
NHS
The Rotherham
NHS Foundation Trust
The Rotherham NHS Foundation Trust
Quality Account
2022/23
Ambitious
Caring
Together

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Part One: Statement on Quality from the Chief Executive

The Rotherham NHS Foundation Trust's Quality Account provides details of the Trust's quality performance and improvement journey during 2022-23. We are proud of a number of significant achievements during the year, but we also acknowledge that there are areas where further improvements are required to ensure the highest quality care and experience is available for our service users and the wider community.

Following triangulation of information from a broad range of sources, including from independent surveys and inspections, we have selected nine quality priorities for 2023-24, which we believe reflect the areas where greatest positive impact can be achieved for the patients in our care and their families. We have created impact statements and posters to promote these to ensure that staff members and the public are all aware of what we are aiming to achieve. As part of our reporting process, we have also taken the opportunity to review our quality priorities for 2022-23 and will use the coming year to continue to build on the progress already made in these areas.

Throughout 2022-23, we continued to feel the impact from the COVID-19 pandemic. Although overall numbers and severity of cases reduced, there were a number of waves of infection seen across the region requiring us to be responsive and adaptable to keep our patients safe and continue to drive forward our recovery programme. I am pleased to report that although there is still a significant number of patients facing lengthy waits for treatment, the Trust remained in the top quartile for Referral to Treatment performance when benchmarked nationally. Hopefully as we learn to live with COVID, the negative impact on our services will reduce further.

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

- I am delighted to report that after significant, sustained improvement work within the Urgent and Emergency Care Centre (UECC), the Care Quality Commission (CQC) have removed all conditions from the Trust Certificate of Registration with the result that there are zero regulatory sanctions against the Trust for the first time since 2015. We will continue to build upon these improvements in the coming year across all Divisions.
- Treatment for cancer has remained an important focus for the Trust during the last year with the national ask being to reduce the number of patients waiting over 62 days on a GP-referred cancer pathway. The Trust has undertaken improvement work particularly in lower gastrointestinal and Urology and has achieved its agreed trajectory.
- The Trust has continued to see sustained improvements to the Learning from Deaths programme and a reduction in mortality levels that are now within the statistically expected range. We will continue to focus on this during the next year.
- The Trust has established a Quality Improvement Programme, under the leadership of a new Head of Quality Improvement. More than 60 team members completed Quality, Service Improvement and Redesign (QSIR) training during the year and the culture of the Trust is developing to be a continually improving organisation.
- Nursing and Healthcare Support Worker recruitment and retention has been hugely successful this year. Through a range of evidence based, targeted interventions we have reduced vacancy and leaver rates within these groups. This has supported the delivery of high quality patient care. The interventions we have made have been

acknowledged as examples of good practice with the Trust being asked to present the story of our progress at a range of regional and national events.
- Alongside this, we have run a successful recruitment programme for medical consultants and have welcomed many professionals to our team over the past year across a broad range of specialties.
- Building upon last year's success, the annual staff survey showed both an increased participation rate and a positive response rate placing us as the third highest scoring acute Trust within the North East and Yorkshire. We will continue to build upon this to ensure that we continue to listen to staff and respond to their feedback.
- Partnership working with Barnsley Hospital NHS Foundation Trust has given us many opportunities to collaborate to improve the quality of clinical care, including mutual assurance visits to review the quality of care being provided in each organisation. We look forward to strengthening these arrangements during the coming year.

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

- Referral to Treatment time remains challenged nationally. The Trust has made successful, focussed efforts to ensure the very long waiters were treated with the Trust meeting the national ask to ensure there were no patients waiting over 78 weeks at the end of the year. This year we will make improvements in waiting times to ensure no patient waits more than 65 weeks for planned care.
- For the coming year, we will be returning to managing and reporting against a 4 hour standard for urgent and emergency care. The national target is to achieve 76% by March 2024. We have developed a comprehensive strategy to support this and will monitor success through our Acute Care Transformation Steering Group.
- We have made a wide ranging variety of changes to improve the experience of patients and service users and are keen to receive feedback on the impact this is having. We plan to have a renewed focus on how we respond to feedback. We will therefore continue to engage closely with a diverse range of service users, listen to what they say and act upon their comments.

As Chief Executive of The Rotherham NHS Foundation Trust, I am proud of the achievements we have made during 2022-23. We continue to build upon the aims in our five-year strategy, through successful achievement of operational and quality ambitions. Our new approach to Quality Improvement is becoming well established in the organisation and this will help us with our ambition to become an outstanding organisation. I look forward to us achieving even greater success in 2023-24 for our service users and staff.

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

R. Jenkins

Dr Richard Jenkins
Chief Executive
June 2023

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

2.1 Priorities for improvement during 2023/24

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 (Qi) seeing it as part of everyday business. Over the last year, this has been a significant focus for the organisation, with the creation of a Quality Improvement Faculty, appointment of a Head of Qi and more than 60 colleagues participating in Qi training.

To embed this culture of quality improvement, the Trust has developed a Quality Governance and Assurance Team to ensure we have the structures and processes to listen to and learn from the views of patients, their families, carers and colleagues. This is supporting the national move to embed the Patient Safety Incident Response Framework (PSIRF). This will help us to be a learning and responsive organisation and above all, this means being open and honest even when something goes wrong.

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

For 2023/24, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process, including communication with colleagues and governors, who were given the opportunity to comment on the draft proposals and shape how these priorities were delivered, along with using the findings from external reviews, incidents, complaints, patient feedback and risks.

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

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

The quality priorities for 2023/24 are:

Patient Safety

- Prevention of Pressure Ulcers
- Management of Sepsis
- Learning from Deaths

Patient Experience

- Health inequalities – Digital Weight Management Programme/Tobacco Treatment Service
- Personalised cancer care at diagnosis
- End of Life Care

Clinical Effectiveness

- Virtual Ward
- Clinical Audit and Effectiveness
- Getting It Right First Time (GIRFT)

Quality Priorities

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SAFETY

Our Priority
Pressure Ulcers

Impact Statement

Our staff will be trained and able to give high quality, personalised wound care for adults, children and young people. The Trust will reduce avoidable harms by 20%. This will improve patient experiences, save money, reduce the number of wounds and the chance of them coming back.

Our Priority
Sepsis

Impact Statement

We will get a senior clinical review for patients with suspected sepsis earlier. We will get them on the right medications earlier, so that patients will get better faster.

Our Priority
Learning from Deaths

Impact Statement

We will do more checks on what medical choices were made by healthcare professionals before a death. This will help us learn, to keep improving the care we provide.

EXPERIENCE

Our Priority
Holistic Needs Assessments for Cancer Patients

Impact Statement

The Trust will make sure that at least 85% of all newly diagnosed cancer patients will be asked about their life and priorities to make sure we are doing all we can to help them, holistically. This will improve their experience by giving them choice and power in their care, and supports them to help themselves and their condition.

Our Priority
End of Life Care

Impact Statement

Everyone's care at the end of their life will be tailored to what they want. This will be planned in advance with their healthcare team. The Trust will provide good palliative and end of life care to all ages. We will support people with their bereavement.

Our Priority
Reducing Health Inequalities

Impact Statement

We will provide access to Tobacco Treatment Services and Digital Weight Management Support to make sure our communities are supported to live long and healthy lives.

EFFECTIVENESS

Our Priority
Virtual Ward

Impact Statement

Frail patients will now be able to be cared for on a 'virtual ward', at home. Being admitted to hospital can sometimes reduce what frail patients are able to do, being cared for at home will avoid unnecessary stays in hospital and can get people home from hospital faster.

Our Priority
Getting It Right First Time (GIRFT)

Impact Statement

We will improve the quality of care given to patients by making sure that care is delivered in a similar way throughout the Trust, and nationally.

Our Priority
Clinical Audit & Effectiveness

Impact Statement

The Trust will take part in local and national 'audits' (checks) to look at and assess the quality of care given and make improvements.

2.2: Statements of Assurance from the Board of Directors

During 2022/23 The Trust provided and/or subcontracted 64 relevant health services, across community and acute services. The Rotherham NHS Foundation Trust has reviewed the data available to them on the quality of care in these relevant health services. The income generated by the relevant health services reviewed in 2022/23 represented 91.7% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2022/23 (noting that income for 2022/23 remains on a block arrangement as per national guidance).

Clinical Audit

During 2022/23, 45 national clinical audits and 10 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation Trust provides. During that period, The Rotherham NHS Foundation Trust participated in 38 (84%) of national clinical audits and 10 (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 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
Case Mix Programme (CMP)	Yes	100%	Not Applicable
Elective Surgery (National PROMs Programme)	Yes	Publication of the PROMs data is currently on hold	Not Applicable
Emergency Medicine Quality Improvement Programme (QIPs): Care of Older People (care in emergency departments)	Yes	Data collection is taking place between April – October 2023	Not Applicable
Emergency Medicine QIPs: Pain in Children (care in emergency departments)	Yes	100%	Not Applicable
Emergency Medicine QIPs: Mental Health Self Harm (care in emergency departments)	Yes	Data collection is taking place between October 2022 – October 2024	Not Applicable
National Audit of Seizures and Epilepsies in Children	Yes	100%	Not Applicable

and Young People (Epilepsy12)			
Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	Yes	100%	Not Applicable
Falls and Fragility Fractures Audit programme (FFFAP): National Audit Inpatient Falls	Yes	100%	Not Applicable
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Yes	100%	Not Applicable
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	100%	Not Applicable
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer	Yes	100%	Not Applicable
National Diabetes Audit - Adults: Inpatient Safety Audit	Yes	100%*	Not Applicable
National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit	Yes	100%	Not Applicable
National Diabetes Audit - Adults: National Core Diabetes Audit	Yes	100%	Not Applicable
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Paediatric Asthma Secondary Care	Yes	100%	Not Applicable
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care	Yes	61%*	Not Applicable
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): COPD	Yes	62%*	Not Applicable
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation	Yes	100%*	Not Applicable

Organisational and Clinical Audit			
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%	Not Applicable
National Audit of Cardiac Rehabilitation	Yes	100%*	Not Applicable
National Audit of Care at the End of Life	Yes	100%	Not Applicable
National Audit of Dementia Care in general hospitals	Yes	100%*	Not Applicable
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project	Yes	100%*	Not Applicable
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management	Yes	100%*	Not Applicable
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	100%*	NA
National Child Mortality Database	Yes	100%	Not Applicable
National Emergency Laparotomy Audit	Yes	0	The trust resource for submission to this audit is under review
National Joint Registry	Yes	100%	Not Applicable
National Lung Cancer Audit	Yes	100%	Not Applicable
National Maternity and Perinatal Audit	Yes	100%*	Not Applicable
National Neonatal Audit Programme - Neonatal Intensive and Special Care	Yes	100%	Not Applicable
National Paediatric Diabetes Audit	Yes	100%	Not Applicable
National Perinatal Mortality Review Tool	Yes	100%	Not Applicable
National Prostate Cancer Audit	Yes	100%*	Not Applicable
Sentinel Stroke National Audit programme	Yes	Band A 90+%	Not Applicable
Serious Hazards of Transfusion: UK National haemovigilance scheme	Yes	100%	Not Applicable

Trauma Audit & Research Network	Yes	68-95%*	Not Applicable
UK Parkinson's Audit	Yes	100%	Not Applicable

National Confidential Enquiry	**Work stream**	**Participation yes/no?**	**% Cases (of those required)**	**Reason for non-participation**
Child Health Outcomes Review Programme	Testicular torsion	Yes	No cases eligible for inclusion	Not Applicable
Child Health Outcomes Review Programme	Transition from child to adult health services	Yes	100%	Not Applicable
Maternal, New-born and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	100%*	Not Applicable
Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	100%*	Not Applicable
Maternal, New-born and Infant Clinical Outcome Review Programme	Perinatal mortality Surveillance	Yes	100%	Not Applicable
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Yes	Organisational questionnaire completion in progress	Not Applicable
Medical and Surgical Clinical Outcome Review Programme	Crohns disease	Yes	60%*	Not Applicable
Medical and Surgical Clinical Outcome Review Programme	Endometriosis	Yes	The patient sample for data collection	Not Applicable

			is awaited from NCEPOD	
Medical and Surgical Clinical Outcome Review Programme	Epilepsy study	Yes	60%	Not Applicable
Medical and Surgical Clinical Outcome Review Programme	Physical Health in Mental Health Hospitals	Yes	100%	Not Applicable

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

*Data for projects marked with * require further validation. Where data has been provided these are best estimates at the time of compilation.*

The reports of 32 national audits/confidential enquiries were reviewed by the provider in 2022/23 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (where appropriate).

