Health and Care Excellence (NICE) in 2015 at £2.3 billion.

The current rate of falls per 1,000 bed days

	2016-17	**2017-18**	**2018-19**	**2019-20**
Falls	611	675	668	689
Bed Days	144,505	145,153	132,557	158207
Falls Rate per 1000 Bed Days	**4.23**	**4.65**	**5.04**	**6.66**

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

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

The Trust continues to participate in the mandatory National Inpatient Falls Survey, 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) (National Institute for Health and Care Excellence, 2017) which identify how a patient is managed following a fall (and has produced positive results for 2019/20) and will help 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 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.

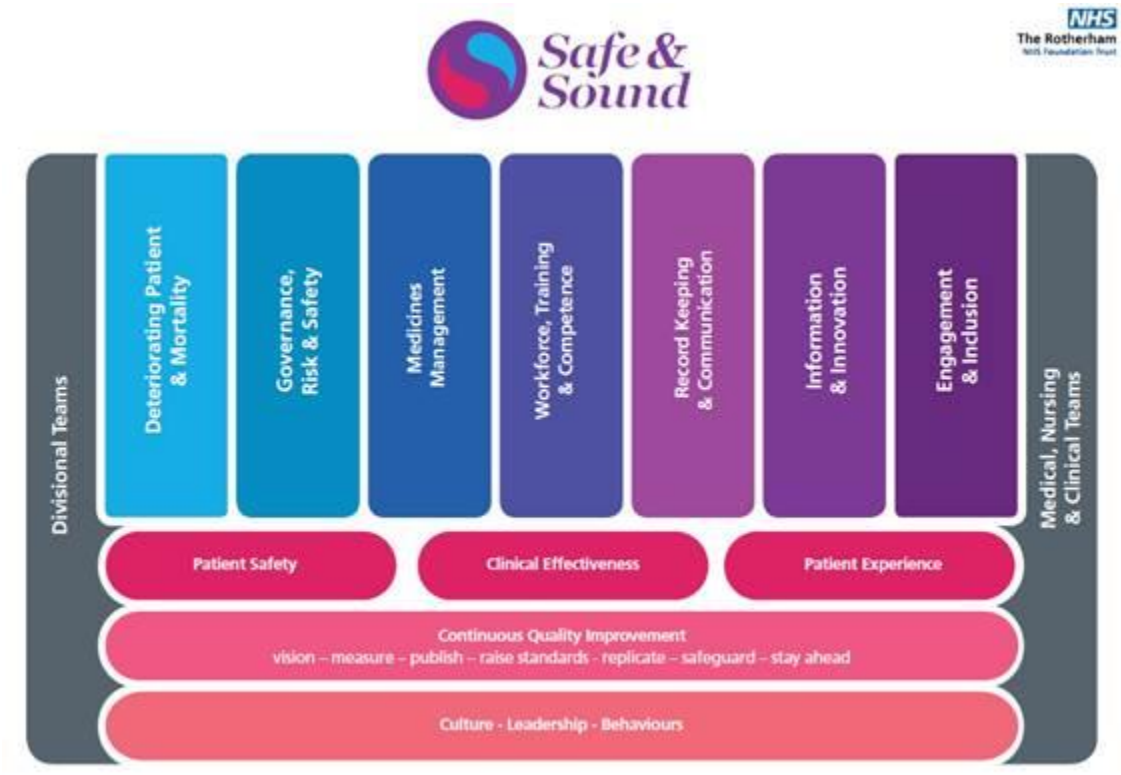
An audit undertaken in 2019 identified 90% compliance regarding the Duty of Candour discussion being undertaken and recorded in the patient's records. Recommendations are being implemented following the audit, including establishing consistent recording of information within central electronic systems,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

To support this, the Duty of Candour policy is being updated to promote identified changes and additional training has been provided.

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



Safeguarding Vulnerable Service Users

The Trust is committed to ensuring Safeguarding is an absolute priority. The Chief Nurse is the Trust's Executive Lead for Safeguarding. The Chief Nurse is supported by the Associate Chief Nurse, Head of Midwifery Nursing and Professions 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.

In relation to adult vulnerability, the work and support by the team includes the Mental Health Act, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The year has seen a continued increase in activity across all work streams with continued challenges posed by the introduction of the Care Act 2014, and the Supreme Court 2013 judgement with regards to the Deprivation of Liberty Safeguards (DoLS).

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

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

- A Trust Safeguarding Nurse Advisor is based in the Multi-Agency Safeguarding Hub (MASH) at Riverside – this team responds to all children safeguarding referrals.
- A Specialist Child Sexual Exploitation (CSE) Nurse is based in the Evolve Team in the Eric Mann building which provides services for survivors of Child Sexual Exploitation cases and is aligned to the Family Health Division.

The Trust continues to be an active partner in the Rotherham 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 Rotherham NHS Foundation Trust has representation on a large number of external Safeguarding strategic and operational groups. This ensures partnership working is embedded across the wider Rotherham Health and Social Care economies.

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

There has been significant activity, in partnership with the TRFT Learning and Development Team and Heads of Nursing, to review the competency levels required by individual job roles to align them with the Safeguarding Adults Intercollegiate document.

A full review of Safeguarding Children Training has also been undertaken in conjunction with colleagues from the Trust Learning and Development Team. This was to ensure all colleagues have the correct level of training aligned to their specific role and recorded via the Electronic Staff Record. Training compliance is monitored via Safeguarding Key

Performance Indicators and reviewed at the Safeguarding Operational Group reporting to the Strategic Safeguarding Group.

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

On-going training and supervision is provided to support practice in embedding the implementation of the MCA and DoLS procedures. The MCA was amended in 2019. This will mean that DoLS will change to Liberty Protection Safeguards (LPS). The arrangements for authorisation of LPS for TRFT patients will move from the Local Authority to sit with TRFT. TRFT 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 Mandatory and Statutory Training offering. Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved in/or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity. TRFT is represented at the Channel meetings, where all cases of those suspected of being exploited are heard.

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

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

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

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

Macmillan Cancer Information Support Service

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

- Extend the hospital based MCISS into the community of Rotherham to ensure equity of service provision and accessibility.
- Expand engagement with the MCISS both geographically and along the cancer journey, working across Rotherham and other aligned organisations such as the MCISS within Barnsley, Sheffield, Doncaster and Chesterfield.
- Work in alignment with Macmillan Cancer Support to raise the profile of the service.
- Maintain the annual revalidation of the Macmillan Cancer Support Quality Environment Mark (MQEM).
- Maintain the National Macmillan Cancer Support 'Quality in Information and Support Services Standard' (MQUISS).
- Achieve the Macmillan Quality Volunteer Standard (MQVS)
- Provide HOPE (Helping People Overcome Problems Effectively) courses to people affected by cancer.
- Utilise the Chief Nurse Fellowship recommendations to deliver Mindful compassion training within the Trust.

During 2019 a total of 7854 people accessed the service and prevented the need for:

- 223 GP appointments.
- 41 Consultant contacts.
- 362 Nurse Specialist contacts.
- 718 other contacts, such as District Nursing and Social Care.

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

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

- Future development of community engagement.
- Future development of an extensive training programme.
- Current expansion and consolidation work to foster closer links and collaborative working practices with:

    - The South Yorkshire Cancer Alliance.
    - Living With and Beyond Cancer Project.
    - Rotherham Health Watch.
    - Voluntary Action Rotherham through their social prescribing programme and the Be Cancer Safe project.
    - Rotherham Hospital Health Information Services and key stakeholders to deliver healthy living and cancer awareness campaigns to the local population.

The MCISS has recruited and retained 12 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 Team of the Year, Top leader, Unsung Hero and Caring Categories.

This year this service was also chosen to take part in a national Macmillan Social Media campaign, a campaign which saw over 13,000 people seeing the story of a user thanking the team for helping him emotionally, physically and financially after his initial diagnosis.

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; the frailty team are working with the National Dementia Alliance to support the Trust in becoming a dementia friendly Trust, consistent with national drivers.

The frailty team is now well established, providing nursing leadership for dementia care within the Trust. All wards have dementia link nurses and link nurse meetings have been combined with the dementia, delirium and person centred care meetings to improve attendance and support improvements and the provision of further support, development and training for these roles. The team have also successfully been running memory cafes within the Trust since August 2019, on the third Wednesday of each month.

The Trust has started to review the ongoing provision of training to support people living with dementia. Currently Tier one training is delivered through e-learning; face to face Tier 2 training has commenced by way of the person centred care days, which are led by the frailty team and scheduled each quarter. A review is currently taking place of availability of training to doctors; the dementia training design and delivery audit tool will be used to monitor the effectiveness of the training.

The frailty team are also supporting dementia screening for the Trust, which has recently improved to 90% compliance. The lead nurse has undertaken her non-medical prescribing course which will further enhance the service and the quality of care provided to patients living with dementia, and another team member is due to start the course in March 2020.
The frailty team are also working closely with the Getting It Right First Time group to ensure that their report recommendations are reviewed and implemented to further improve the quality of care for patients and families living with dementia.

Learning Disability

The Rotherham NHS Foundation Trust is committed to improving the experience for people who have learning disabilities/and or Autism. We have a Lead Nurse in Learning Disabilities and Autism and currently two trainee nursing associates specialising in Learning disabilities. They focus on all aspects of patient care pathway and experience within Trust, whether people attend as an outpatient, planned inpatient or are admitted through the Emergency Department. Ensuring as a Trust we are making reasonable adjustments for people with additional needs by doing the following:

- We have an electronic flagging system in place to identify that a person has a learning disability from their medical records. This information then populates a live database for the Learning disabilities team at Trust to access.
- Championing the use of the Traffic light system, a person centred assessment tool for people with learning disabilities and Autism that helps staff to learn about how to care appropriately for each individual. We also replicate the traffic light system with magnet symbols on patient headboards, ward boards and medical notes.