Title	**Published**	**Report Reviewed**	**Action(s) to improve quality of care**
Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (21/22)	Yes	Yes	The latest report has been reviewed and discussed. No actions required.
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People (20/21)	Yes	Yes	Implementation of a new Paediatric outpatient appointment template on Meditech. Engage all staff to request Electro-Encephalo Graph as soon as epilepsy is suspected by use of first appointment checklist. Division to recruit psychology support for chronic diseases.
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database (2021)	Yes	Yes	In order to improve time to Fracture Liaison Service assessment within 90 days, the introduction of extra clinics has been requested. Annual leave slots will be used for DEXA scans in order to improve time to DEXA within 90 days.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit Inpatient Falls (2021)	Yes	Yes	A meeting is taking place with the Clinical Lead to review the latest reports and recommendations

Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (2021)	Yes	Yes	The Physiotherapy team will undertake a local audit to identify why there are delays in mobilising patients after surgery
National Bowel Cancer Audit (21/22)	Yes	Yes	General Surgery team has updated the Enhanced Recovery after Surgery protocol, and assigned an Enhanced Recovery after Surgery champion to improve Risk-adjusted post-operative length of stay after major resection >5 days. Plan to further investigate outlier status for neo-adjuvant therapy.
National Oesophago-Gastric Cancer Audit (20/21)	Yes	Yes	The latest report has been reviewed and discussed. No actions required.
Maternal, Newborn and Infant Clinical Outcome Review Programme; Perinatal mortality surveillance	Yes	Yes	The latest report and recommendations have been reviewed and discussed, pending comparison with local results
Medical and Surgical Clinical Outcome Review Programme; Epilepsy	Yes	Yes	The latest report and recommendations are under review
National Diabetes Foot Care Audit (20/21)	Yes	Yes	The latest report has been reviewed and discussed. No actions required
National Diabetes Inpatient Safety Audit (NDISA) (20/21)	Yes	Yes	A policy to support diabetes self-management in hospital is currently being developed.
National Core Diabetes Audit (20/21)	Yes	Yes	As part of the routine diabetes review (9 annual care processes), the undertaking of foot assessments will be considered in respect of time taken in clinic to carry out. Structured education processes are in place, insulin pumps and technology i.e. continuous glucose monitoring to help people achieve individualised targets.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (21/22)	Yes	Yes	A COPD clinical lead is required to take forward this workstream, as well as a COPD clinical nurse specialist for the Trust. A non-invasive ventilation (NIV) clinical lead is also required for inpatients and patients on home NIV.

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Adult Asthma Secondary Care (21/22)	Yes	Yes	An Asthma nurse for inpatients at the Hospital is required. Joint clinics with colleagues from Sheffield are held at Breathing Space for asthma patients.
National Asthma and COPD Audit Programme (NACAP): Paediatric Asthma Secondary Care (21/22)	Yes	Yes	Triage nurse in UECC to be allowed Patient Group Directions to prescribe first dose of steroid to enable steroid prescription in first hour of attendance to hospital. Education and support for smoking leaflet to be easily available on Ward and clinics and added to Meditech.
National Audit of Breast Cancer in Older Patients (NABCOP) (21/22)	Yes	Yes	No actions were required as all criteria were met or exceeded national rates
National Audit of Cardiac Rehabilitation (21/22)	Yes	Yes	Options are being considered on how to implement service change to reduce inequalities in cardiac rehabilitation provision. A hybrid menu option is delivered to patients, whereby cardiac rehabilitation can be delivered by home, clinic or group-based methods or virtual.
Myocardial Ischaemia National Audit Project (20/21)	Yes	Yes	Guidance has been developed to enable identification of eligible patients and facilitate the streamlining of referrals. Systems for bed allocations have been maximised in order to optimise access to cardiac care on admission. Junior Doctors will receive training during their induction as to the correct pathway to follow in order to reduce the length of hospital stay as appropriate. Better liaison with Community cardiac rehabilitation teams will be encouraged in order to maintain accurate, complete and up to date records ensuring that referral to cardiac rehabilitation is documented where necessary.
National Audit of Cardiac Rhythm Management (20/21)	Yes	Yes	To improve the completeness of the data and ensure that data is inputted by all regional operators. This has been highlighted in previous years and needs to be improved. For

			important fields, centres should aim for 100% completeness. Further staff training is needed to ensure data fields are input correctly. A complications audit will be carried out and findings feedback to implanting consultants. Findings of the complications audit will be discussed at the Cardiology Governance meeting.
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (20/21)	Yes	Yes	In response to the recommendation regarding the use of in-patient echocardiography for patients with acute heart failure, echo's are requested for all heart failure patients presenting with decompensating heart failure symptoms, unless they have recently been scanned. A heart failure information technology tool integrated in Meditech is under progress which will guide clinicians various invitations, referrals and disease modifying drug prescriptions. The heart failure referral service to be highlighted at the grand round and any teaching for junior doctors. Development of a business case for a further heart failure nurse is in progress.
National Joint Registry (21/22)	Yes	Yes	The latest report has been reviewed and discussed. No actions required
National Neonatal Audit Programme (21/22)	Yes	Yes	A record of parental consultation in 24 hours will be added to the daily huddle sheet. The Registrar will document in the daily summary sheet if a parent was present on ward round. Ward based Consultant/Neonatal Consultant will meet parents for all new admissions and this will be documented. Retinopathy of prematurity screening, online referral, is part of the Special Care Baby Unit digitalisation process.
National Child Mortality Database (21/22)	Yes	Yes	The latest report and recommendations are under review

National Emergency Laparotomy Audit (20/21)	Yes	Yes	The Trust process for submission to this audit is under review
National Paediatric Diabetes Audit (20/21)	Yes	Yes	Staff to be reminded to record all blood pressure and foot examinations. Ensure completion of Key processes submission. Escalate Transition care gap to the risk register and further to the Medical Director and the Chief Executive. Recruitment of a Psychologist to address the Psychology service gap is required. Continue high standards of care to achieve good HbA1c mean and median averages.
National Perinatal Mortality Review Tool (21/22)	Yes	Yes	To facilitate for more people to access to input data to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) database to ensure that Neonatal consultants also have access to complete notification, surveillance and inputting of data
National Prostate Cancer Audit (20/21)	Yes	Yes	The latest report and recommendations are under review
National Smoking Cessation Audit (21/22)	Yes	Yes	The Trust will identify Healthcare professionals (Champions) to deliver a tobacco dependency treatment service to support patients who wish to give up smoking. Smoking status of all adult patients admitted to hospital will be recorded. All inpatients who smoke will be referred to the specialist tobacco dependency treatment service. The Trust will introduce a system for collecting data on adult inpatients who are prescribed medication for tobacco dependency in order to drive the delivery of National Institute for Health and Care Excellence (NICE) recommended interventions in such patients. The number of inpatients referred to and engaging with the tobacco dependency treatment service will be recorded and monitored to ensure the programme is working effectively. A training programme (Very Brief Advice) will be introduced for all front-line staff so that they are competent in supporting

			and treating tobacco dependency. Attendance at training will be recorded and monitored. Whilst in hospital, the Trust aims to provide at least 90% of patients who smoke with 'Very Brief Advice' training.
Serious Hazards of Transfusion: UK National haemovigilance scheme (21/22)	Yes	Yes	The latest report and recommendations are under review
Sentinel Stroke Audit Programme (21/22)	Yes	Yes	The latest report and recommendations are under review
The Trauma Audit & Research Network (21/22)	Yes	Yes	The latest report and recommendations are under review
UK Parkinson's Audit (2022)	Yes	Yes	Written information booklets by Parkinson's UK in relation to Lasting power of attorney and end of life issues/care planning are available and offered to patients at each clinic appointment. The standard clinic checklists for ensuring 100% of non-motor symptoms and activities of daily living are discussed have been reviewed and updated.

Review of Local Clinical Audits

The reports of 114 clinical audits were reviewed by the provider in 2022-2023 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 2022/23 that were recruited to participate in research approved by a research ethics committee was 629 [data taken from the National Institute for Health Research (NIHR) Open Data Platform 06 June 2023].

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 2022/23

Study Type	Number of studies
NIHR Portfolio Commercially sponsored	0
NIHR Portfolio Non-commercial	31
NIHR Portfolio Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	2
Non-portfolio The Rotherham NHSFT Sponsored	4
Other Non-portfolio (supporting academic qualifications)	0
Studies undertaken at TRFT which required no Capacity & Capability review	0

CQUINs (Commissioning for Quality and Innovation)

The national CQUIN schemes were re-instated in 2022/23. Of the total number of national schemes, 10 were applicable to TRFT. As per national guidance, the Trust identified 5 schemes against which to assign a financial value. As part of 2022/23 contract setting, the values associated with these schemes were agreed to be included in the fixed element as authorised and approved by NHS England. Trust performance against each indicator has been submitted quarterly in line with the national CQUIN reporting timetable. The CQUIN schemes the Trust is reporting against are detailed in the table below:

2022-23 National CQUIN Scheme

ID	Title	Financial Value Assigned
CCG1	Staff Flu Vaccinations	Yes
CCG2	Appropriate Antibiotic prescribing for Urinary Tract Infections in Adults aged 16+	Yes
CCG3	Recording of National Early Warning Score (NEWS2), escalation time and response time from unplanned critical care admissions	No
CCG4	Compliance with timed diagnostic pathways for cancer services	Yes
CCG5	Treatment of community acquired pneumonia in line with BTS care bundle	Yes
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery	No
CCG7	Timely Communication of changes to medicines to community pharmacists via the Discharge Medicine Services	No
CCG8	Supporting patients to drink, eat and mobilise after surgery	No
CCG9	Cirrhosis and fibrosis test for alcohol dependent patients	No
CCG14	Assessment, diagnosis and treatment of lower leg wounds	Yes

The final submission of the quarterly CQUIN performance is due in June 2023 in line with the national CQUIN reporting timetable.

Care Quality Commission Registration and Periodic Reviews/Specialist Reviews

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

In April 2022 the registration status was 'Registered with Conditions' due to:

- Condition notified under Section 31 of the Health and Social Care Act 2008 was issued in October 2018 following a series of visits by CQC to the Urgent and Emergency Care Centre (UECC), requiring the Trust to mitigate the risks relating to the Paediatric Emergency Department, with a specific focus on medical and nurse staffing levels. The Section 31 was removed in May 2022
- Condition(s) notified under the Health and Social Care Act 2088 in August 2022 following a follow-up visit to the Urgent and Emergency Care Centre in March 2022. This was removed in March 2023

CQC Inspection 2022

As a follow up to the CQC Inspection of the Urgent and Emergency Care Centre in May 2021, the Department was re-visited in March 2022. A Section 29a Warning Notification had been served in August 2021 Although improvement was noted at the re-visit in March and the Section 29a Warning Notice was not renewed, five conditions under the non-urgent pathway were issued. These covered the timely and appropriate application of a mental health or physical health risk assessment, the environment, safeguarding and compliance with the Trust mandatory training standard.

A submission in response to the conditions has been provided to the CQC each month between September 2022 and March 2023 providing evidence of improvement. The Application(s) to have all five conditions removed was submitted on 25 January 2023. The outcome of the Application(s) was received on 27 March. All five conditions have been removed from the Trust Certificate of Registration with the result that there are zero regulatory sanctions against the Trust for the first time since 2015.

There have been no further formal inspection visits during 2022/23. The current CQC ratings are illustrated below:

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

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

CQC ratings for the Trust Hospital services

	Safe	Effective	Caring	Responsive	Well led
Urgent & Emergency Services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate
Medical Care	Requires Improvement	Good	Good	Good	Requires Improvement
Surgery	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Good	Requires Improvement
Maternity*	Good	Good	Good	Good	Good
Children and young people	Requires Improvement	Good	Good	Good	Good
End of life care	Good	Requires Improvement	Good	Good	Good
Outpatients and diagnostic imaging	Good	(Inspected not rated)	Good	Good	Good

CQC ratings for Trust Community

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

(Source: Care Quality Commission)

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

How the Trust makes use of the CQC Inspection report

The Trust CQC Inspection Report provides a rich source of intelligence for the organisation, identifying where there is evidence of best practice but also where further intervention is required. The Trust also reviews Inspection Reports from other organisations to optimise further learning opportunities.

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

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

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

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

A Programme of Quality Assurance for each CQC Core Service has been initiated through 2022/23. The Quality Assurance Programme is supported by colleagues from Barnsley Hospital NHS Foundation Trust, who provide external validation and feedback on the safety

and quality of care delivered. All Core Services completed a Quality Assurance Review during 2022/23, which sets out the work programme for the forthcoming year.

CQC Engagement

The Trust has continued to build on their positive working relationship with the Trust CQC representatives. An engagement meeting takes place each month, attended by CQC colleagues, the Trust Executive and identified clinical teams. Issues and patient safety risks are discussed, in addition to opportunities for the clinical teams to present the work they are doing and the resulting improvements to patient care. CQC have sign posted a number of other Trusts to the organisation as the Trust is able to demonstrate a number of exemplary practices from which other healthcare providers can learn. An example of this is the development and implementation of a comprehensive Mental Health Risk Assessment Document for patients attending the Urgent and Emergency Care Centre.

The Trust is also required to report any breaches of the **Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)** to the CQC.

The CQC only require employers to inform them about any exposures that are judged to be 'significant' or 'clinically significant'.

> The CQC say that *"When there is an accidental or unintended exposure to ionising radiation, and the IR(ME)R employer knows or thinks that it is significant, they must investigate the incident and report it (under Regulation 8(4)).*

We have reported 15 radiation incidents to our local Radiation Protection Advisor in total for the period between 1 April 2022 – 31 March 2023. These are submitted for a radiation dose report and recommendations, none of these met the criteria to be reportable to the CQC.

All Radiation incidents are recorded internally on DATIX and reported to the Radiation Protection Advisor. All radiation incidents are investigated and learning outcomes identified and shared.

These incidents have been investigated and have been escalated through to the Clinical Support Services Divisional Quality Governance Committee meetings, the Radiation Protection Meetings on a quarterly basis and then to the Trust's Health and Safety Committee, to provide assurance as to the quality of the investigation and the robustness of the remedial actions taken.

Special Reviews and Investigations

The Trust has participated in one Specialist Review during 2022/23. An external Royal College Review was commissioned for the Endoscopic Retrograde Cholangio Pancreatography Service.

Data Quality

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

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

- 99.9% (99.9% for 2022/23) for admitted patient care
- 100.0% (100.00% for 2022/23) for outpatient care
- 99.8% (99.7% for 2022/23) 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 2022/23) for admitted patient care
- 100% (100% for 2022/23) for outpatient care
- 100% (99.9% for 2022/23) for accident and emergency care

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

Information Governance Toolkit (DSPT) attainment levels

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

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

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

The Trust's Data Security and Protection Toolkit Audit Report overall score for 2021/22 was 'Substantial Assurance'. and Toolkit 'Standards Met'.

The Trust will submit again by 30 June 2023 and is aiming for full compliance – assurance will also be sought from the auditors prior to the end of May 2023.

Payment by Results

The Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission. (Note: NHSI Comment: References to the Audit Commission are

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

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

The Trust engaged in implementing the NHS Spine to the clinical information system MediTech in January 2018 and are the first Trust using Electronic Patient Record (MediTech) to transition to Patient Demographics Service in the country. The Trust has been attaining data completeness rates well above the national average, across all of its core commissioning data set submissions, and the evidence of this can be seen via the NHS Digital Data Quality Dashboards.

The Trust was subject to the mandatory Clinical Coding Information Governance audit in December 2022, during the 2022/23 reporting period as required by NHS Digital. The Trust again achieved an Information Governance rating of level three (Advisory), for the sixth year running, which is the highest possible rating that can be achieved. An aggregate percentage score of 99.23% was achieved across the four domains audited.

Data Quality Index (HRG4+ based)

As the Trust no longer utilises CHKS for its external monitoring of data quality the department has transitioned to utilising the Data Quality Maturity Index (DQMI), which is published by NHS Digital and is readily available for the public to access and review the data outputs. These measures are different to the CHKS indicators, so a decision has been taken to establish a new baseline for measuring the data maturity, starting from last financial year 2021/22.

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

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

Clinical Coding

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

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	99.5%	99.17%	98.49%	99.74%

(Source: The Rotherham NHS FT Information Governance Audit Report 2022/2023)

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

In 2021/22 the Trust worked with the following actions to improve clinical coding and data quality and these continued throughout 2022/23:

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

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

Improvements and actions to further improve clinical coding during 2023/24 include:

- Working with Electronic Patient Record Team and Clinical Services to improve digital documentation and improve the data captured therein

	Areas selected for focussed improvement activity	Baseline period FY	Base line Value	Target	Qtr 1 2022-23	Qtr 2 2022-23	Qtr 3 2022-23	Qtr 4 2022-23	YTD 2022-23	Progress
IMPROVING DATA QUALITY	IDQ-1 DQMI ECDS	2021-22 **	69.2	Increase	68.6	82.2	82.5	83.2	8302	
	IDQ-2 DQMI APC	2020-21 **	98.9	Increase	98.7	98.8	98.7	98.9	98.9	
	IDQ-3 DQMI CSDS	2020-21 **	93.0	Increase	93.4	93.7	93.6	93.6	93.6	
	IDQ-4 DQMI MSDS	2020-21 **	99.6	Increase	99.5	99.7	99.7	99.6	99.6	
	IDQ-5 DQMI OP	2020-21 **	99.2	Increase	99.3	99.3	98.9	98.9	98.9	
	IDQ-6 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015-16	99.8%	Increase	99.9%	99.9%	99.9%	99.9	99.9%	

	IDQ-7 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015-16	100%	Maintain	100%	100%	100%	100	100%	
	IDQ-8 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015-16	99.9%	Increase	100%	100%	100%	100	100%	
	IDQ-9 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015-16	99.9%	Maintain	100%	100%	100%	100	100%	
	IDQ-10 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015-16	86.6%	Increase	99.7%	99.7%	99.7%	99.8	99.8%	
	IDQ-11 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015-16	99.1%	Increase	100%	100%	100%	100	100%	

Learning from Deaths

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

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

Deaths which require an SJR are either identified during the Medical Examiner Scrutiny, from locally held data, from Mortality Benchmarking data and/or after recommendation by any Trust Clinician/Clinical Team.

The Trust reviews alerting diagnostic groups each month at the Trust's Mortality Group meeting. Mortality Benchmarking data provides the Trust with reports which identify diagnostic groups where modelling has determined that there is a statistically significant level of excess deaths. The Mortality Group will use this information alongside past information, to determine how to investigate the alert. Investigations comprise of coding reviews and where appropriate SJRs are requested for deaths in the diagnostic group.

Learning from Deaths - Medical Examiner Scrutiny

The Medical Examiner Service is now fully implemented and operational. This service provides independent scrutiny of all Trust deaths. Part of this scrutiny involves escalating deaths to the Trust which should be considered for an SJR or for investigation. The Medical Examiner Service have been working with primary care and community partners to create processes for the scrutiny of community deaths.

For 2022/23 the Service moved its target for Medical Examiner Scrutiny timeliness from 1 month to 5 days, from the date of death. The monthly average for the year is 77%. Any scrutinies not completed within this time frame are completed soon after.

Medical Examiner Scrutiny Figures for 2022/23:

Month of Death	No of Adult TRFT UECC & Inpatient Deaths	Medical Examiner Scrutinies Completed	Medical Examiner Scrutinies % Completed	Medical Examiner Scrutinies % Completed < 5 Days
Apr-22	110	108	100%	57%
May-22	98	98	100%	70%
Jun-22	97	97	100%	86%
Jul-22	93	93	100%	96%
Aug-22	79	79	100%	91%
Sep-22	92	92	100%	59%
Oct-22	111	100	100%	82%
Nov-22	100	100	100%	95%
Dec-22	133	133	100%	80%
Jan-23	122	122	100%	42%
Feb-23	76	76	100%	91%
Mar-23	105	105	100%	98%
2022/23 TD	**1216**	**1216**	**100%**	**Average 79%**

Learning from Deaths – Structured Judgment Review (SJR)

The Trust aims to complete SJRs within 60 days of death, for those that are recommended for a review close to the date of death. This is to promote a rapid cycle of learning.

This aim has not been met. The Trust's SJR process for 2022/23 where a large cohort of largely untrained Clinicians (in the SJR Review Method) are allocated reviews infrequently on a rota basis has not delivered for the Trust. A new process in in place for 2023/24, which has a smaller team of trained SJR Reviewers with protected time and who complete the reviews regularly.

SJR Figures for 2022/23:

Month of Discharge	No of Adult TRFT Inpatient Deaths	SJRs Requested	SJRs Completed	SJRs Outstanding	% Completed With 60 Days	Overall Care Score < 3	Avoidability Score < 4
Apr-22	102	26	12	14	23%	1	0
May-22	85	29	11	18	31%	0	0
Jun-22	87	27	11	16	22%	1	0
Jul-22	85	25	14	11	28%	0	0
Aug-22	67	18	12	6	17%	0	0
Sep-22	78	19	7	12	21%	0	0
Oct-22	96	26	14	12	27%	0	0
Nov-22	87	27	13	14	11%	2	0
Dec-22	112	28	14	14	29%	1	0
Jan-23	99	16	4	12	13%	1	0
Feb-23	63	17	7	10	29%	0	0
Mar-23	99	24	7	17	29%	1	0
2022/23	**1060**	**282**	**126**	**156**	**24%**	**7**	**0**

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

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

There have been 7 SJRs in 2022/23 where the overall care has been judged to have been poor. These reviews have been presented at a Mortality Group meeting and/or discussed with the relevant clinical team. Two of the cases were referred to the Serious Incident Panel for investigation.

Intelligence and Learning

Thematic Analysis Reports have been produced whereby the informative freetext comments from SJRs are allocated to categories/themes based on the element of health care they refer to and whether they are positive, negative or neutral. In addition, these reports contain analysis and breakdown of the Phase of Care Scores and the Problems in Health Care sections.

These reports have been distributed to the various groups and teams in the Trust to review them in order to design and implement new/changes to health care processes that will prevent the reoccurrence of these problems or promote good practice for future patients.

Learning from Deaths - Learning Disabilities Deaths and the Learning Disabilities Mortality Review Programme (LeDer)

The LeDer Programme is a Commissioner-led review of deaths for patients with Learning Disabilities and Autism (autism was included from April 2022), regardless of the place of death. Provider Trusts are frequently asked to assist with a LeDer review when they have been involved in care provision for that patient.

TRFT completes SJRs for all inpatient deaths for those with Learning Disabilities.

Deaths for patients are identified by a Learning Disability Flag in Meditech, indicated by the Medical Examiner after a scrutiny, a request from the Matron for Learning Disabilities and Autism, or by a request from the ICB LeDer Team.

LeDer Requests & SJR Figures for Adults with a Learning Disability

Month of Discharge	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Avoidability Score < 4
Apr-22	0	0	0	0	0
May-22	1	1	0	0	0
Jun-22	3	3	0	1	0
Jul-22	1	1	0	1	0
Aug-22	1	1	0	0	0
Sep-22	1	1	0	0	0
Oct-22	3	2	1	0	0

Nov-22	1	0	1	0	0
Dec-22	4	4	0	0	0
Jan-23	0	0	0	0	0
Feb-23	2	2	0	0	0
Mar-23	1	1	0	0	0
2022/23	**18**	**16**	**2**	**2**	**0**

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

TRFT is looking to add an Autism Flag in MediTech, which will be pulled into the Mortality Insights Reports. Work for this is ongoing between, the Health Informatics Team, the MediTech Team and the Matron for Learning Disabilities & Autism.