- Provide bespoke training regarding learning disabilities and Autism, in conjunction with our local advocacy organisation – delivered where possible by experts by experience.
- Continue to build links with established organisations to support learning, such as Speak Up, CHANGE organisation, Health Education England and Royal Mencap.
- Facilitating a programme of mentorship for Learning Disability Nurse/Generic social work students at Sheffield Hallam University, providing shadowing and training opportunities to the Trust's Trainee Nurse Associates.
- Providing bespoke training for the Undergraduate Adult branch nurses at Sheffield University.
- Facilitating a learning disability/autism sub group. 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 Health watch. This enables the Trust to learn from patient experience to change and alter practice/systems and pathways.
- Working closely with the volunteer coordinator at the Trust to mentor and support our volunteers in the Trust who have a learning disability/Autism.
- Working closely with colleagues within the Trusts' community teams, such as Community Matrons, Fast Response and district nurses to ensure community care plans are in place for people with a learning disability and/or Autism to minimise frequent admissions to hospital services.
- Working with our complex care colleagues around the transition of young people from child to adult services within our Trust.
- Implementing relevant Learning disability and Autism strategies within the Trust and working in conjunction with partnership organisations borough wide.

Future plans:

- To work with the CCG and Local authorities to look at an electronic flagging system to identify people with Autism with an electronic flag on their medical records, with obtained patient consent. Or to work around how we can make these reasonable adjustments for people with Autism.
- To expand the use of Trainee Nurse associates within the learning disability team, working throughout 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 service user focus groups to help the Trust adapt and change the environment of the hospital to be accessible for people, for example the signage around the Trust.
- Applying guidance from the Accessible Information standard (2015) to ensure all patients have information about their care/treatment/appointments in a format which is accessible for them. This work will be across wards and departmental areas within the Trust.
- To work with the Trust Equality and Diversity Steering group, to look at how the Trust can actively encourage people with Learning Disabilities and or Autism to take on voluntary or paid roles at the Trust.
- Focusing on specific care planning tools for people with Learning disabilities and or Autism, to help improve individual patient pathways and responsiveness of the Trust.
- Our Lead nurse in Learning Disabilities to look at reducing unnecessary admissions to hospital for people with learning disabilities. Utilising the non-medical prescribing

qualification they have gained and working with local GPs and Trust community practitioners.

- To engage the Trust in the Autism accreditation process, through the National Autistic Society. This will start early 2020, with the pilot to commence in Adult and Paediatric UECC, with a Trust wide roll out planned following this.
- Plans to look at the reduction in waiting times discomfort, in areas such as outpatients and UECC. Proposal for a trial of a hand held buzzer system, for people with LD and Autism, where they are not fixed to waiting in the designated area and they can move around the Trust. When the appointment is ready, the hand held buzzer will sound or vibrate indicating the patient and or care team need to return back to the appointment area.

Engaging with Colleagues

Workforce remains one of the biggest challenges faced in the NHS. This is why our staff are key to the success of the organisation and the delivery of excellent patient outcomes. As a Trust we have strived to deliver against our operational plan over the last 12 months in line with our five-year strategy. In order to engage meaningfully with our colleagues, we committed to undertaking Together We Can© (TWC) methodology by working with 10 teams across the organisation to involve them in changes and improvements in their area of work.

The NHS Annual National Staff Survey

The annual NHS National Staff Survey (NSS) gives colleagues in the Trust an opportunity to tell the organisation what it is like to work at the Trust. It also gives an opportunity to reflect on and help to prioritise the focus and actions to support continual improvement. The Trust response rate to the survey saw a 10% increase in participation rates (48%). 82% of the staff that have responded have face to face contact with patients or service users as part of their job.

Last year the National Staff Survey changed its reporting style to ten themes. In 2019 this has developed further into being eleven themes with the addition of Team working. Each theme scores 0-10 with 10 being good. The Trust has shown a slight improvement in five of the ten themes, however, compared to our benchmarking group we have not seen the degree of change we would like to. There are three areas where the Trust has shown better than national average results - Equality, Diversity and Inclusion, being safe in terms of violence and bullying and harassment.

Morale is the most improved theme in our staff survey going from 5.8 to 6 (out of 10).

The new theme this year is team working and the Trust scored 6.5 out of 10 in comparison to the peer benchmarking group 6.7.

Our commitment was to support staff to maintain good mental health and work to improve muscular skeletal injury as a result of work. Compared to last year's National Staff Survey results the work we have undertaken has shown improvement in both action on health and wellbeing and reduced muscular skeletal problems as a result of work.

We committed to continue our focus on colleague wellbeing and implementation of our Employee Assistance programme. We have seen an increased uptake of the Employee Assistance programme as well as participation in the Trust's local wellbeing activities, including a new pilot for complementary therapies which have been well received.

In line with the Stevenson/Farmer report Thriving at Work, our mental health champions have continued to support colleagues across the organisation who may have experienced difficulties with mental health. We will continue to build on this work to maintain and excel the standards within the report.

Themes

This year the National Staff Survey results have a new category (Team working) in addition to the ten themes reported last year. The graph below shows this year's results.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.5	6.8	6.3	8.0	8.6	9.7	7.4	7.6	7.3
Your org	9.2	5.8	6.8	6.0	5.2	7.2	8.2	9.5	6.6	6.7	6.5
Average	9.2	6.0	6.9	6.2	5.5	7.5	8.2	9.5	6.8	7.1	6.7
Worst	8.3	5.2	6.5	5.7	4.4	7.1	7.5	9.3	6.2	6.5	6.2
Responses	1,986	2,001	2,001	1,963	1,807	1,716	1,966	1,971	1,986	2,020	1,987

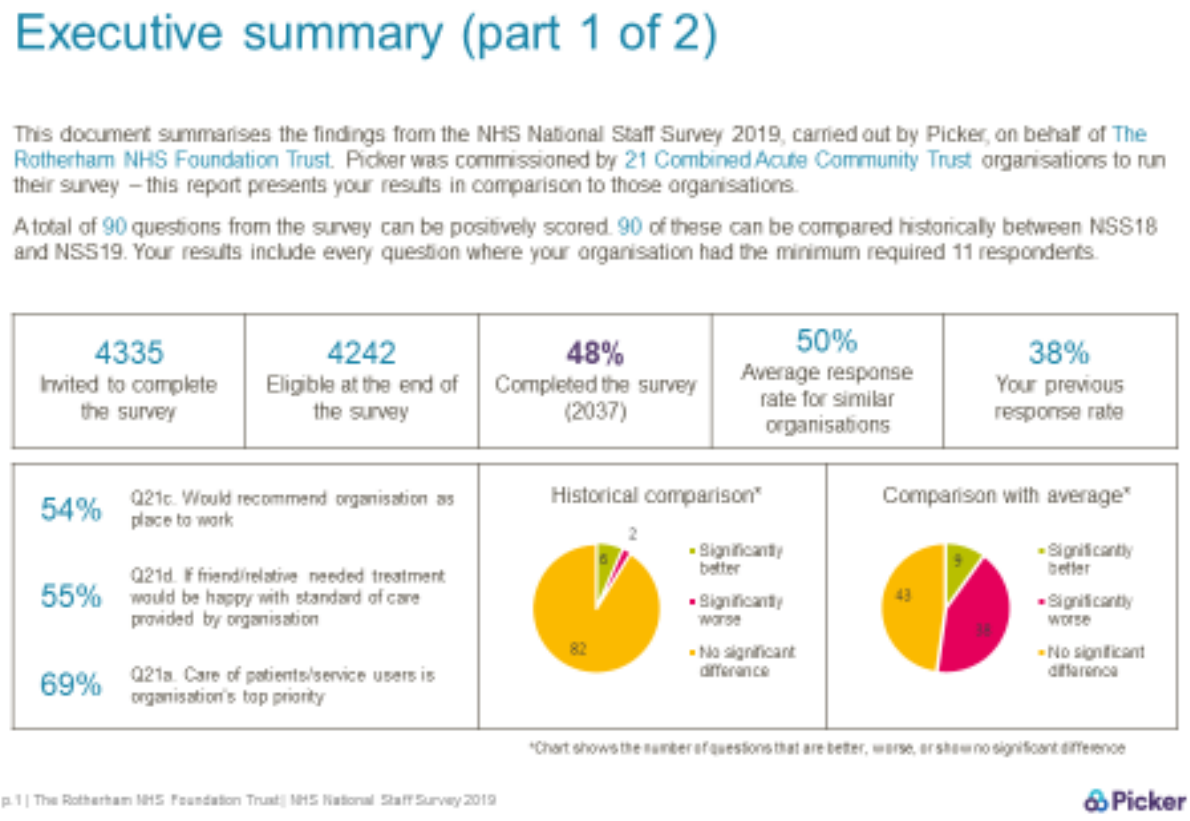
5

Compared to last year the Trust has shown a slight improvement in 5 of the ten themes:

- Immediate managers
- Morale
- Quality of appraisal
- Safety culture
- Staff engagement

The remaining 5 are unchanged and Team working is 6.5

The chart below summarises the Trust findings from the national staff survey 2019, carried out by Picker who were also commissioned by 21 similar Acute and Community Trusts. The chart represents the results in comparison to those organisations.



Executive summary (part 1 of 2)

This document summarises the findings from the NHS National Staff Survey 2019, carried out by Picker, on behalf of The Rotherham NHS Foundation Trust. Picker was commissioned by 21 Combined Acute Community Trust organisations to run their survey – this report presents your results in comparison to those organisations.

A total of 90 questions from the survey can be positively scored. 90 of these can be compared historically between NSS18 and NSS19. Your results include every question where your organisation had the minimum required 11 respondents.