The Trust is also going to add a flag for deaths for patients with a Serious Mental Illness (SMI). This will initially be based on national recognised SMI ICD10 Codes, and is expected to be in place by June 2023. A request to Health Informatics was submitted on 10 January 2023.

The outstanding SJRs from October and November 2022 are being reallocated to the SJR Review Team.

2.3: Reporting against core indicators

SHMI

The Department of Health asks all Trusts to include in their Quality Account information on a core set of indicators, including Patient Reported Outcome Measures (PROMS), using a standard format. This data is made available by NHS Digital and in providing this information the most up to date benchmarked data available to the Trust has been used and is shown in the table below, enabling comparison with peer acute and community Trusts. The Summary Hospital Level Mortality Indicator (SHMI) is a mortality measure produced by NHS Digital. The score is a ratio between the number of patients expected to die, based on England figures, and the actual number of deaths.

The SHMI takes account of a number of factors, including a patient's condition and age. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the England average, which is 100. Trusts are put into 3 bands based on statistical analysis of the score. Band 1 is 'Higher than Expected', Band 2 is 'As Expected', and Band 3 is 'Lower than Expected'. SHMI figures are released monthly. These are reviewed by the Trust and discussed at the Trust's Mortality Group. SHMI figures are broken down into diagnostic groups, of which 10 are given bandings. Any diagnostic group that has a statistically higher number of deaths than expected is discussed at this meeting.

SHMI Quarterly Figures

12 Month Period End Month	Sep-21	Dec-21	Mar-22	Jun-22	Sep-22
SHMI	109.35	107.32	106.43	105.02	105.11
Banding	As Expected	As Expected	As Expected	As Expected	As Expected
% of Deaths with Palliative Care Coding - TRFT	34	38	40	42	45
% of Deaths with Palliative Care Coding - England	39	39	40	40	40

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

Patient Related Outcome Measures (PROMS)

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.

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time. We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known (taken from NHSD Website).

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

	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	Apr 21 - Mar 22	96.25%	national data not yet available		
		Apr 22 - Dec 22	95.44%	national data not yet available		
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over (total cases)	Apr 20 - Mar 21	38.6	45.6	140.5	0
		Apr 21 - Mar 22	27.8	43.72	138.4	0
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison)	Apr 21 - March 22	51.88	national data not yet available		
		Apr 22 - Dec 22	68.8	national data not yet available		

Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	Apr 21 - March 22	0.44%	national data not yet available
	Apr 22 - Dec 22	0.21%	national data not yet available

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

*** C-diff next publication due September 2023 for April 2022 to March 2023.**

*** Patient safety - collection system has now changed, and data is not comparable. No updated national data available for reporting by Trust**

% of Admitted patients assessed for VTE													
Target = 95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	**95.4 0%**	95.5 6%	96.2 7%	96.3 7%	96.7 0%	96.7 1%	95.8 2%	95.4 2%	92.0 4%	92.8 2%	94.5 4%	94.5 0%	95.3 0%
2022/23	**96.5 9%**	97.3 1%	97.2 9%	96.4 1%	95.8 3%	95.3 6%	96.4 2%	97.4 9%	96.6 7%	96.6 1%	96.7 0%	96.8 9%	96.6 0%

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

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

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
12a. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period.	Data validated and published by NHS Digital. The Trust's SHMI value has fallen during the year and been consistently in the As Expected band.	The Trust has a monthly Mortality Group meeting and all Divisions within the Trust hold regular mortality meetings, which feed into this overall Trust Group. This Group in turn reports to the Clinical Effectiveness Committee, chaired by the Deputy Medical Director. Data (SHMI and HSMR) and incidents are reviewed to help identify trends and areas of concern. A summary of the Trust's performance and mitigating actions taken is shared in Board reports. Mortality data and actions being taken are reported in the

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
		Mortality and Learning from Deaths Report to the Board.
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only patients receiving care from the team are included in the data.	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) primary hip replacement surgery (ii) primary knee replacement surgery during the reporting period.	The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital. The latest reporting periods vary between the types of surgery performed. Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement.	PROMS are measures recorded pre and postoperatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time. We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
		provide a timeframe for this. We will provide further updates as soon as this is known (taken from NHSD Website)
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 30 days of discharge from the Trust (as per national reporting and benchmarking consistency).	Internal Trust data is used for reporting of re admissions for the performance reports for the Board of Directors, the Divisions, the CSUs and for the Service Line Monitoring reports. The methodology has been matched to the Model Hospital methodology to ensure consistency in benchmarking with other organisations.	The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data. The Transfer of Care Team works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission of Care Home Patients and works with the sector to improve effectiveness. With observations and assessments now being recorded as non-elective admissions, there will be a natural increase in the number of reported readmissions each month. These are reviewed by divisional teams so the true readmissions can be investigated, and appropriate actions taken.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's performance is drawn from reviewing the position achieved, against the 10 sections and the 48 questions asked in the CQC national Inpatient Survey. The survey is mandatory and undertaken annually, the most recent data is from the survey conducted with patients who had an overnight stay in the Trust in November 2021.	The CQC published the 2021 patient survey results in September 2022. This year, we invited Picker to deliver a facilitated feedback session with all divisions to explain the rationale behind the data. From this a Trust wide Quality improvement plan was developed with Divisions which included improvement in patient information, nutrition, hydration and person-centred care.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
	Full results are available later in this report.	The Trust patient experience Tendable (audit system) questions were reduced and aligned to the CQC inpatient survey.
21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	Department of Health conduct an annual independent survey of staff opinion.	50% of colleagues would recommend the Trust as a provider of care to their family or friends, as detailed in the National Staff Survey.
21.1 - Friends and Family Test (FFT) - new questions fully embedded. Improved evidence of learning from feedback, “you said we did”. The national change to the FFT questions is now made up of a single mandatory question, which is then followed by at least one open question to enable a free text response, so that users can provide their feedback in the detail they want and in their own words. Within the Trust, and in collaboration with stakeholders, the following questions were agreed. 1. Overall, how was your experience of our service (mandatory question) 2. What worked well? 3. What could we do better?	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, acute inpatient, UECC and the second maternity touch point – Labour and Birth), this will no longer be possible because	The numerical data from the 1 April 2020 is not comparable between NHS organisations; this was also a factor in the ending of national reporting on the percentage response rate achieved. Therefore, examples of learning from patient experience and actions taken as a result of feedback are discussed and recorded as part of Divisional Governance Meetings. This includes the sharing of information and improvements “what’s working better”. Divisions have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any action required are developed and closely monitored to meet the expectations of their patients’ feedback. Following the introduction of the electronic survey the FFT dashboard has been used to provide data to the divisions,

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
	there is now no limit upon how often a patient or service user can give their feedback.	FFT Steering Group and the Patient Experience Group. From April 2023 activity and learning will also feature within the Divisional quarterly patient experience reports based around the framework of the Yorkshire Patient Experience Toolkit for Patient Experience Group.
23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Data is no longer submitted nationally.	The Trust will continue to monitor VTE rates, and report through local performance meetings and the Divisional meetings.
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 and UK Health Security Agency. Reports are issued on a quarter by quarter basis with the annual report issued during Quarter 1 of the following year.	The Trust has monitored rates through Root Cause Analysis (RCA) and audits and report through local clinical governance structures to the new Infection, Prevention and Control Group.
25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Data validated and published by NHS Digital (National Reporting and Learning System (NRLS)); latest data is for the period April 2022 to March 2023. This was the latest reporting period where the Trust has submitted its data and it has been validated by the NRLS Team. Number of NRLS reportable incidents occurring in this period	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures. As the Trust transitions into the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE), there will be more systems-based approaches to learning from incidents. Data may not be presented in the same way but there will be internal regulation to ensure there are no gaps.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
	was 8672. The percentage of severe harm or death was 0.22%.	

(Source: Trust Information System)

His Majesty's Coroner's Inquests 2022/23

During the relevant period the Trust received 54 referrals from His Majesty's Coroner, compared with 58 referrals from the previous year. These included both confirmed inquests and preliminary investigations. This represents only a slight decrease compared with the previous financial year.

His Majesty's Coroner heard 26 inquests during the last financial year, 17 of which required attendance by the Trust, a total of 9 inquests were read under Rule 23. External solicitors were instructed to represent the Trust's interests. The majority of the attended inquests were listed for 1-2 days. The Trust is expected to attend 17 inquests in 2023/24 which are referrals received during 2022/23.

His Majesty's Coroner did not exercise her powers under The Coroners (Investigation) Regulations 2013 to issue reports to the Trust asking for action to be taken to prevent future deaths in 2022/23.

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

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2022/23

A summary of the Trust's nine quality priorities for 2022/23 is provided below.

Patient Safety

- Digitally Requested Investigations Are Reviewed and Responded to Appropriately
- Digital Identification of Clinically Unwell Patients to Drive Quality Improvements
- Improve Medication Management Throughout the Organisation

Patient Experience

- Develop Comprehensive and Accessible Patient Information Materials
- Develop a Robust Process to Measure and Improve Following Patient/User Feedback

- Develop and Embed the Mental Health Strategy

Clinical Effectiveness

- Reduction in Hospital Acquired Infections
- Continuation of Mortality and Learning from Deaths Improvement Work
- Identify and Develop a Quality Improvement Tool for the Organisation

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

Domain: Patient Safety

Title – Digitally Requested Investigations Are Reviewed and Responded to Appropriately

Executive Lead – Medical Director
Operational Lead – Deputy Medical Director

Current position and why is it important?

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

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

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

- To ensure that all patient investigations are requested electronically via Meditech and remove paper requests where possible
- To ensure robust processes are in place to review patient results/reports via the electronic patient record system
- To improve the quality of patient care by ensuring that all investigations are reviewed and acted upon
- To prevent 'missed results'
- To ensure that all clinicians are trained in the use of the results acknowledgment modules of Meditech, where results can be viewed, acknowledged and acted upon
- To ensure that clinicians use this module to review all patient results
- To ensure that where results cannot be reviewed on Meditech, ICE, an alternative electronic system for results, is used instead

What did we achieve?

The majority of blood tests can now be requested on the Meditech system. The laboratories and Meditech team have worked hard to increase the number of investigations that can be

requested electronically. The main exceptions are requests for blood transfusions and more particular tests such as requests for cytology and histology.

There has been a significant increase in clinicians using electronic requests for blood tests and radiology requests are completed electronically.

There has been a significant increase in clinicians, “manual acknowledgement” of results to 79.2%. This means that the majority of clinical teams are now requesting, reviewing and acknowledging radiology and laboratory results on the electronic Meditech system. The haematology team in particular have embraced the acknowledgement of results for their patients despite the need to review thousands of results every week.

This increase in manual acknowledgment of results has given the Trust assurance that investigations are requested electronically and actioned appropriately.

The MAST training in Electronic Patient Record mastery has improved for all staff to 45% and for medical staff to 56%, but this remains below the desired level and clinical teams have been advised to complete their training.

The Standard Operating Procedure for critically abnormal results has already been completed.

How was progress monitored and reported?

The Deputy Medical Director for Quality chaired the Trust Results Flagging and Acknowledgement Task and Finish Group and this was then handed over to the Associate Medical Director for Health Informatics. The group met on a monthly basis. The outputs were reviewed at the Trust’s Patient Safety Committee (bimonthly reports) and then Quality Committee on a quarterly basis.

The Trust Diagnostic Testing Policy has been reviewed and is being shared with clinical teams in order to ensure that we have appropriate polices and processes in place to ensure that all results are reviewed. The Power BI Results acknowledgment module has been reviewed and used to drive improvements.

What further actions need to be undertaken?

The Trust will continue to support teams in order to complete the work needed on the Emergency Department tracker. There have been persistent challenges with the IT support for laboratories, which has had an impact on changes such as adding abnormal results to the Emergency Department tracker and requests for additional blood tests (referred to as “add-on” requests). All teams will complete their Electronic Patient Record Mastery training as required.

Title - Digital Identification of Clinically Unwell Patients to Drive Quality Improvements

Executive Lead – Medical Director
Operational Lead – Deputy Medical Director

Current position and why is it important?

The identification of clinically unwell patients is an important step in identifying a deteriorating patient. The Trust aims to identify these patients in a digital manner by monitoring their NEWS2, sepsis response, Acute Kidney Injury and abnormal investigations.

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

The aim of this Quality Priority is to ensure that we identify unwell patients early with systems in place to flag if a patient deteriorates and processes to respond in a timely manner to any patient deterioration.

- The Trust aims to identify these patients in a digital manner by monitoring their NEWS2, sepsis response, Acute Kidney Injury and abnormal investigations
- To ensure that all deteriorating patients are recognised and clinical escalation process followed
- To ensure that the NEWS2 escalation policy is followed in line with the National guidance

What did we achieve?

Quality Improvement work has been carried out on the deteriorating patient by the Quality Improvement Matron and the Practice Development Team.

All wards have white boards on ward areas which can be used to highlight any patient deterioration. This is available via Sepia (one of the Trust's electronic systems).

There has been an improvement in the use of the Deteriorating Patient Review Form.

- The NEWS2 Power BI dashboard has been created and can be accessed by ward teams in order to drive improvements
- The Sepsis Power BI dashboard called "sepsis insights" is available to teams to review
- The Quality Improvement work has demonstrated an improvement in the number of observations completed on time
- There has been an improvement in MAST training in sepsis with training in sepsis in adults improved to 73% (Medical staff and Advanced Nurse Practitioners 75%) and training in sepsis in children now 83% (78% for medical staff and Advanced Nurse Practitioners)
- The Trust has appointed a team member to support the Business Intelligence Team in order to drive Quality Improvement work
- The baseline audit for sepsis care in our admission areas has demonstrated areas for improvement in our management of sepsis

How was progress monitored and reported?

Regular updates were presented to the Deteriorating Patient and Sepsis Group and the Patient Safety Committee.

The Power BI modules for Clinical effectiveness allowed greater monitoring of the HSMR due to sepsis, as well as the crude mortality which remains in the "as expected" range.

Monthly Tendable audits were performed for the deteriorating patient, which included adherence to the Trust's NEWS2 policy, compliance with completion of the fluid balance charts and completion of the Acute Kidney Injury bundle and sepsis pro forma where needed.

What further actions need to be undertaken?

With the appointment of a new team member to support the Business Intelligence Team in order to drive Quality Improvement work, this will help to support this work such as creating an Acute Kidney Injury dashboard.

The review and update of the Trusts' NEWS2 policy will be completed. The update will include the management of Acute Kidney Injury and ensuring that the Trust's policy on escalation of a deteriorating patient, is in keeping with National policies.

Title* – *Improve Medication Management Throughout the Organisation

Executive Lead – Medical Director
Operational Lead – Chief Pharmacist

Current position and why is it important?

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

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

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

The objectives of this work are:

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

Measures used to determine progress are:

- Audits for storage and security of medicines
- Audits for controlled drug documentation
- EPMA data in relation to missed doses
- Harm levels reported in incidents

What did we achieve?

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

How was progress monitored and reported?

Work was undertaken at ward level and progress was monitored and reported through:

- Divisional Quality Governance meeting
- Medication Safety Committee
- Quality Committee

What further actions need to be undertaken?

Further work is required (and is underway) to produce an electronic dashboard that takes information from the EPMA system and presents it in a way that identifies action is required real time, e.g. flagging a missed dose as soon as the time it was prescribed has passed so that action can be taken quickly to give the dose.

Domain: Patient Experience

Title - Develop Comprehensive and Accessible Patient Information Materials

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Programme Overview Including Objectives

- Patients tell us that having the right amount of information is important to them and must be produced to meet the accessible information standard
- Objective 1: Write a bedside information folder to inform patients everything they need to know about being an inpatient. Ensure translation of the folder is completed in the most commonly used languages
- Objective 2: Develop a template for a Welcome Board outside each clinical area, giving patients information to help their admission or attendance, using QR codes to reduce the need for additional leaflets
- Objective 3: Develop and build communication stations for all clinical areas to provide a resource to help reduce health inequalities and met assessable information standards

Planned Outcomes and Measures of Success

- Outcome1: Bedside information folder is written, published and converted to hard copies and five top languages

- Success Measures: Patients feel better informed about being an inpatient, measured in the themes around patient information decreasing in the thematic analysis
- Outcome 2: Welcome Boards are co-created with clinical teams to ensure patients are better informed about what they need to know and are signposted to the relevant website for their clinical condition
- Success Measures: 91 Welcome Boards are in place across the Trust and being used by patients and families for improved information
- Outcome 3: Communication stations are built, individually for all the relevant clinical areas and are delivered for use
- Success Measures: The communication stations are well used and both staff and patients feedback they have made a difference to patients needing accessible information

What did we achieve?

- Outcome 1: Bedside information folders electronically produced and published on the Trust website. Language options are also available as the new Website is compliant with accessible information standard. Hard copies also received and delivered to all ward areas. This includes versions in the five most commonly used languages in Rotherham other than English
- Outcome 2: The welcome boards have been designed, printed and put into place (93 different designs and 91 boards). New Boards were ordered to match the various ward moves
- Outcome 3: Communication stations now delivered to the clinical areas. The Learning Disability resource folder has been written and additional pictorial content purchased

Title - Develop a Robust Process to Measure and Improve Following Patient/User Feedback

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Programme Overview Including Objectives

- Patients give us feedback through a variety of ways. These include the annual CQC surveys performed through Picker, the friends and family test and complaints, concerns and compliments through the Patient Experience Team
- Objective 1: Our framework for thematic analysis will ensure we work on priorities from patient feedback
- Objective 2: Staff using patient experience data will have the skills to interpret trends and identify areas for action
- Objective 3: Trained governors will be able to improve our real-time patient feedback using the Tendable App

Progress against planned activities and deliverables

- Tendable audit questions have been reviewed in line with the CQC survey and reduced to half the number of questions to make this easier for patients to answer. For

independent support on using Tendable with patients – training has been given to Governors, ICB Place colleagues and a volunteer. The monthly independent audits are still being established

- Each Tendable audit captures responses from five patients. There has been a continuous increase in the number of Tendable audits performed
- Feedback was collated into highest scoring areas, lowest scoring questions, longest outstanding issues and any clinical areas not completing the audit. A revised feedback report is produced each quarter for the Patient Experience Committee (and monthly for the Patient Experience Group)
- Divisions use this information in their six-monthly patient experience report to the Patient Experience Group, triangulating themes from all their patient experience data and the impact of planned quality improvement work

    - Quarter 1 – 68 Audits, 340 patients – average score 94.2%
    - Quarter 2 – 103 Audits, 515 patients – average score 89.5%
    - Quarter 3 – 206 audits, 1030 patients – average score 90.4%
    - Quarter 4 – 138 audits, 690 patients – average score 90.6%
    - Progress was reported through the quarterly Patient Experience Committee and Quality Committee the month after

What further actions need to be undertaken?

- Objective 1: We will continue to thematically analyse all patient experience data to ensure quality improvement plan is in line with changes needed, using the Yorkshire and Humber Patient Experience Framework, divisions will develop maturity in thematic analysis and provide assurance in identifying themes, trends, linked to quality improvement
- Objective 2: Continue monthly Division feedback presentation, using the agreed framework to demonstrate themes, tends and learning
- Objective 3: Use increasing amount of patient feedback in thematic analysis in quarterly patient experience report

Title - Develop and Embed the Mental Health Strategy

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Mental Health care and provision in acute Trusts continues to be a challenge for the NHS. Physical and mental health care have traditionally been delivered separately. The CQC stated that: 'While investment and improvements in mental health services are welcome, physical and mental health services will only truly be equal when we stop viewing physical and mental health as distinct. Services need to be built around all of people's needs and not determined by professional or interest groups. There is increasing recognition of the importance of integrating services across health and social care'.

Therefore, TRFT identified a need to provide a mental health strategy that is reflective of the Rotherham PLACE, and provide strategic aims in terms of how we should deliver care to our patients.

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

The objectives of this work are to provide a strategic plan on how care should be delivered within TRFT. The objectives of this work are:

- Provide data and analysis of current mental health requirements
- Review the PLACE data in terms of key challenges
- Identify key area of focus to improve care delivery
- To work in collaboration with Rotherham Doncaster and South Humber NHS Foundation Trust

What did we achieve?

The Mental Health Strategy is now completed in draft and will be published in Quarter 2, 2023/4. The strategy demonstrates the key challenges in Rotherham and how as a Trust, we will aim to identify priorities to improve patient health and care.

How was progress monitored and reported?

Progress was monitored through the Mental Health Steering Group and the Safeguarding Committee to ensure any key risks were identified early. During the development of the strategy, the medical emergencies in eating disorders guidance required further evaluation and a gap analysis. This was also reported through the Mental Health Steering Group and incorporated into the strategy.

What further actions need to be undertaken?

The draft report will be circulated to the Mental Health Steering Group, Safeguarding Committee and Quality Committee prior to final agreement at Trust Board in quarter two of 2023/4. There will be an associated implementation plan that will aim to drive the agenda whilst progress is tracked through the appropriate groups and committees.

Domain: Clinical Effectiveness

***Title* - Reduction in Hospital Acquired Infections**

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

Programme Overview Including Objectives:

- Infections are classed as Hospital acquired when they occur after admission and within defined timescales. The following infections are nationally mandated to be reported as hospital acquired if they occur two days or more after admission and the Trust has a

maximum trajectory based on previous data that if breached may result in financial penalty if there are lapses in the quality of care identified during case review by the ICB place colleagues

- MRSA bacteraemia, Escherichia coli (E.Coli) bacteraemia, Pseudomonas aeruginosa bacteraemia, Klebsiella species bacteraemia, Clostridium difficile
- The following infections are not externally reportable however they are also being monitored internally:
    - Glycopeptide Resistant Enteroccus if causing infection (not colonisation) that occurs two days or more after admission
    - Carbapenamase Producing Enterobacteriaceae (CPE) if causing infection (not colonisation) two or more days after admission
- Objective 1: To have a reduction in preventable hospital acquired infections
- Objective 2: To demonstrate compliance with the Infection Control Board Assurance Framework (against all domains that are within our control)
- Objective 3: To have a timely response to any changes in national IPC guidance where appropriate for the organisation (and with rationale provided where deviation is required)
- Objective 4: To see an improvement in compliance with hand hygiene and Infection Control mandatory training

<u>Planned Outcomes and Measures of Success</u>

- Outcome 1: Review each case within 4 weeks of the infection being reported
  Success measure: Each case reviewed, and learning disseminated to clinical teams
- Outcome 2: Demonstrate compliance with Infection, Prevention and Control Board Assurance Framework (against all domains within control)
  Success Measure: The current Board Assurance Framework is out of date and the updated version was not received as at the end of the financial year
- Outcome 3: New national guidance is received, and appropriate gap analysis completed and taken through relevant committees
  Success Measure: Committees are sighted on new IPC guidance and can provide assurance on where TRFT are compliant
- Outcome 4: Improved compliance in hand hygiene and IPC mandatory training
  Success measure: Monitor monthly Mandatory and Statutory Training (MaST) rates through IPC Group and provide quarterly update at IPC Committee.