4335	4242	48%	50%	38%
Invited to complete the survey	Eligible at the end of the survey	Completed the survey (2037)	Average response rate for similar organisations	Your previous response rate

54%	Q21c. Would recommend organisation as place to work
55%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
69%	Q21a. Care of patients/service users is organisation's top priority

Historical comparison*

Comparison with average*

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

Picker

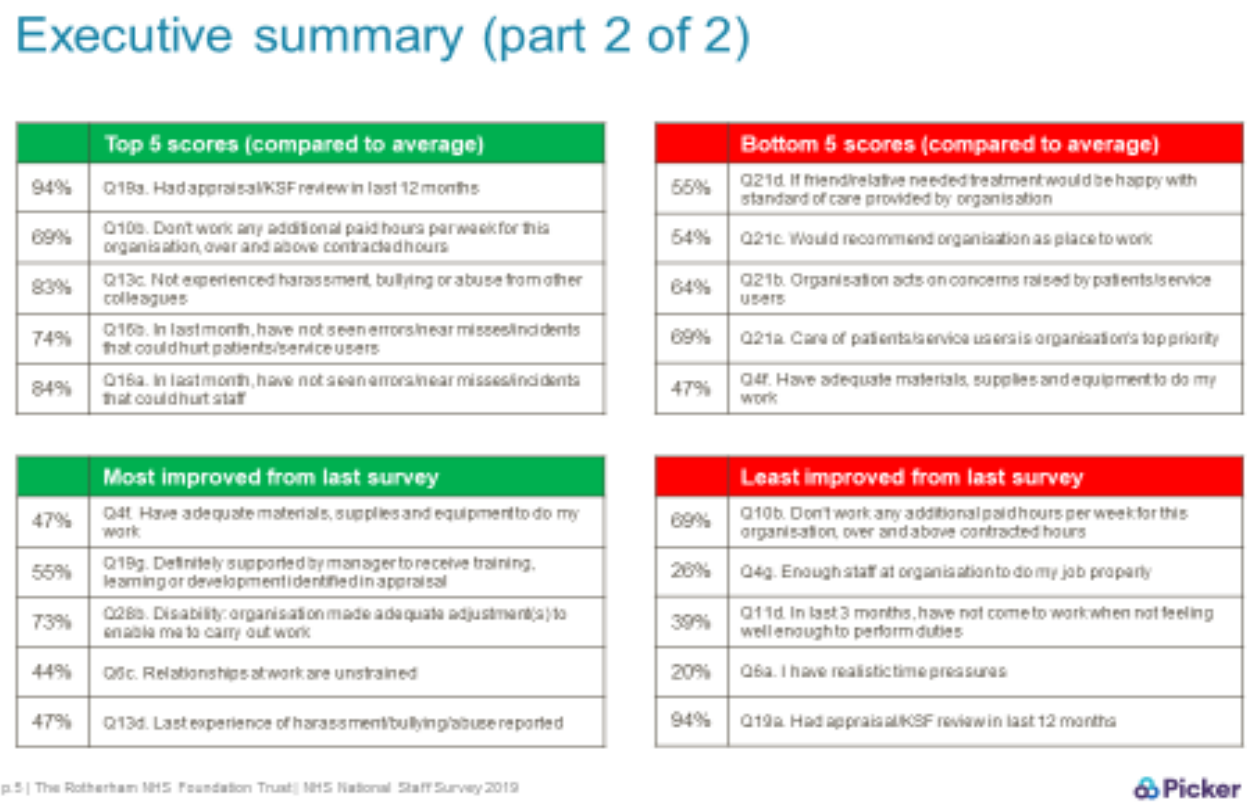
The following 6 questions from the staff survey indicate a statistically significant improvement compared to previous Trust performance:

- Ability to meet conflicting demands on my time and work
- Adequate equipment/supplies to do my job
- Relationships at work are unstrained
- Appraisal performance review: clear work objectives defined definitely agreed
- Supported by manager to receive training/learning/development identified in appraisal
- Staff not planning on leaving the organisation

The following 2 questions show statistical significant deterioration:

- Don't work any additional paid hours per week over and above contracted hours
- Had appraisal in the last 12 months

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



Executive summary (part 2 of 2)

	Top 5 scores (compared to average)
94%	Q19a. Had appraisal/KSF review in last 12 months
69%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours
83%	Q13c. Not experienced harassment, bullying or abuse from other colleagues
74%	Q16b. In last month, have not seen errors/near misses/incidents that could hurt patients/service users
84%	Q16a. In last month, have not seen errors/near misses/incidents that could hurt staff

	Bottom 5 scores (compared to average)
55%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
54%	Q21c. Would recommend organisation as place to work
64%	Q21b. Organisation acts on concerns raised by patients/service users
69%	Q21a. Care of patients/service users is organisation's top priority
47%	Q4f. Have adequate materials, supplies and equipment to do my work

	Most improved from last survey
47%	Q4f. Have adequate materials, supplies and equipment to do my work
55%	Q19g. Definitely supported by manager to receive training, learning or development identified in appraisal
73%	Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work
44%	Q6c. Relationships at work are unstrained
47%	Q13d. Last experience of harassment/bullying/abuse reported

	Least improved from last survey
69%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours
26%	Q4g. Enough staff at organisation to do my job properly
39%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
20%	Q6a. I have realistic time pressures
94%	Q19a. Had appraisal/KSF review in last 12 months

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Picker

Performance against priority areas

The Trust continues in its ambition and commitment to support projects and activities to improve colleague engagement. Despite our ambition the Trust has not performed as well as it would have liked. Towards the end of 2019 the Trust has met its commitment to revitalise the staff wellbeing offering through hosting engagement listening events to hear from colleagues from across the organisation what they would like to see and where changes can be made. This has been used to inform the People Plan in line with national requirements. To this end, all things workforce will sit within the People Plan to ensure a clear strategy is understood. The Pulse survey was not introduced and will be adapted to meet the holistic needs of the People Plan. The commitment to undertake the Together We Can programme has been met and continues as business as usual. Where dedicated staff survey listening events have taken place, the service continues to see improved staff survey results year on year. We have implemented staff inclusion networks – BAME, LGBT+ and Disability, including the introduction of Disability Passport which makes it easier to remain and be supported at work. The Trust received local recognition for the introduction of its innovative approach to adoption leave more inclusive and easier to access. The Trust has performed well against Flu achieving 80% of front line workers vaccinated.

Staff Friends and Family Test
The Trust invites colleagues to participate in the staff friends and family test. Since the last survey the Trust has seen a small improvement in staff recommending the Trust as a place to work and being happy with the standard of care provided by the organisation should a family or friend need treatment.

Data is collated from colleagues each quarter, asking two key questions:

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

	Quarter 1 2019/20		Quarter 2 2019/20	
	Response %	**Response Count**	**Response %**	**Response Count**
Extremely likely	22	24	33.2	69
Likely	42.2	46	42.8	89
Neither likely or unlikely	10.1	11	9.1	19
Unlikely	10.1	11	4.8	10
Extremely Unlikely	11	12	8.2	17
I don't know	4.6	5	0.5	1
No response	0	0	1.4	3
	Quarter 3 2019/20		**Quarter 4 2019/20**	
	Response %	**Response Count**	**Response %**	**Response Count**
Extremely likely	12.9%	252	*	
Likely	40.8%	799		
Neither likely or unlikely	30%	587		
Unlikely	11.2%	220		
Extremely Unlikely	5.1%	99		
I don't know	0	0		
No Response	0	0		

* Due to the coronavirus pandemic, Trusts were asked to temporarily suspend the Staff FFT therefore there was no data submission or publication of results.

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

	Quarter 1 2019/20		Quarter 2 2019/20	
	Response %	Response Count	Response %	Response Count
Extremely likely	26.6	29	36	75
Likely	41.3	45	39.4	82
Neither likely or unlikely	9.2	10	8.2	17
Unlikely	13.8	15	5.8	12
Extremely unlikely	8.2	9	7.2	15
I don't know	0.9	1	2.4	5
No response	0	0	0.96	2
	Quarter 3 2019/20		**Quarter 4 2019/20**	
	Response %	**Response Count**	**Response %**	**Response Count**
Extremely likely	12.1%	238	*	
Likely	43.1%	846		
Neither likely or unlikely	29.9%	587		
Unlikely	10.3%	203		
Extremely unlikely	4.5%	88		
I don't know	0	0		

* Due to the coronavirus pandemic, Trusts were asked to temporarily suspend the Staff FFT therefore there was no data submission or publication of results.

Monitoring Arrangement and future priorities and how they will be measured
This area will need to be confirmed when we get direction from Executive Team and governance arrangements have been agreed.

Freedom to Speak up (FTSU) Guardians
The FTSU Guardian (FTSU) role was first introduced at the Trust in July 2015 in response to the Francis report, with the appointment of six FTSU Guardians. In September 2016 a Lead Guardian was appointed, which enabled the separation of the FTSU Guardians from the HR functions of the organisation. Subsequent to this appointment ten further FTSU Guardians have been recruited to ensure that all Divisions have representation. All of the FTSU Guardians have a suitability interview and undertake the role on a voluntary basis in addition to their substantive post; two of these have also attended the national Guardians office training session. A new 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 FTSU Guardians. The regional network meets every two months and there are biannual national events which our FTSU Guardians have been supported to attend. In December 2019 TRFT hosted the Regional Meeting which was attended by a representative from the National Guardians Office. October 2019 was national FTSU month, during which we hosted Russell Parkinson from the NGO; Russell met with the Chief Nurse and Medical Director before spending time

with staff who had previously raised concerns. The FTSU Guardian month aimed to raise the profile of FTSU Guardians across the Trust and saw several events including the launch of a regular newsletter.

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

In its response to the Gosport Independent Panel Report (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 TRFT can raise concerns with their Trade unions, line managers, colleagues or other supervisors, health and safety, security manager, Human Resources, professional regulator, Trust chaplains and to any of the FTSU team via face to face, telephone (including voicemail linked to e-mail address), e-mail, drop in clinic once a month at each site and anonymously via letter to the FTSU Lead.