<u>Progress against planned activities and deliverables</u>

- Regular reviews of hospital acquired infections have taken place in consultation with Rotherham Place Partners for Quarters 1, 2 and 3 under an 'RCA process'. While providing reassurance the hospital acquired infections has been reviewed, there is no Post Infection Review learning for the health care professionals involved in the care of the patient. A proposal has now been agreed for Post Infection Review between the clinical teams and IPC and corporate nursing teams, starting April 2023. This will ensure the process of post infection review is in line with Patient Safety Incident Response Framework (PSIRF)
- A mattress replacement audit has now been completed. 45 mattresses were condemned, 68 mattress covers were replaced, based on the audits completed by the Tissue Viability Team. Plans for an annual mattress replacement audit are still to be confirmed and communicated with clinical teams
- A proactive deep clean schedule is now in place with progress made against clinical areas and wards in Medicine. Learning from this proactive cleaning programme has

including training on standards of cleanliness, inspection and sign off process and standards of routine ward level bed cleaning between patients
Progress against trajectories is reported each month at IPC Group. The target of no more than 19 cases of hospital acquired C.Difficile infection occurring has not been met, with 37 cases for 2022/23. The C.Difficile trajectory for 2022/23 for TRFT is one of the lowest in the country as it was based on the actual number in the 12 months to November 2021. This does not take into account that the end of year figures for TRFT were comparable with other similar sized Trusts. There have also been CPE outbreaks identified and internal and external incident meetings have taken place to ensure robust actions are in place

- Compliance with the Infection Control Board Assurance Framework that was issued during COVID-19 was assured but is now outdated as COVID-19 restrictions ceased. A new IPC Hygiene Code self-assessment was received mid-December and refreshed in March 2023. The new Board Assurance Framework had still not been received at the end of the reporting period.
- Compliance with training continues to be monitored monthly. IPC training has dipped slightly and is currently at 84%. Divisions of Medicine and Corporate Services and Corporate Operations are not at required levels and are working to improve this. Hand hygiene continues to improve each month but is not yet at the required level overall

What did we achieve?

- The dates for the new Post Infection Review (PIR) process have now been agreed, to start in the new financial year
- Thematic analysis from the PIR to be incorporated into the IPC workplan
- The Deep clean schedule has progressed slowly and will continue into the new financial year
- The Mattress replacement audit was completed and dates for the 2023/24 audit to be agreed
- The Hygiene Code (Health and Social Care Act 2008 Code of practice on the prevention and control of infections and related guidance) was received in December and updated in March 2023. There are ongoing actions to refresh and update with this code by Quarter 1 2023/24
- The new IPC Board Assurance Framework is expected any time and will be updated in line with changes over the past 2 years
- Infection Control and Hand Hygiene training compliance will be tracked at divisional level and unsatisfactory improvement will be escalated to the divisional performance meetings

How was progress monitored and reported?

Through the quarterly Infection, Prevention and Control Committee.

What further actions need to be undertaken?

The Red-Amber-Green (RAG) rating is maintained on amber to reflect the breach of the C.Difficile and Pseudomonas trajectories.

***Title** – Continuation of Mortality and Learning from Deaths Improvement Work*

Domain: Clinical Effectiveness

Title – Continuation of Mortality and Learning from Deaths Improvement Work

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

Current position and why is it important?

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

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

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

The aim and objectives including the measures and the metrics

Aim:

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

Objectives:

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

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

What did we achieve?

Enhanced learning from the Learning from Deaths Program

During 2022/23 Thematic Analysis Reports were produced for SJR completed for deaths in 2021/22, and for deaths in Quarter 1 and 2 2022/23. A report will be completed for Quarters 3 and 4 in June 2023.

These reports have been distributed to the Trust and Divisional Mortality Leads. They have also been shared with the Patient Safety Team and various groups for whom this analysis is relevant including the Deteriorating Patient and Sepsis Group and the Medicine Safety Committee.

All SJRs 2022/23 deaths where the overall care score (2) has been judged to have been poor, or the deaths judged to have been likley avoidable (0) have been presented at a Mortality Meeting, where decisions were made as to any required course of further investigation/escalation.

The Mortality Matters publication has been published for most months in 2022/23. Topics have included the learning from mortality reviews, the Thematic Analysis of SJRs and specific clinical areas such as Sepsis.

Better Consistent Presentation/Review of the Trust's Deaths

Mortality Reviews continue to be presented in local formats at Division and Specialty Mortality Meetings. This is because the vast majority of SJRs contain little or zero free text. SJRs for 2023/24 deaths will contain this important freetext information and will be used for presentation.

Training time for Trust Clinicians

This was delivered in 2022/23. During 2022/23 Quarter 4 the Trust appointed an SJR Review Team, comprising of 6 clinicians. These clinicians have protected time for this role. The bulk of this time is allocated for the completion of SJRs, however 2 hours per annum are allocated per reviewer for training related to the Learning from Deaths Process.

Better timeliness for SJR completion

A review of the SJR process in 2021/22 revealed that the majority of SJRs were being completed by untrained reviews with no protected time. The large cohort of reviewers were completing these infrequently, which did not allow mortality review skills to be developed. As a result, TRFT's SJR were of a varied consistency, completeness and timeliness.

There are 3 stages to achieving timeliness for SJRs. The first is the timeliness of the ME Scrutiny and the relaying of the SJR recommendations to the Trust's Learning from Death and Mortality Manager.

The second stage is the allocation of SJR requests to the Divisions Reviewers. The third is the completion of the review. There have been significant improvements in the first 2 stages.

The majority of ME Scrutinies are completed within 5 working days, and the SJR recommendations forwarded to the Trust on a weekly basis. Within 2 working days, these recommendations are processed and send to the divisions for completion. It is the completion time for the SJRs themselves that has meant that the 60 days target from death to completed review has not been met.

During 2022/23 the TRFT has worked with the NHSE/I Better Care Tomorrow Team and designed a process that will deliver consistently good quality SJR. This involves funding review time for a smaller team of dedicated trained reviewers.

The review team has now been recruited and is in place to complete reviews for deaths in 2023/24. All of the review team have completed or viewed the NHSE/I Better Care Tomorrow SJR Reviewer Training.

How was progress monitored and reported?

Progress was monitored and updates provided through the Trust's Mortality Group, which reports to Clinical Effectiveness Committee.

360 Assurance completed a re-audit report in January 2022, to determine if the Trust had implemented actions resulting from the 2020 audit regarding the effectiveness of governance relating to Learning from Deaths. Action points were agreed with deadlines throughout 2022/23.

A monthly highlight report is submitted to the Trust Clinical Effectiveness Committee and to the Quality Committee and bi-monthly to Trust Board. The report relates to delivery of the Operational Plan 2022/23 Priorities and in this case – Mortality and summarises progress made against the milestones and performance targets.

The timeliness for SJR completion has been monitored monthly. SJR completion rates have been included in reports on the agenda of the Trust and Divisions Mortality Groups. In addition, lists of uncompleted SJR at individual SJR level have been provided at the Divisional Mortality Groups.

What further actions need to be undertaken?

From April 2023, a new SJR completion process is commencing at TRFT. The new process will be closely managed and monitored to ensure it delivers good quality, complete and timely SJRs.

It is expected that SJRs will be allocated to the review team each week and the review completed within 4 weeks of allocation. The concept of a backlog should disappear and the culture of a rapid cycle of learning adopted.

An increase in the quality and completeness of SJRs will be monitored by taking baseline figure with regards to the number of free text comments included for SJRs in 2021/22. The number of comments for 2023/24 SJRs will be compared against this baseline.

Further work will be needed with regards to how intelligence from the Learning from Deaths programme is shared within the Trust and how this intelligence is used to drive improvements. The increased quality and completeness of SJR will deliver more and better intelligence. The SJR Thematic Analysis reports will continue and will be completed more frequently to match the increase in volume of freetext comments.

The SJR+ system provides an analytical reporting tools including dashboards. The Learning from Deaths & Mortality Manager and Health Informatics colleagues will view this information to determine its content and how this can be shared/used by the Trust.

***Title* - Identify and Develop a Quality Improvement Tool for the Organisation**

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

"Improving quality is about making health care safe, effective, patient-centred, timely, efficient and equitable. It's about giving the people closest to problems affecting care quality the time, permission, skills and resources they need to solve them. In the history of the NHS, there has never been a greater focus on improving the quality of health services." – The Health Foundation.

In order to provide outstanding services, it is crucial that colleagues in our organisation are capable and supported to lead innovative and fast paced service change and improvements through re-starting, re-designing or developing new processes, pathways and services.

To that end, it is proposed that the Trust takes a strategic and systematic approach to quality improvement (Qi), TRFT has started using Quality, Service Improvement and Redesign (QSIR) as a programme of Quality improvement. By the end of March 2023 there will have been 3 cohorts of 62 practitioners with a further four cohorts of 15 practitioners for the remainder of 2023. Work is ongoing to deliver both QSIR F the one-day course and QSIR V a virtual course. Negotiation is also taking place to have e-learning modules available for all staff on the basics of Qi.

Qi is also part of medical leadership development, preceptorship and care certificate programmes to reach a wide range of staff from all levels. All nursing preceptees starting March 2023 will attend Qi theoretical training as the programme is already planned. From September 2023 all preceptees will attend theoretical training and put that knowledge into practice, undertaking a Qi initiative and present the outcomes back at the end of the programme.

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

Development of Qi strategy for TRFT and Qi self-assessment is currently underway. This will enable work to start on areas that require development and is a baseline measure of where the Trust currently is on its long-term Quality improvement journey.

What did we achieve?

59 QSIR practitioners by end of March 2023 and 4 faculty members. Establishment of 4 further cohorts for QSIR Practitioner programmes, 5 groups through 2023 of QSIR Fundamentals 1-day course. E-learning modules available from the Academic Health Science Network on the basics of Qi, accessed via Electronic Staff Record.

How was progress monitored and reported?

Progress of QI projects for the QSIR programme will be monitored using Audit Management and Tracking Qi module for recording projects. A spreadsheet for each cohort with names and projects planned to monitor against plan is underway.

What further actions need to be undertaken?

Completion of self-assessment as to where the Trust is against a suite of processes developed by The Health Foundation, also to be completed with the Executive Team.

3.1.2 Additional information about how we provide care

Friends and Family Test

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

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

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

Divisions have continued to provide examples of learning on a monthly basis through the FFT Steering Group and from April 2023 activity and learning will feature within the Divisional quarterly patient experience reports based around the framework of the Yorkshire Patient Experience Toolkit and presented to the Patient Experience Group.

Support will continue to be provided by the Head of Patient Experience and Engagement to encourage learning from feedback. Divisions also have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any actions required are developed and closely monitored to meet the expectations of their patients' feedback.

Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and continues to have zero occurrences within inpatient wards, despite additional challenges presented during and after the pandemic. There is also an internal process for monitoring and reporting 'pass by' breaches of mixed sex accommodation. In 2022/23 there were no reported breaches for pass-by of toilet facilities.

In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit level 2 care to base wards. Despite development of a new process to prevent this, there have been 12 occurrences this year due to unavailability of an appropriate ward bed within the agreed 4 hour time period.

Never Events

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

All Datix incidents are checked daily by the Quality Governance and Assurance Unit so any incident reported which has not been identified as a Never Event would be amended by the team.

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

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

During 2022/23 the Trust has reported no Never Events.

If a Never Event were to occur, a robust Root Cause Analysis would be carried out and an action plan created with monitoring through Divisional Governance processes to ensure completion. All action plans are also tracked through the Organisational Learning Action Forum tracker to ensure corporate oversight. The Patient Safety communication bulletin is used to ensure Trust wide sharing of the learning from these incidents to improve the quality of care for patients and prevent future occurrences.

Patient-led assessments of the care environment (PLACE)

The PLACE assessment was suspended by NHSE/I for 2020 and 2021 due to the ongoing focus in activity associated with the pandemic and the recovery towards business as usual. The PLACE assessment was reintroduced in Autumn 2022 as part of the drive towards business as usual. The table below shows the PLACE scores for 2022.