All concerns are responded to within 5 working days. If colleagues wish to meet with a guardian to discuss their concerns, meetings are arranged at a time and venue convenient to the 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 FTSU Guardians. To date feedback has been mainly positive with colleagues finding it easy to contact a FTSUG and pleased with the support that has been received.

To date in 2019/20, the FTSU Guardians have received 21 concerns. The concerns have related to attitudes and behaviour (5), with colleagues being directed to HR or union support for further advice. Of the remainder, 6 to policy and procedures, 1 to Patient experience, 5 to quality and safety, 3 to performance and capability and 1 to other. It is expected that the number of concerns raised will be the same as the previous 12 months. This may be due to TFRT being one of the only Trusts nationally to have FTSU as a MAST subject. This training ensures staff are aware of FTSU and what to do if they suffer a detriment and how to escalate it, if it does indeed occur. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors with regular reporting to the Operational Workforce Committee.

Key learning from the 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 15 November 2019, The Rotherham NHS Foundation Trust's annual Proud Awards took place to celebrate dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

Held at Magna and hosted by Heart Yorkshire's Dixie, the event saw more than 350 colleagues, partner organisations and guests alongside the shortlisted nominees.

This year, more than 400 nominations were received, including a fantastic response from patients and members of the public who submitted over 100 entries for the Public Recognition category alone.

Chief Executive, Louise Barnett, was joined by the Chairman, Martin Havenhand, the Executive Team, Governors and Non-Executive Directors, as well as representatives from Rotherham CCG. The health reporter from the Rotherham Advertiser, Chloe West, was also in attendance to help present the Public Recognition Award.

The 2019 winners are:

Core Values – Ambitious
Stella Krain – Community Hospital Admission Avoidance Team

Core Values – Caring
Dr Magdalena Turzyniecka - Pathology

Core Values – Together

Mr Stuart Richards - ENT

Partnership Award
Fortem Northern Trainee Management Team

Learning and Development Award
Dawn White – Therapy Services

Unsung Hero Award
Beverley Lomas – Special Care Baby Unit

Outstanding Volunteer Award
Andrew Moore and John Lipski

Our Top Leader Award
Joanne Greenlees – Community Nursing

Clinical Team of the Year Award
Parenteral and Enteral Nutrition – Nutrition and Dietetics

Non-Clinical Team of the Year Award
Security

Shining Star of the Year Award
Wendy Perry – Estates and Facilities

Outstanding Quality in Care Award
Jennie Swift – WHAM (Weight, Health and Attitude Management 0-19 Service)

My Idea Made a Difference Award
SCBU Outreach Parent and Baby Group

Public Recognition Award
Dr Binu Varughese – Gastroenterology

Governor's Award for Excellence in Healthcare
Mr Indranil Chakrabarti – Orthopaedic and Hand Surgeon

Chief Executive's Award
Dr Richard Went – Clinical Haematology

Chairman's Award
Dr Clare Windsor – Critical Care
Portering Team – Estates and Facilities

Lifetime Achievement Award
Dr Fiona Fawthrop - Rheumatology

Implementing the priority clinical standards for 7-day hospital services
The Trust has developed 7 Day Service plans as part of the Divisions' operational plans linked to local requirements. Part of the operational plan providing increased services with the acute facilities, ensuring that pathways are available 24/7. The ongoing priority in relation to this is the maintenance and increased development of:

- Weekend board rounds.
- Consultant reviews.
- 7-day Hospital at night services rolled out to 24 hours at weekends.
- 7-day cover of the Ambulatory service.
- 7-day Consultant cover within the AMU.
- Complete outreach and Hospital at night teams' business case.

The Trust participates in the national 7-Day Services self-assessment. The 2019 assessments show partial compliance with the 4 national standards. The Trust will be taking the learning and feedback from this into the self-assessment due in June 2020.

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 10.13%; the equivalent of 15 posts out of an establishment of 150 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.

External Agency Visits, Inspections or Accreditations
During 2019/20 there have been 17 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 NHS Improvement, 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 Target >=92%													
	YTD	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2018/19	**93.99%**	**94.35%**	**94.57%**	**94.32%**	**94.82%**	**95.07%**	**94.07%**	**94.43%**	**94.37%**	**93.80%**	**93.10%**	**92.01%**	**92.98%**
2019/2020	**91.6%**	**92.59%**	**92.57%**	**92.89%**	**92.59%**	**91.98%**	**92.17%**	**92.13%**	**92.15%**	**91.60%**	**91.0%**	**91.0%**	**86.4%**

(Source: Meditech)

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

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

RTT (referral to treatment) consultant-led waiting times only apply to services commissioned by English NHS commissioners and for those patients that English

commissioners are responsible. Therefore, RTT pathways commissioned by non-English commissioners are excluded from the calculation."

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

The Trust continues to monitor performance against the Referral to Treatment time - decline in performance throughout the winter months failing the year end position just under the 92% target at 91.6%.

The A&E four hour waiting time target

When the four-hour target was introduced in 2004 it helped to significantly reduce the lengthy waits faced by many patients. But 15 years on the NHS faces different challenges, and from what people tell us it is clear that the time is right to look again at this core measure. NHS England's Medical Director identified that "to build an NHS that is fit for the future, a review of the old targets was needed which have such a big influence on how care is delivered, to make sure that they take account of the latest treatments and techniques, and support, not hinder, staff to deliver the kind of responsive, high-quality services that people want to see."

The Healthwatch National Director also identified that "What shapes people's experiences of A&E is often not how long they wait, but the quality of care they receive and how that care is delivered.

The NHS review of clinical standards in March 2019 confirmed that the NHS's flagship performance markers may be stopped with changes to A&E targets accompanied by new plans for waiting times for cancer, mental health and planned operations. TRFT were one of fourteen hospitals chosen to pilot the new "rapid care measures" brought in by the NHS under plans to replace the flagship four-hour A&E standard. The trials started in May 2019 with the cohort of hospitals involved in the pilot representing a "range of geographies and performance against the previous 4 hour A&E standard.

The Trust is involved with the pilot of the four new standards set out in the NHS's review of clinical standards, which includes identifying life-threatening conditions faster, reducing emergency time for critically ill patients, and the main waiting time for all patients.

The new standards aim to measure:

- Time to Initial Assessment in A+E
- Time to be seen by a Clinician
- Mean Total Wait in A+E (At TRFT we are also monitoring expanded on this to monitor quality and safety of our patients to monitor 12 hours spent in A+E and 6 hours to admit.)

Cancer National Waiting Times

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

Metric	Target	2014/15	2015/16	2016/17	2017/18	2018/19	2019/2020
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%
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%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%	99.21%	97.6%	97.6%	97.5%
Cancer 31 day wait for 2nd or subsequent treatment – surgery	94%	100%	98.67%	96.85%	98.8%	98.5%	95.5%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100.00%	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%
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%
Consultant Upgrade	TBC	TBC	94.72%	91.95%	92.8%	88.5%	87.3%

(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 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

Cancer Standards 62 Day 2018/19	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	81.8%	87.1%	83.5%	85.7%	85.2%	86.2%	80.0%	86.6%	75.7%	69.8%	75.7%	72%
Numerator	54	57.5	43	57	54.5	53	50	51.5	39	44	40.5	33.5

Denominator	66	66	51.5	66.5	64	61.5	62.5	59.5	51.5	63	53.5	46.5

Performance Against Targets

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

Screening:
Achieving screening targets can be challenging due to the small numbers of patients within the screening programme. We are striving to improve year on year, however due to low numbers this can be challenging. 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 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

DTOCs													
Target <=3.5%	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2018/19	2.89%	3.10%	2.26%	1.82%	2.52%	4.42%	3.16%	4.24%	2.80%	2.61%	4.06%	1.78%	1.90%
2019/20	4.16%	2.43%	3.01%	3.94%	4.82%	3.78%	3.22%	3.94%	5.41%	5.26%	5.24%	5.63%	2.74%

(Source: Trust Information System)

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

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

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

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

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

There has been a recent spike in the DTOC figures due to current demand. The demand for support for discharge from IDT has risen significantly, with figures from last winter being reported between 30-40 on average in terms of medically fit patients known to IDT. This year, the highest figures reported so far known to IDT have been 96 patients medically fit, thus increasing the likelihood of people being delayed and resulting in a higher DTOC report. Whilst there are high numbers of people being delayed, people are not being delayed for a significant length of time.
(Source: Trust Information System)

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

(Meditech). The numerator is the number of patients cancelled by the hospital for non-clinical reasons i.e. lack of equipment and the denominator is the number of operations carried out.

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

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

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

The total full year performance for 18/19 was 0.78%, which is within the agreed target of 0.80%. The total performance for 19/20 YTD is 1.11% which is a failure of the standard.

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

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

Incidence of C.Difficile

Number of reported cases of C.Diff													
Target = <11	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2018/19	8	0	1	0	2	1	0	2	0	1	0	0	1
2019/20	35	0	2	3	1	3	3	4	2	2	8	5	2

(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 previous years.

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.

TRFT had been challenged with the second to lowest case rate per 100,000 bed days for a general hospital in the country.

All cases of hospital acquired C.Difficile are reviewed in depth by the Infection Prevention and Control (IPC) team. Shared ownership of completion of the Root Cause Analysis (RCA) investigation with the clinical divisions has continued. All cases are reviewed by the CCG Lead nurse in Infection Prevention and Control to determine if any lapse in quality of care is identified during the whole care pathway.

National and local priorities and regulatory requirements:

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

National and local priorities and regulatory requirements: -								
The Trust is assessed through the submission of wide range of data.								
Measure	Department of Health	NHS Improvement	2017/18		2018/19		2019/20	
			Year-end position	National Target	*Year-end position	National Target	*Year-end position	National Target
Number of cases - clostridium Difficile infection (C-difficile)	x	x	15	>26	8	>26	35	>26
Number of cases - MRSA	x	x	3	0	1	0	1	0
Delayed transfers of care	x	x	4.61%	3.50%	1.90%	3.50%	4.16%	3.50%
Infant health & inequalities: breastfeeding initiation	x	x	57%	66%	66.50%	66%	67.90%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	95.92%	95%	96.10%	95%	80.63% up to end Feb-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%	90%	84.40%	90%	72.70%	90%
Non - Admitted	x	x	95%	95%	95.40%	95%	93.60%	95%
Incomplete	x	x	95%	92%	95.01%	92%	91.60%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	0.60%	Less than 1%	0.49%	Less than 1%	0.67%	Less than 1%
Patients waiting less than 4 hours A&E	x	x	84.95%	95%	85.65%	95%	not reported	95%
Cancelled operations for non-medical reasons	x		0.73%	0.80%	0.80%	0.80%	1.11%	0.80%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		91.34%	90%	93.60%	90%	93.10%	90%
Patients who spend at least 90% of their time on a stroke unit	x		75%	80%	81%	80%	59.3%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		81%	60%	70%	60%	63.5%	60%

Anti-Cancer Drug Treatments - Chemotherapy	x		100%	98%*	100%	98%*	100%	98%*
Surgery	x		98.80%	94%*	98.50%	94%*	97.90%	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		90.80%	90%*	94.90%	90%*	94.10%	90%*
Urgent GP Referral	x		84%	85%*	81.30%	85%*	75.80%	85%*
31-Day Wait For First Treatment (Diagnosis To Treatment)								
All cancers	x		97.60%	96%*	97.60%	96%*	97.50%	96%*
Two week wait from referral to date first seen								
All cancers (%)	x		95.10%	93%*	93.80%	93%*	92.80%	93%*
For symptomatic breast patients (cancer not initially suspected)	x		90.90%	93%*	85.70%	93%*	88.20%	93%*
SHMI	x		103.13	100	112.42	100		100
Please note : the data for April 19 - March 20 is not published until August								
(Source: Various Information Systems including InfoFlex/Open Exeter and								

For further details of readmission rates see Appendix 2.

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 2019/20 and indicates both the significance and the emphasis placed on safety, quality, patient experience and clinical effectiveness by the Trust.

During the year, the Trust once again welcomed the Care Quality Commission who carried out inspections at the Trust. Whilst improvement was seen in some areas, in particular within UECC, the overall rating for the Trust remains as 'requires improvement'.

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 improve our rating overall and in specific areas where improvement is required.

It was a demanding year for the NHS in general, with Covid-19 hitting right at the end of the NHS 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.

It is disappointing that some local standards were not met during the year, such as our diagnostic test waiting time and some cancer standards. The Hospital mortality rate has been acknowledged as being too high, rising throughout the year. As I said during my response at the Annual Members Meeting, the Council of Governors will pay scrutiny to this during 2020/21. We were also disappointed that the target for completion of Mandatory and Statutory Training (MAST) was not met, a perennial issue.

There were areas of improvement and positivity including increasing medication safety, improvement in the experience of older children when transitioning to adult services and increased compliance with policies from the National Institute for Health and Care Excellence (NICE).

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

The end of year financial position of the trust was extremely disappointing although it was encouraging that the ICS was in balance overall which meant that the trust was not penalised. The Trust continues to work closely with partners throughout the South Yorkshire and Bassetlaw Integrated Care System and Governors are supportive of proposed arrangements to improve patient experience and care. For example, the

move of the ophthalmology service from the trust building to the Rotherham Community Health Centre.

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

Gavin Rimmer

Lead Governor, The Rotherham Foundation Trust.

Statement from NHS Rotherham Clinical Commissioning Group – 14th May 2020

Throughout 2019/20, The Rotherham NHS Foundation Trust (TRFT) have worked with NHS Rotherham Clinical Commissioning Group (RCCG) to secure continuous improvements in the three domains of Patient Experience, Patient Safety and Clinical Effectiveness through engagement from TRFT clinicians and executives at contractual meetings and other key committees between the two organisations. The joint Contract Quality Meeting continues to have strong representation and 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.

RCCG recognise the significant amount of work that has been undertaken in relation to learning from deaths in particular the case review studies that have taken place both internally and externally. Whilst mortality remains an issue for the Trust, in particular in relation to coding, it is evident that actions have been taken and put in place to address quality of care, case-mix and coding most notably with the level of scrutiny that is now applied by the medical examiner service and the technical adjustments to the process in Meditech to support clinicians.

The Safe and Sound Framework developed by the Chief Nurse and Medical Director to deliver the Quality Improvement Strategy and Quality Improvement Plan is noted as a significant achievement by the Trust. The framework includes a Safe and Sound Quality Scorecard Report which 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 and TRFT participate in an annual programme of clinically led visits. The purpose of these visits is to facilitate assurance about quality and safety of healthcare services; providing an opportunity for commissioners to inspect facilities and engage directly with patients, clinicians and management to hear any concerns and ideas for improvement under a guarantee of anonymity. The visits focus on the patient journey and full end to end pathway. One visit took place during 2019/20 to the Acute and Community Heart Failure Service. Overall the visit concluded with positive feedback from RCCG clinicians with a series of recommendations for improvement to be implemented. Also of particular note was the positive feedback from the patients during these visits. A programme of visits will be agreed for 2020/21.

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 October 2018, the Care Quality Commission served a condition on the Trust registration relating to mitigating the risks within paediatric Urgent and Emergency Care Centre with a focus on medical and nursing staffing levels. Following this the Urgent and Emergency Care Service was inspected in August 2019. Comprehensive action plans have been developed to address the inspection findings and TRFT provide robust updates through the joint Contract Quality meetings with RCCG. RCCG recognises the hard work that has been put into not only developing the plans but addressing the immediate concerns raised by the CQC. RCCG will continue to work in a supportive manner with TRFT as well as seeking assurance on delivery of the plan and identifying notable improvements.

RCCG is supportive of the way in which the Trust's key quality priorities for 2020/21 have been developed through a consultation process involving colleagues, governors, patient and members of the public.

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

Sue Cassin
Chief Nurse
NHS Rotherham CCG

Statement from Healthwatch Rotherham

Thank you for inviting us to comment on this year's Quality Report. Healthwatch Rotherham has undergone some changes since the last Quality Report and the service is now hosted by Citizens Advice Rotherham. We are also no longer responsible for the Independent Complaints Advocacy Service (ICAS) which will enable us to concentrate on our core activities which include promoting and supporting the involvement of local people in commissioning and the provision and scrutiny of local care services.

We hope to continue our work with the Patient Experience Group and some of its sub groups including the Learning Disabilities Team where we have exchanged information and built up a good relationship which has proved effective on both sides. We fully support the priority to ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability and Autism. This will complement the work already being undertaken on the hospital passport and easy read information provided to Patients with a Learning Disability and Autism.

The implementation of the Medical Examiner Office is a welcomed addition to TRFT and will bring comfort to families who feel there were issues with the care a loved one received, and this will give them the opportunity to have their voice heard and find answers.

We will follow with interest the development of the Discharge Checklist. Whilst speaking to residents about their discharge from hospital we discovered that 58% of patients felt they were not given clear information on their discharge and who to contact for further support or health advice after leaving the hospital.

Healthwatch Rotherham is increasing its involvement with Cancer Care services in Rotherham working with the Macmillan Cancer Advocacy Service, Living with and Beyond Cancer Team more recently the Cancer Alliance Quality Improvement Initiative where we are hoping to hold some joint engagement sessions with our seldom heard communities. Last year we provided 4 volunteers to take part in the PLACE (Patient Led Assessment of the Care Environment) Assessments and we hope we can continue this as it gave us a valuable insight into the different departments of TRFT which we can share with residents. We would like to thank the staff and volunteers of TRFT for their part in keeping us safe in what has been and continues to be challenging times and we hope to strengthen our current relationship with the Trust over the coming year.

Lesley Cooper
Service Manager
Healthwatch Rotherham
22/10/2020

Statement from Rotherham Health Select Commission

The TRFT sub-group from the Health Select Commission (HSC) held a detailed discussion on progress on the quality priorities in February 2020. This was then followed by an additional session on 3 November 2020, with Members having had the opportunity to consider the draft Quality Account. Members appreciated having the opportunity to review this information and asked questions and made recommendations with regard to challenges, performance and delivery of further quality improvements.

The HSC was concerned by the findings form Staff Surveys, in which 47% of respondents reported they did not have enough materials, equipment and supplies to do their jobs properly. Members were disappointed to see that only 20% of respondents felt the time pressures associated with their work were reasonable. It was further noted that only 55% would be comfortable if their own loved one were to receive care at the hospital. Members find these numbers concerning as they reflect the feelings of staff before the pandemic began. Members are keen to see the effects of the proposed measures to improve patient experience and safety, particularly as regards sepsis, community acquired pneumonia, and end of life care. Members expressed concerns around staff absences as the pandemic places additional strain on resources. Members would also like to see improvement of outlying measurements regarding cancer screening wait times. Scrutiny of progress in these areas will be included in the Select Commission's work programme for 2021.

Members noted the positive progress made on the quality priorities during the year, in particular with electronic prescribing, and improvements in CQC assessments of several service areas. Members were also encouraged by the enhanced efforts to maximise learning from incidents and to leverage the audit process for quality improvement.

Members noted that the Trust is being proactive by bolstering its collecting feedback from families, and by ensuring the staff receive the right training to ensure they handle data responsibly and deliver the best possible quality of care for example to individuals with autism or learning disabilities. Members have noted that where appropriate, this training may be informed by consultation with local Autism groups. These efforts toward more universal design of services, as well as efforts to improve Inclusion and Diversity are positive moves.

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

Overall there is a lot of work to do to improve "outlier" status, but Members are very supportive of the quality improvement culture. The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members, by attending meetings and providing information, as well as taking on board their comments and concerns. The Commission expects this to continue and looks forward to working closely with the Trust again in 2019-20.