Inspected	**TRFT score - 2019**	**TRFT score - 2022**	**National average score**	**Highest NHS Trust score**	**Lowest NHS Trust score**
Cleanliness	100%	**99.32**	98.05%	100%	70%
Food overall	98.03%	**94.73**	91.27%	99%	71.67%
Organisation (of) Food	95.93%	**95.49**	91.16%	99.75%	66.31%
Ward food	100%	**94.51**	90.75%	100%	67.21%
Privacy, dignity & wellbeing	93.88%	**81.33**	87.22%	98.94%	57.87%
Condition, appearance & maintenance (of buildings and facilities)	100%	**96.24**	95.69%	100%	81.62%
Dementia (meeting needs)	90.53%	**75.81**	82.21%	99.54%	55.03%
Disability (meeting needs)	90.38%	**80.41**	83.54%	99.42%	57.42%

The National CQC Patient Experience Surveys for Acute Trusts

The Maternity Survey 2022 was carried out by Picker, on behalf of the Trust. 299 patients were invited to take part in the survey and 166 completed the questionnaire (response rate 65%). 94% were mothers who had previously given birth and 22% of respondents said they had a long-term condition.

The Trust scored no areas of statistically significant improvement, with nine out of 53 scores significantly worse than the organisational average.

The Adult Inpatient Survey 2021 received June 2022 was carried out by Picker, on behalf of the Trust. 1250 patients were invited to take part in the survey and 449 completed the questionnaire (response rate 38%). 82% of participants said they had a long-term condition. The Trust scored no areas better than expected, 38 areas about the same and 9 areas worse than expected.

Throughout 2022, Divisions have been invited and attended a facilitated workshop, provided by Picker to go through the results and statistical significance.

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

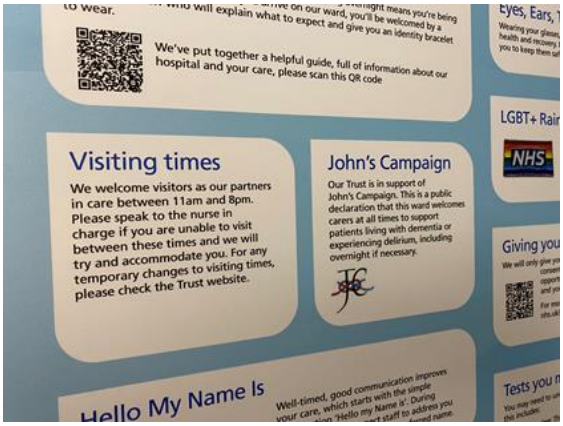
Rather than each Division create action plans from this thematic analysis, The Yorkshire Patient Experience Toolkit (PET+) is being used as an evidenced based approach to enhancing patient experience through listening to patients and frontline teams who deliver the care.

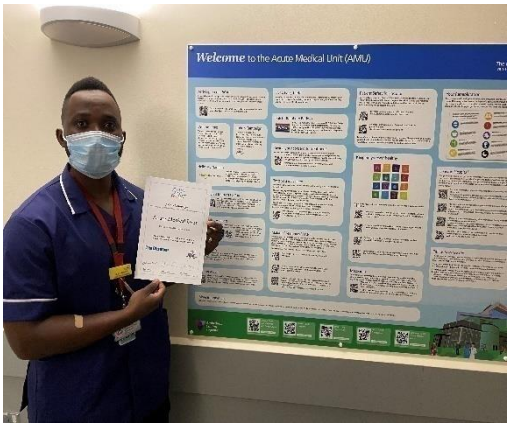
Divisions take it in turns to present their patient experience analysis, using the PET+ framework, to the Patient Experience Group twice a year.

Quality Improvements in Patient Experience are detailed below:

<u>April 2022</u>

Standardised visiting times were brought in on all the adult inpatient wards (11 am – 8pm and the Trust signed up to John's Campaign to welcome carers of people living with Dementia.





May 2022

The Sleep Helps Healing (Shh) campaign was launched to help reduce noise at night and support therapeutic working environments for colleagues. A range of visual pull up banners were provided to each ward as well as a Sound Ear, which lights up when noise reaches a level that would wake a sleeping patient.

June 2022

To support improvements in patient hydration and nutrition, the new traffic light water jug system was introduced. This is a simple, visual way of being able to tell at a glance how much water a patient has had to drink in a day. The old 'Protected Mealtimes' was dropped in favour of the more family inclusive 'Making Mealtimes Matter'.

July 2022

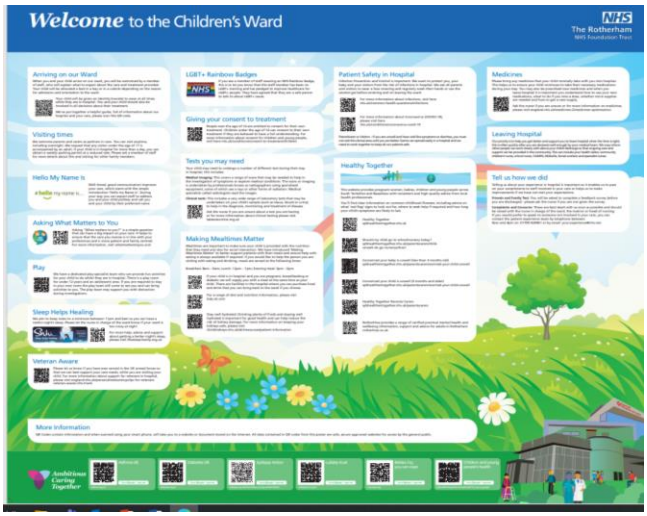
To try and reduce lost dentures, hearing aids and glasses, new Eyes, Ears and Teeth bags were introduced as single patient use storage for patients.

Quarterly Inpatient Tea-Parties

To help embed the new traffic light water jug system and making mealtimes matter – themed inpatient tea parties were introduced. These helped link patients to events in the local community (Queens Jubilee, Macmillan Coffee Morning and Remembrance) while also encouraging ward teams to get creative with how they encourage social dining.

August 2022

The new Welcome Boards to all clinical areas were co-produced with 33 different designs, including the improvements introduced so far throughout the year. Over 90 boards were placed around the Trust and updated after some planned ward moves.

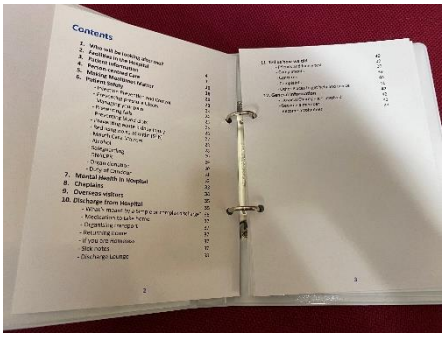


September 2022

Veteran Aware Accreditation was achieved, and the award received at the Veteran Covenant Healthcare Alliance national conference in Birmingham. The plaque was unveiled on Remembrance Day in November.

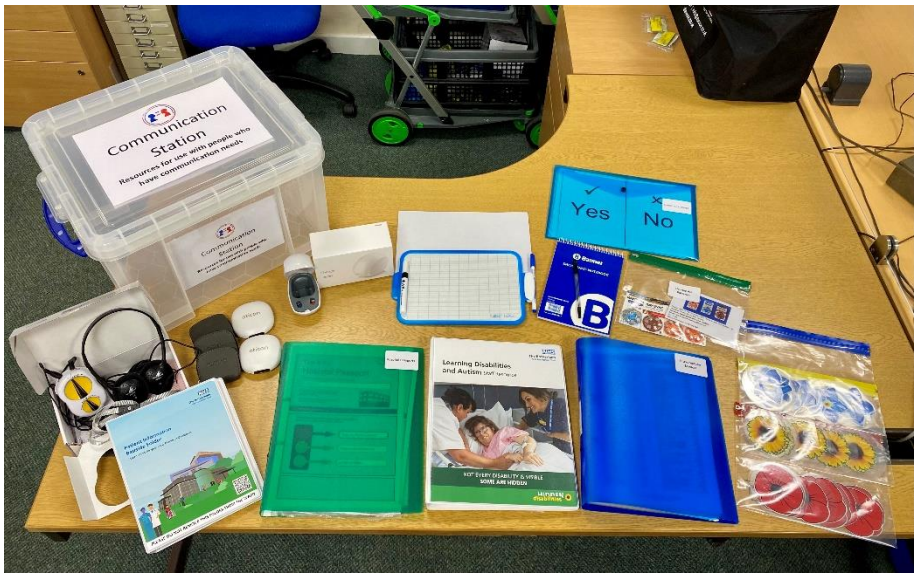
October 2022

Following digital publication of the new bedside book on the Trust website, the hard copies of the English version were received. This standardised book helps to explain some of what patients and families need to know about being an inpatient in the hospital.



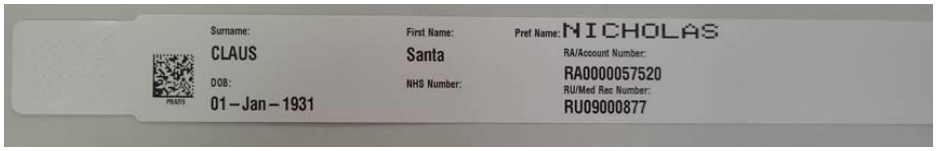
November 2022

Communication Stations, which had been developed with the clinical areas over the past few months were launched across the Trust. Each box helps to support the accessible information standard and includes various items to help communicate with all patients.



December 2022

Work on the electronic care plan was modified to allow a question on a patient's preferred name. This can now be updated to reflect what a patient prefers to be called on their wrist band.



January 2023

The new Learning Disability and Autism resource folder was co-created with people living with Learning Disability and Autism. This helpful resource has a photo library to aid communication and also signposting for further help and support from the Learning Disability and Autism team. The folders were delivered to all the clinical areas (and stored in the communication stations).

February 2023

Due to the various ward moves, new welcome boards were updated, ordered and placed in the new ward areas (B10, Sitwell, Stroke Unit and Rockingham).
The translated hard copies of the new Bedside Information folders arrived to be kept in each wards communication stations.

March 2023

To support an ongoing focus on nutrition and hydration – a week of events was arranged for Nutrition and Hydration Week 2023 with support from Dieticians, Speech and Language Therapists.

Healthcare Associated Infections

The Chief Nurse is the Director of Infection Prevention and Control (DIPC) and published the annual infection prevention and control report in June 2022.

Throughout the year detailed updates on the incidence of healthcare associated infections have been provided to the Infection Prevention and Control and Decontamination Committee which reports to the Quality Committee. During 2022/23 there has been a change in the governance process and committee structure with a monthly operational Infection Prevention and Control Group meeting taking place chaired by the assistant DIPC which reports to a quarterly strategic Infection Prevention and Control and Decontamination Committee chaired by the DIPC which reports to the Quality Committee.

The substantive Associate Specialist in Microbiology and Consultant Clinical Scientist provide the microbiology cover for the Trust. There are two posts advertised for substantive Consultant Medical Microbiologists. Cross cover Microbiologist support continues with Barnsley.

Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridioides Difficile (C-difficile) are both alert organisms subject to annual improvement targets. The MRSA bacteraemia target for 2022/23 was ‘zero preventable cases’ which has been achieved.

The C-difficile trajectory was 19 cases to year-end which has been breached with 37 cases to date. 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
2021/22	**1**	0	0	0	1	0	0	0	0	0	0	0	0
2022/23	**0**	0	0	0	0	0	0	0	0	0	0	0	0

Number of reported cases of C.diff													
Target = <24 Target <19 in 2022/23	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	**26**	2	1	3	2	0	1	2	2	6	3	2	2
2022/23	**37**	4	0	3	3	0	5	5	2	4	5	2	4

(Source: Trust Winpath System)

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

The post-infection review (PIR) process done jointly with the ICB place Nurse was recommenced but this process has been reviewed as the learning does not sit with the individual clinical areas. The new PSIRF process is due to commence during 2023 and PIRs will be completed as part of a new harm free care panel.

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

From February 2020 onwards there has been the challenge of COVID-19 pandemic management, which continues to put pressure on the whole system with intermittent high in-patient capacity and cohorted isolation which has been further challenged during the winter of 2022/23 with a high increase of Influenza cases. All changes in practice are communicated out based on the changes in national guidance alongside local COVID prevalence and knowledge of the built environment where clinical care is provided.