Cllr Robert Elliott
Vice Chair, 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 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19.*
- the content of the Quality Account is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period April 2019 to 31 March 2020.
    - papers relating to quality reported to the board over the period April 2019 to 31 March 2020.
    - feedback from commissioners dated 14/05/2020.
    - feedback from governors dated 14/05/2019.
    - feedback from local Healthwatch organisation dated 22/10/2020.
    - feedback from Overview and Scrutiny Committee dated 2/11/2020
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5/5//2020.
    - the national patient survey 20/06/2019.
    - the national staff survey 28/02/2020.
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 20/05/2020.
    - CQC inspection report dated 31/01/2019.

- the Quality Account presents a balanced picture of the NHS foundation Trust's performance over the period covered.

- the performance information reported in the Quality Account is reliable and accurate.

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these 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
3 November 2020

Chief Executive
3 November 2020

Appendix 1: Review of Local Clinical Audits

The reports of 94 local clinical audits were reviewed by the provider in 2019-2020 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

CSU	Title	Actions to improve care	Project No
A&E	Paediatric Priority 2 Re-audit	Nursing staff to review data each month on priority 2 paediatric patients and present the results every 6 months at the Governance and Consultant Meetings.	R1045
A&E	Documentation re-audit	Highlight the good medical practice achieved on documentation via an information chart and safety huddles in the department.	S1834
A&E	7 Day Re-attendances in Paediatric Emergency Department (ED)	Highlight in safety huddle and induction of new Doctors, the need to give good verbal and written advice and to document this in patient notes.	R1113
A&E	Priority 2 adults in the Emergency Department	Improve education and training in triage regarding categorization of priority 2 patients and highlight the need to document the time seen by a clinician in staff huddles.	R1114
A&E	Audit of the management of paediatric burns patients presenting to the ED	Results to be highlighted and discussed with the Junior Doctors, Middle Grades and Consultants.	R1121
A&E	Management of UTI in children in the Emergency Department	Results to be discussed and highlighted at an ED Quality Governance meeting. A Quality Improvement Project is being undertaken to assess the practice in the Urgent and Emergency Care Centre (UECC) regarding the management of urinary tract infections.	S1823
AMU	Venous thromboembolism (VTE) prophylaxis prescription practice in Acute Medical Unit (AMU) setting	Audit results and information on the risk assessment tool and venous thromboembolism (VTE) prescription practice guidelines, will be presented in two departmental educational meetings, in order to improve engagement of the health care team which may contribute to closing the gap between evidence-	R1096

CSU	Title	Actions to improve care	Project No
		based guidelines and prescribing practice.	
Anaesthetics	Retrospective audit of Octogenarians undergoing emergency surgery	Poster to be created to alert emergency theatre staff to be aware of high risk patients aged over 80 years old.	S1760
Anaesthetics	Audit of wound soaker and Rectus sheath block	Re-audit to be undertaken looking at length of stay	S1611
Anaesthetics	Availability of Anaphylaxis Treatment Packs	Anaphylaxis packs to be organised for theatres (and resus department if required). Responsibility to check and maintain the packs along with daily checks/ resus trollies to be confirmed	R1105
Anaesthetics	Unplanned admissions from Day Surgery 2018	Undertake an evaluation of the breast surgery service	R987
Anaesthetics	Emergency Theatre: Urgency, Supervision and out of hours - re-audit	National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) grade to be assigned by the operating consultant	S1693
Anaesthetics	Audit of pain relief post total knee replacement	Revised guideline regarding use of Oxycodone in pain management to be produced.	S1610
Community Adult Services	A re-audit of the retrospective use of clinically documented local anaesthetic administration information within Doncaster, Rotherham and Barnsley community Dental Services	Results to be shared with colleagues at local meetings highlighting the need to record the name of the local anaesthetic used, expiry date, batch number, dose administered, site and topical use.	R892
Community Adult Services	Quality of Radiographs in Barnsley, Doncaster and	Highlight the need to report every radiograph taken on a custom screen and tick the main reason for justification. A calibration exercise	R1080

CSU	Title	Actions to improve care	Project No
	Rotherham Community Dental Service 2018	to be carried out at team meetings to ascertain if radiograph quality is being recorded to consistent standards.	
Community Adult Services	Are the Royal College of Surgeons guidelines for the extraction of first permanent molars of poor prognosis being adhered to within the Rotherham NHS Trust community dental services?	Create and introduce a proforma in the electronic notes for the recording of clinical indices in relation to first permanent molar extractions.	R1098
Community Adult Services	Quality of Radiographs taken in Barnsley Community Dental Service 2017	Feedback the results of the audit and reiteration that all radiographs taken must be justified and reported on.	R976
Community Adult Services	CDS service-wide Antibiotic Prescribing Audit	Results to be feedback to Community Dental Staff (CDS) and discussed at the CDS Clinical Governance Group meeting. Relevant training and guidance on antibiotic prescribing and stewardship to be signposted to clinicians. A poster on antibiotic stewardship in relation to toothache will be displayed in all CDS clinics. A custom screen on the patient electronic record to be produced to include indication, drug, dose, frequency, course and review and patient specific comments.	R1101
CYP Service	Audit of resuscitation facilities for community paediatrics	Escalate to all paediatric community line managers that the resus policy states that Basic Life Support training renewal is mandatory for all staff. Confirm with Trust resus team responsibilities and content for resus equipment kits in the various types of outreach settings and implement.	S1793
CYP Service	Re-Audit of Diabetic Keto Acidosis	Raise awareness of British Society for Paediatric Endocrinology and Diabetes (BSPED) and adopt	S1891

CSU	Title	Actions to improve care	Project No
	Management in CYP	proforma/ Integrated care pathway based on the guidance.	
CYP Service	Quality Measurement Audit for Initial Health Assessment in Looked After Children (LAC)	Colleagues to be reminded that consent should be documented in part C (summary).	S1740
CYP Service, Safeguarding	Audit of child protection medical reports	Disseminate results and advise all trainees and consultants on areas that were not compliant to facilitate improved completion. Clinical Safeguarding Lead to develop and implement guidelines including a tick list to guide assessments.	S1708
CYP Service, Safeguarding	Re-audit of Quality of the Multi Agency Risk Assessment Conference (MARAC) Research Forms	Support new practitioners understanding of MARAC process & documentation, providing continuous feedback on gaps and concerns	R1077
CYP Service, Safeguarding	Audit of the quality of Electronic Multi-Agency referral forms (EMARF) to MASH from TRFT health staff and that the completed referrals have been attached correctly in to the child's health record	Staff to be reminded of correct procedure for filing completed EMARFs and team leaders to ensure staff are following the correct record keeping processes.	R850
CYP Service, Safeguarding	Safeguarding Survey Monkey - Community	To develop and distribute dates for bespoke training for TRFT colleagues to support areas identified from survey	R1137
Dermatology	British Association of Dermatologists national clinical audit Phototherapy Service	The light therapy guideline/Standard Operating Procedure (SOP) to be updated and implemented. Minimal Erythema Dose (MED) will be implemented into the phototherapy service.	R968

CSU	Title	Actions to improve care	Project No
Dermatology	RFT skin MDT audit on the Performance of Computed Tomography scans for Staging of Patients with IIB Cutaneous Melanoma.	To only perform scans routinely for patients with IIIB disease and above unless there is a clinical indication or advised by the Skin MDT and to refer all patients with stage IB melanoma >1.0mm to skin MDT for consideration of sentinel lymph node biopsy (SLNB) as per e current guidelines.	R1091
Dermatology	Bullous Pemphigoid Audit	Colleagues to be directed to the British Association of Dermatologists (BAD) guidelines for Bullous Pemphigoid (BP) and NICE guidelines on bone protection for patients at risk of osteoporosis. The means to document risk factors and important comorbidities in the medical notes to be developed. Memo and teaching session on blood pressure and urine dip stick at each clinic for patients on high dose or long-term oral steroid.	R1064
Dermatology	More than Just a Quick Look	Re-design the Dermatology referral form in conjunction with other specialities. To discuss the possibility of having a named Dermatologist every week who can be contacted for telephone advice. To produce a Dermatology referral algorithm and make available on the wards. To encourage GPs to contact the Dermatology department directly if they are concerned about an unwell patient instead of sending the patient directly to Acute Medical Unit (AMU). This will enable the patient to be seen quicker, treatment initiated on time and can help to shorten the patient stay.	R1124
Dermatology	Re-audit of the diagnosis of treatment of low vitamin D levels in patients diagnosed with melanoma	Education to be provided to clinical staff, highlighting the need and process of measuring vitamin D. A melanoma proforma to be developed for use at melanoma diagnosis consultations. Arrange treatment for patients with suboptimal vitamin D levels	S1904

CSU	Title	Actions to improve care	Project No
Dermatology	Time from decisions to treat Basel Cell Carcinoma (BCC)	Audit number of BCC's being biopsied vs excision	R979
Endoscopy, General Surgery	Post Polypectomy Colonoscopy Surveillance	Re-audit after introduction of forthcoming new guidelines from National Institute for Health & Care Excellence (NICE)/Public Health England (PHE) as these may radically change current practice.	S1848
ENT	Appropriateness of referral of Hearing Loss for Magnetic Resonance Imaging of internal acoustic meatus (MRI IAM's)	Develop a proforma to standardise Referral Criteria to NICE Guideline NG98 for dissemination at all new ENT Doctor's Induction. All grades to be educated in economics of MRI referrals including NHS England Tariffs for referrals and new and follow-up patients in ENT outpatients.	S1840
ENT, General Surgery, Orthopaedics, Urology	Audit of the WHO safety checklist	Discuss audit the findings within teams	S1584
General Surgery	Assessment of the quality of documentation of discharge summaries in the surgical wards	To merge TTOs and discharge summaries so that the patients get a copy of both by the time they are discharged To standardise the clinical narrative in the discharge summaries	S1832
General Surgery	Patient Admission Documentation Audit	Update clerking proforma to better match national guidance and create electronic record	R1104
General Surgery	Audit of Unplanned Admissions from Day Surgery 2018	Repeat audit with sample from all theatres, and liaison from anaesthetics department.	S1815
General Surgery	Audit of General Surgery Operative Notes	Modify electronic operation notes to comply fully with the guidelines and adopt single electronic operation notes to reduce variability.	S1922
GU Med	Re-audit of HIV Post-exposure prophylaxis following sexual exposure (PEPSE) use	Ensure that the PEPSE proforma is completed fully at each appointment, noting high risk patients to formal recall system. Create a text reminder to encourage attendance at follow up appointments	R1100

CSU	Title	Actions to improve care	Project No
GU Med	Chlamydia 3 month Post treatment re-test	Ensure patients are booked in to see a Healthcare Advisor when attending for treatment or is present in outreach setting if the patient declines to attend hospital site. Amend Healthcare Advisor proforma to include tick boxes to encourage uptake	R1088
GU Med	Hepatitis C in Genito-Urinary Medicine - adherence to British Association for Sexual health & HIV (BASHH) Guidelines	Update proforma to include checkbox for 'tattoo recipient'. Create an STI handbook with up to date guidelines for Hepatitis C Virus testing indications. Develop a proforma for use when a patient is diagnosed with Hepatitis C Virus	R783
GU Med	FSRH combined hormonal Contraception National UK Benchmarking audit 2019	Amend IT template to add discussion of perfect use efficacy to counselling; To add extended pill taking regimes to counselling. Discuss with staff to accept counselling once re risks of CHC is acceptable	R1118
Lab Med	Rotherham NHS Foundation Trust ability to meet National guidelines for laboratory communication of abnormal potassium results	Relevant Standard Operating Procedures (SOPs) to be updated and staff communicated with regarding the importance of following these. Clarification to be sought regarding the process for escalation if staff in the laboratory are unable to contact the clinical teams. An indices document to be produced in line with the recommendations of the clinical team. A risk stratification to be agreed.	R1071
Lab Med	Compliance with Transfusion Integrated Care Pathway	Promote culture of haemovigilance with training to continue to focus on consent, bedside checklist and competency compliance	R1030
Medicine	Lumbar puncture documentation	Revise the lumbar puncture proforma with the recommended changes and include in the induction booklet	S1788
O&G	Re-audit of repeat Surgical Evacuation of miscarriage	Review all cases that have not been added to Incident register (Datix) to determine cause	S1884

CSU	Title	Actions to improve care	Project No
O&G	Audit on lower segment caesarean section (LSCS) World Health Organisation (WHO) checklist	Introduce and monitor electronic WHO checklists	R1116
O&G	Re-Audit of Massive Post Partum Haemorrhage	Amend Post Partum Haemorrhage (PPH) scribe sheet to provide prompts to capture all the relevant information. Ensure risk factors are identified and documented in plan of care.	S1890
O&G	Foetal monitoring in labour (Cardiotocography -CTGs)	Raise awareness by disseminating audit learning points at relevant meetings and training	R1055
O&G	Audit of Antenatal Cardiotocography (CTG)	Label the Cardiotocography (CTG) machine that is not able to print RU number. Attach reminder on all CTG machines of required documentation.	R1123
O&G	Shoulder dystocia continuous audit 2018.	Create display on labour ward and via MAST to Highlight correct diagnosis and circulate 'learning from audit' to document exactly what was said to the mother in delivery.	R717
O&G	Re-audit of Caesarean Sections Category 1&2	Consider fetal blood sampling if Cardiotocography (CTG) is non-reassuring. Implement Electronic World Health Organisation checklist for all Caesarean sections.	S1838
O&G, Safeguarding	Audit of documentation in Maternity Safeguarding Packs (green packs)	A task and finish group will be set up to review the safeguarding pack as a whole	S1596
O&G, Safeguarding	Safe Sleep Assessment Reaudit 2019	Safe sleep Champions to continue to disseminate up to date information and to promote the use of the SOP.	R1082
O&G, Safeguarding	Re-audit of Perinatal Domestic Abuse Screening	Ensure colleagues are informed that women must be seen alone to ask routine enquiry questions & the electronic record (Meditech) used for documentation of routine enquiry for domestic abuse screening	R1085

CSU	Title	Actions to improve care	Project No
		(consider making the domestic abuse question a mandatory field)	
O&G, Safeguarding	Documentation of who accompanies women during labour	To circulate to all colleagues in Maternity to remind all to record the name and relationship of people accompanying women in labour/birth. To add information to Safeguarding Supervision session on Midwifery MAST programme on recording the name and relationship of people accompanying women in labour/birth on Midwifery. To repeat the audit to assess progress	S1814
OMFS	Documentation Audit 2018/19	Disseminate the national and local record keeping guidelines via department meetings and provision of paper copies to ensure that all are aware of the standards required	S1771
OMFS	Are the appropriate investigations being undertaken for patients admitted with orofacial infections?	Re-iterate to Dental Core Trainees the importance of these special tests and advise on how to add test to 'favourites list' on Meditech as prompt.	S1820
OMFS	Monitoring and improving the quality of OPG radiographs	Improve the diagnostic quality of Orthopantomogram (OPG) by revising the processing of films and replacing the OPG machine	R943
OMFS	Audit to assess Oral & Maxofacial Surgery (OMFS) staff awareness of emergency medical equipment and drugs	Basic Life Support (BLS) training to be provided at department level to ensure 100% compliance. Information will be incorporated information into the Dental Core Trainees handbook and local induction.	R1078
OMFS	Audit of adherence to selection criteria for apicectomies	Practice to be aligned with Mexborough Dept., and NHS England guidelines.	S1562
OMFS	Temporal Artery Biopsies - are we maintaining the	To raise awareness with the referring specialties of using the temporal biopsy proforma	S1744

CSU	Title	Actions to improve care	Project No
	standards? (Re-audit)		
Ophthalmology	Getting It Right First Time (GIRFT) Clinical Risk and Prioritisation Audit	While electronic records are being developed implement a feature in current system (Meditech) that does not allow a visit summary to be accepted unless the follow up is requested.	S1869
Ophthalmology	World Health Organisation (WHO) laser checklist - reaudit	Simplified checklist to be used for each eye. Nurse and Dr to check patient details together for quality assurance	S1867
Ophthalmology	Follow up vs discharge guidelines	Inform all staff grades that when in doubt they should seek advice from a consultant	S1872
Ophthalmology	Audit of outcomes of treating visual impairment due to diabetic macular oedema	Move patients to a one stop clinic for treatment, implement longer acting treatments where possible and involve GP in holistic approach to optimise results in primary care.	S1822
Ophthalmology	Retinopathy of prematurity screening audit	Improve documentation by updating referral letter template	R1066
Ophthalmology	Post eodymium:yttrium-aluminum-garnet (Nd:YAG) laser Peripheral Iridotomy (PI) Gonioscopy audit	Remind colleagues of the importance of Gonioscopy pre and post laser treatment	S1879
Ophthalmology	Personal Cataract audit	To continue auditing annually personal cataract surgery results to ensure quality of care	R1095
Ophthalmology	Periocular tumours	Collect data prospectively before operating until histopathology report completed	R1142
Ophthalmology	Documentation Re audit (2019/20)	Remind all doctors to write name, signature and GMC no. on records; also to write clearly diagnosis and management plan. Nurses and health care support workers to keep the current good track of documentation, - using patient's identification stickers on all pages	S1857
Ophthalmology	Retinal Vein Occlusion (RVO) Protocol Compliance	Re-audit in 12 months	R1143

CSU	Title	Actions to improve care	Project No
Ophthalmology	Deep sclerectomy - re-audit of operative record keeping	Consultant, assistant, theatre staff nurse and health care support workers to make sure that procedure record sheet is placed in the ophthalmology section after the patient's last consultation follow up sheet to keep it in chronologic order, as per Trust Documentation standards	S1894
Ophthalmology	Diabetic macula oedema (DMO) pathway compliance	Re-audit in 12 months	S1914
Ophthalmology	Eye Emergency Clinic (Re-Audit)	Casualty clinic telephone triage to be taken out of casualty clinic room and Trial for staff nurses and orthoptists to take the phone calls and grade referrals accordingly with support from Emergency Eye Clinic (EEC) doctor. Receptionists and secretaries not to book general clinic patients to EEC and keep 1 or 2 consultant clinic slots available for EEC patient follow ups. Switchboard not to transfer calls from patients directly to casualty clinic and must advise for professional review unless justified (under our care or post-surgery).	s1931
Orthopaedics	Orthopaedic On the Day Cancellations - re-audit	Re-audit every 6 months to monitor on the day cancellations	S1784
Orthopaedics	Fluoroscopy documentation re-audit	A yearly audit of radiation doses to be undertaken and an audit of compliance of documentation of procedure radiation level.	R1092
Orthopaedics	Re-audit of compliance with British Elbow and shoulder Society guidelines for traumatic unidiretional shoulder instability	A shoulder dislocation pathway will be developed, whereby patients with a first time dislocation will be sent for physiotherapy and referred directly to a shoulder surgeon	R1120
Orthopaedics	Documentation Audit 2019/20	To produce a poster to display in the wards, which details the entries which should be made in patient	S1858

CSU	Title	Actions to improve care	Project No
		notes ie location, printed name. Raise awareness with staff regarding documentation via ward induction and trauma meeting.	
Patient Safety, Trust wide	Adherence to Trust Duty of Candour Policy (patient safety)	The current Trust Duty of Candour policy will be updated and issued to all staff via the Intranet and will be reviewed at the Patient Safety Committee	S1868
Patient Safety, Trust wide	Naso-gastric (NG) Tube Insertion Audit (Patient Safety)		S1919
Pharmacy	Adherence to prescribing standards for Insulins and Metformin	New insulin card to be introduced across the inpatient wards following a pilot of the form. Training sessions on how to use the new insulin charts to be delivered to Doctors and other staff across the hospital	S1808
Pharmacy	Documentation of Allergy status on prescription charts	Staff to be reminded that Allergy /ADR Status Kardex comprises of two sections: the medicine/ substance and the description of allergy /reaction which must both be completed and then confirmed on Post Take Ward Round (PTWR). Consider developing a dedicated section on allergies and adverse reactions in electronic records (Meditech) and Electronic Prescribing and Medicines Administration (EPMA).	S1717
Pharmacy	Retrospective analysis of Drug allergy documentation	Develop communications to re-enforce the importance of confirming allergy status at all times: decision making, prescribing, administration and dispensing. Consider developing a dedicated section in paper and electronic records for allergy status in line with NICE guidance.	S1787
Radiology	A&E computerised tomography (CT) head timings audit	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.	R831

CSU	Title	Actions to improve care	Project No
Rheumatology	Early Inflammatory Arthritis Audit: Follow Up at 3 and 6 Months	Clinical Lead to discuss with Business manager process for booking follow up appointments Increase documentation of DAS28 criteria (measure of disease activity in rheumatoid arthritis) by using specific DAS sheet. Develop Nurses to develop a SOP for Disease-modifying anti-rheumatic drugs (DMARD)	R1133
Rheumatology	Documentation Audit 2019/20	To remind all staff of the standards set by the Trust	S1860
Safeguarding	Quarterly Audit of compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) requirements Q3	To maintain quarterly audits and feed back to staff to continue to drive improvements in compliance with MCA and DoLS requirements	R967
Safeguarding	Female Genital Mutilation (FGM) Multi-agency audit	Multi-agency meeting to consider roll out of information on FGM including referral criteria and risk assessments	R1067
Safeguarding	Quality of Contacts/ Referrals and the application of thresholds by partners and within the MASH	Interim arrangement: To provide a word version of the new Multi-Agency Referral Form to all partners. . All partners to share information with practitioners to reinforce message about consent prior to referral and review their safeguarding protocols to ensure that any actions around drift and delay with contacts and referrals are addressed.	R1110
Safeguarding	Audit of child sexual exploitation assessments for any woman aged 18 under Maternity	For a consistent approach Maternity Managers/Safeguarding Midwife to decide the appropriate gestation to undertake CSE screening and holistic assessment of teenage pregnancy.	S1905
Safeguarding, Trust wide	Contact between parents and their children who are admitted to hospital with	To devise a formal- joint RMBC and TRFT written documentation and procedure for supervision arrangements; which is discussed and agreed by all parties; hospital	S1831

CSU	Title	Actions to improve care	Project No
	safeguarding concerns and requiring full child protection investigations	staff, social worker and parents, family involved, with a copy of these on these in the child's hospital record.	
Therapy Services & Dietetics	Local Hip Sprint 2	To improve the percentage of patients mobilised out of bed on the day of, or day following hip fracture surgery by liaising with local Trusts and occupational therapists to identify additional equipment that could be recommended to purchase. All hip fracture patients to receive daily Physiotherapy during the first 7 days post surgery.	S1915
Urology	Prospective audit on indications of flexible cystoscopy	All patients admitted with relevant conditions (haematuria, recurrent urinary tract infection (UTI), single UTI or epididy moorchitis in male) will be offered a flexible cystoscopy and results discussed in Urology Governance and with Multi-Disciplinary Team (MDT) meetings.	R1053

Appendix 2: Readmissions within 28 days

Emergency Re admissions within 28 days of discharge from Hospital		
Age Bands	1st April 2018 - 31st March 2019	1st April 2019 - 31st March 2020
Age 0- 15 years	7.00%	6.68%
Age 16 years and above	10.72%	10.49%

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

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

Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2019/20

Detail of Visits	Date of Visit
Healthcare Safety Investigation Branch	4 April 2019
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	9 April 2019
Health Education England 'Monitoring of the Learning environment' visit - monitoring of outstanding conditions	18 April 2019
GIRFT Endocrinology follow up visit	28 June 2019
GIRFT Hospital Dentistry	29 August 2019
Resuscitation Council UK accreditation of ALS course	14 – 15 September 2019
GIRFT Anaesthetics and Perioperative Medicine	20 September 2019
Human Tissue Authority Inspection of RGH	26 September 2019
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	8 – 9 October 2019
NHS England Quality Surveillance Team clinical chemotherapy service review visits (adult solid tumour only)	17 October 2019
PLACE inspections	18 October 2019
GIRFT Geriatric	24 October 2019
GIRFT Rheumatology	19 November 2019
Y&H Neonatal Operational Delivery Network Neonatal Unit Peer Review Visit	22 November 2019
GIRFT Cardiology	25 November 2019
GIRFT Respiratory Medicine	27 November 2019
GIRFT Breast Surgery Visit	29 November 2019

(Source: Trust Database)

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Acronyms

A&E	Accident & Emergency Department
AMD	Associate Medical Director
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
CCG	Clinical Commissioning Group
CHKS	Comparative Health Knowledge System
CSE	Child Sexual Exploitation
C-difficile	Clostridium Difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
Datix	Computer software used by health services for risk management and reporting incidents
DIPC	Director of Infection Prevention and Control
DNACPR	Do not attempt cardio-pulmonary resuscitation
DoLS	Deprivation of Liberty Safeguards
DSPT	Data Security and Protection Toolkit
EDD	Estimated Date of Discharge
EMR	Electronic Medical Record
EPR	Electronic Patient Record
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GAfREC	Governance Arrangements for Research Ethics Committees
GP	General Practitioner
HbA1c	HbA1c is your average blood glucose (sugar) levels for the last two to three months
HDU	High Dependency Unit
NHS DIGITAL	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
IDT	Integrated Discharge Team
IG	Information Governance
IT	Information Technology
IV	Intravenous
Lab Med	Laboratory Medicine
LAC	Looked After Children
LOS	Length of Stay
MARAC	Multi Agency Risk Assessment Conference
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MCISS	Macmillan Cancer Information Support Base
MDT	Multi-Disciplinary Team
MQEM	Macmillan Cancer Support Quality Environment Mark
MRSA	Methicillin-Resistant Staphylococcus Aureus
NELA	National Emergency Laparotomy Audit
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OMFS	Oral and Maxillofacial Surgery
PDSA	Plan, Do, Study, Act

PIR	Post Infection Review
PLACE	Patient-led Assessment of the Care Environment
QC	Quality Committee
RCA	Root Cause Analysis
RMBC	Rotherham Metropolitan Borough Council
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
TRFT	The Rotherham NHS Foundation Trust
TTOs	To Take Out
YTD	Year To Date
VTE	Venous Thromboembolism

Glossary

Clinical Coding	The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.
Comparative Health Knowledge System (CHKS)	A web based performance benchmarking system, utilised by many Trusts.
Commissioning for Quality and Innovation (CQUIN)	A series of nationally and locally agreed improvement targets, linked to a proportion of Payment by Results funding as an incentive to achieve agreed outcomes.
Data Quality Index	A composite indicator reflecting data quality, provided by CHKS.
Datix	An Incident reporting system used by many NHS Trusts.
Exemplar Health Care	Exemplar is one of the UK's leading providers of specialist nursing care and neurorehabilitation for adults with complex needs.
FFFAP	Falls and Fragility Fracture Audit Programme, led by the Royal College of Physicians, gathering and analysing data on serious harms across the NHS.
HbA1c	HbA1c is your average blood glucose (sugar) levels for the last two to three months.
Healthwatch	The independent consumer champion that gathers and represents the public's views on health and social care services in England.
Mencap	Mencap is a UK charity for people with a learning disability. Mencap also support their families and carers.
Monitor	Sector regulators for health services in England.
Mortality Rate	The rate at which patients die in a hospital. Data is collected nationally by NHS DIGITAL and enables Trusts to look at trends in Mortality Rates and make comparisons with other hospitals. Mortality is generally measured in one of two ways: The Hospital Standardised Mortality Ratio (HSMR) measures the actual number of deaths occurring in a hospital compared to the number of deaths that might have been expected. The SHMI is a ratio of the actual number of patients who die against the number who would be expected to die on the basis of average England figures. The SHMI ratio includes those patients who die within 30 days of discharge from hospital.
Never Event	Defined by the 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.
NHS Digital	Provider of data for the NHS; formerly known as the Health and social care information centre (NHS DIGITAL).
NHS Improvement	NHS Improvement (NHSI) was launched on 1 April 2016. It was formed from the two previous regulators, Monitor and the Trust Development Authority (TDA) and has also taken on responsibility for Patient Safety

	data and the National Reporting and Learning System. The emphasis is on support for providers.
OPCS-4	The OPCS Classification of Interventions and Procedures (OPCS-4) is a Fundamental Information Standard which is revised periodically. The classification is used by Health Care Providers and national and regional Organisations. OPCS-4 is used to support operational and strategic planning, resource utilisation, performance management, reimbursement, research and epidemiology. It is used by NHS suppliers to build/update software to support NHS business functions and interoperability.
Patient-led assessments of the care environment (PLACE)	PLACE is a way of assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. They look at how the environment supports patient privacy and dignity, the meeting of dietary needs, cleanliness and general building maintenance. Results from the annual assessments are reported publicly to help drive improvements in the care environment; they show how the Trust is performing by comparison with other Trusts across England. For more information visit www.england.NHS.uk/ourwork/qual-clin¬lead/place.
Ribotyping	Ribotyping is a molecular technique that takes advantage of unique DNA sequences to differentiate strains of bacteria.
Risk Assessment Framework	This document sets out Monitor's approach to making sure NHS. Foundation Trusts are well run and can continue to provide good quality services for patients in the future.
Safeguarding	A process used to identify adults and children at risk and provide protection against further harm.
The Secondary Uses Service (SUS)	The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
Voyage	Voyage Care supports thousands of people with learning and physical disabilities, brain injuries, autism and other needs across England, Scotland and Wales. They offer person centred care and support in a range of settings and have experience of supporting people to move from one type of service to another as their needs change or they become more independent.