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

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

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

There has been an outbreak of Monkeypox in the UK as well as across Europe and the US and whilst this viral illness has now reduced in case numbers and didn't impact within hospital admissions as was first anticipated, considerable resource was put into preparation for all areas and updating documents as guidance updated on a frequent basis during the initial months of the outbreak.

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

The trajectories for 2023/24 are as follows:

- Clostridioides Difficile (C.difficile) -TBC
- MRSA bacteraemia - 0 cases
- E.coli bacteraemia - TBC
- Klebsiella bacteraemia - TBC
- Pseudomonas aeruginosa bacteraemia - TBC

Reducing the incidence of Falls with Harm

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

	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
Falls	741	799	796	892	921	1048	1044
Bed Days	144,505	145,153	132,557	158,207	118,098	151, 353	152,201
Falls Rate per 1000 Bed Days	**5.12**	**5.50**	**6.00**	**5.63**	**7.79**	**6.92**	**6.85**

Monitoring of all falls is undertaken daily by the Quality Governance and Assurance Unit 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 Committee.

The Trust continues to participate in the mandatory National Inpatient Falls Survey, the results of which are used to inform the Falls group action plan, which is continually being amended to reflect the most recent falls management initiatives. The Trust has reviewed its current falls assessment documents and released them as electronic forms, which include mandatory fields such as completion of Lying and Standing blood pressure. This will not only improve patient care but facilitate completion of national Commissioning for Quality

and Innovation (CQUIN) targets. The Trust's Falls Policy has been reviewed to reflect all changes to the way falls are managed and has been uploaded on the Patient Safety page of the Hub.

Duty of Candour

'Duty of Candour' requirements are set out in the Health and Social Care Act Regulation 20: Duty of Candour (Health and Social Care Act (2008). The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust (Report of the Mid Staffordshire NHS Foundation Trust Enquiry, 2013), which recommended that a statutory duty of candour be introduced for health and care providers, to ensure a more honest and open culture in the NHS. From October 2014 there was a statutory requirement for Trusts to implement the Duty of Candour requirements.

Duty of Candour is monitored closely by the Quality Governance and Assurance Team.

An audit of compliance regarding the Duty of Candour discussion had been undertaken during 2021-22. Following on from this, the process for assurance on compliance to Duty of Candour has been strengthened through ongoing monthly monitoring by the Quality Governance and Assurance Team. This is reported through to local governance, Patient Safety Committee and Quality Committee. Non-compliance is reported onto the Datix system and reported through the Patient Safety Committee monthly. This is further supported through a rolling training programme delivered by the Quality Governance and Assurance Team.

Safeguarding Vulnerable Service Users

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

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

- A Trust Safeguarding Nurse Advisor is based in the Multi-Agency Safeguarding Hub at the Local Authority. This team responds to all children safeguarding referrals. This allows The Rotherham NHS Foundation Trust (TRFT) to share appropriate information in a timely way and supports the achievement of good outcomes for children
- A Specialist Child Exploitation Nurse service (now two 3 day posts) is based in the Evolve Team in the Local Authority. This provides services for survivors of Child Exploitation and those identified as vulnerable and at high risk of being exploited and is aligned to the Family Health Division. This service was previously the Child Sexual

Exploitation service but has widened the remit to reflect the growing concerns linked to criminal exploitation of children in addition to sexual exploitation. The service will also be closely working with the Youth Justice Service as part of the role and providing health assessments and support to young people known to youth justice. The role is to provide robust, flexible and needs-led support to vulnerable children and young people. This involves two merged strategies. One to support the health needs of the child or young person, the other is to work in partnership to disrupt and prosecute alleged abusers.

In relation to adult vulnerability and adults at risk, the work and support by the team includes the work streams of Domestic Abuse, Multi-Agency Public Protection Arrangements, Mental Health Act, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The year has seen a continued increase in activity across all work streams with sustained challenges posed by the embedding and implementation of the Care Act 2014, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

The MCA (2005) was amended (MCA[A], 2019) and introduced the Liberty Protection Safeguards (LPS), which will replace the DoLS. Work had begun to ensure the changes made to the MCA, introducing the Liberty Protection Safeguards and phasing out DoLS throughout the acute Trust, was progressed, however, this was delayed pending the release of the updated Code of Practice. The draft Code of Practice was released and the national consultation on this document completed. However, the requirement set for this to be fully implemented by March 2022 has now been deferred. An announcement on 5 April 2023 by the Department of Health & Social Care explained that the progression of the implementation of LPS arrangements has been delayed 'beyond the life of this parliament'. On-going training and supervision will continue to be provided to support practice in embedding the implementation of the MCA and DoLS procedures.

The Trust will continue to work with partner agencies to develop a structure to support this when final arrangements are announced. In the meantime, the Safeguarding Team are continuing to offer MCA training, and are progressing the MCA and Safeguarding Champions network to ensure staff are confident and competent to discharge their responsibilities under the MCA. The Trust has appointed a 0.5 WTE MCA/LPS Lead Nurse to take forward improvements in the implementation of the MCA, DoLS & LPS (as appropriate). This also adds resource to the existing Adult Safeguarding Team.

The Trust continues to be an active partner in the Rotherham Safeguarding Children Partnership, the Rotherham Safeguarding Adult Board and the Rotherham Health and Wellbeing Board. In addition, robust governance structures are in place to ensure the Trust has representation on a large number of external Safeguarding strategic and operational groups. This ensures partnership working is embedded across the wider Rotherham Health and Social Care economies.

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

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

The recording of training on Electronic Staff Record is overseen by the Learning and Development Team. The Trust employs a blended learning approach to enable staff to gain the required competencies, with a variety of training media available.

The Trust implemented a 'Think Family' strategy, and training provision reflects this model. Other e-Learning has been developed, with voice-over attached, to support our staff in achieving their MaST requirements. This gives staff a choice in using a method of learning and development which suits their individual needs.

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

The Trust's Safeguarding Vulnerable Service Users Strategy, alongside our strategies for working with those with poor mental health and those with a learning disability, are embedded in the organisation. Key performance indicators, against which safeguarding performance is monitored, are in place and reported, via the Safeguarding Committee, to the Quality Committee. In addition, a number of safeguarding standards are in place and monitored externally via South Yorkshire Integrated Care Board (Rotherham Place).

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

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

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

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

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

Improvements include the safeguarding safety huddles, now embedded across the children's pathway, the development of new policies and review of existing policies, which

are reviewed and updated in line with any changes to legislation and guidance. Stronger governance arrangements have been embedded and there is now increased engagement in improving MaST compliance rates across the Trust.

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

Dementia Care

The Trust signed up to John's Campaign in April 2022. This is a public declaration that the ward/ clinical area welcomes carers at all times to support patients living with dementia or experiencing delirium, including overnight if necessary.

On 23 November 2022, to celebrate National Healthcare Support worker day, a virtual Dementia Tour was organised through Train2Care. This interactive bus took colleagues through a virtual experience of what it would feel like for a patient to be living with Dementia and experience unfamiliar noises and environments. This helped to kick start plans for Person Centred Care training in 2023.

In February 2023, the new Person-Centred Care Practitioner started and work to plan a new programme of education finalised. This new day will be held at the Advanced Wellbeing Research Centre for 10 dates over 2023. This will be delivered by Trust subject matter experts to a multi-disciplinary audience.

The day will be interactive with the new Frailty Suit being offered as a virtual experience for what it would be like to live with frailty. Tier 2 dementia training will be incorporated into this day.

Plans to develop a training video for Tier 1 Dementia education are now in place for 2023.

<u>Dementia & Delirium Screening</u>

The Trust currently collates, and reports data based on the Dementia Screening guidance: (inpatient stays of longer than 72 hours and over the age of 65). This data is currently manual for this purpose as automated reports that can be pulled from Meditech are still being tested. Between April 2022 and January 2023, 6573 patients over the age of 65 with an inpatient stay longer than 72 hours were eligible for screening. Of those patients, 6245 were screened for both Dementia and Delirium (95%) and 266 just for delirium.

Learning Disability and Autism Team

The Rotherham NHS Foundation Trust is committed to improving the experience for people who have learning disabilities and Autism. The Trust has a Matron in Learning Disabilities and Autism one Nursing Associate specialising in Learning Disabilities and a specialist practitioner in learning disabilities and autism. The team remains under review to assess this staffing level and service need. The team focus on all aspects of the patient care pathway and experience within the Trust. The team supports patients who are outpatients, inpatients, going through planned surgery, midwifery, are admitted through the UECC and includes the transitions of young people to adult services. The team also has a role to play in the prevention of re-admissions to hospital; visiting patients in the community to assess

their needs, whilst liaising with Community Services to prevent admission to hospital where possible. The Learning Disability and Autism team ensure that the Trust are making reasonable adjustments for people with additional needs by undertaking the following:

- Using an electronic flagging system to identify that a person has a learning disability from their medical records. This information then populates a live database for the Learning Disability team to access
- The same electronic flagging system is now in place for people with Autism/Autistic people, should they consent to having this information flagged
- Championing the use of the Hospital passport, which is a person-centred assessment tool for people with Learning Disabilities and Autism, which helps staff to learn about how to care appropriately for each individual. The Hospital passport, is based on a traffic light symbol of need, comprising of three sections, red, amber and green. A current initiative will be implementing the traffic light symbol as a magnet, on patient headboards, ward boards and medical notes. The symbol will raise awareness to staff needs the need to read the Hospital passport
- The team offers excellent outcomes for patients with a learning disability and autism coming through our Day Surgery Unit, on a bespoke pathway. This offers a full holistic assessment of the persons care needs, in order to set up a robust plan to enable that individual to safely and positively come to the hospital for their planned surgery, or investigations requiring anaesthetic
- Providing bespoke training regarding learning disabilities and Autism in conjunction with the local advocacy organisation. This is delivered where possible by experts with experience
- Continuing to build links with established organisations to support learning, such as Speak Up, CHANGE organisation and Health Education England
- Facilitating a programme of mentorship for Learning Disability Nurse/Generic Social Work Students at Sheffield Hallam University, providing shadowing and training opportunities to the Trust's Trainee Nurse Associates
- Providing bespoke training for the Undergraduate Adult Branch Nurses at Sheffield University
- Facilitating a Learning Disability/Autism Patient Experience Sub Group. This has members from Community Learning Disability Teams, care providers for people with Learning Disability, such as Mencap, Voyage and Exemplar Health care, the Local Authority and Healthwatch. This enables the Trust to directly learn from patient experience in order to improve practice/systems and pathways
- Working closely with the Volunteer Coordinator to mentor and support volunteers in the Trust who have a Learning Disability/Autism
- Working with the wider equality and diversity agenda around health inequalities work for this patient group
- Working closely with colleagues within the Trust's Community Teams, such as Community Matrons, Fast Response and District Nurses, to ensure community care plans are in place for people with a Learning Disability and/or Autism, to minimise frequent admissions to hospital services
- Working with complex care colleagues around the transition of young people from child to adult services within the Trust. This transition work involves acute colleagues in Sheffield Teaching Hospitals and Sheffield Children's Hospital
- Implementing relevant Learning Disability and Autism strategies within the Trust and working in conjunction with partnership organisations borough wide
- Continued work around the implementation of the Accessible Information Standard with the Trust's Equality and Diversity Leads

- Championing and using the Learning Disability Mortality Review programme (LeDeR) process, in conjunction with the Integrated Care Board (ICB) leads. This process is across agencies to learn from the deaths of people with a Learning Disability
- Implementing the learning from the LeDeR programme throughout the Trusts governance pathways
- Ensuring that reasonable adjustments are made to Trust care pathways. Examples of reasonable adjustments may include being listed as first on a surgical list to decrease potential anxiety around waiting, or having someone who knows the person really well, to support them on their journey into the Trust
- Championing the use of the Mental Capacity Act (MCA), assisting with best interest processes and the use of Deprivation of Liberty Standards (DoLS) where appropriate
- Helping to reduce the length of stay in hospital by working with Medical Professionals, Allied Health Professionals and Social Care Professionals (on average a person with a learning disability and or Autism, may have a longer than average inpatient stay compared to the general population)
- The Trust have implemented new staff resource files for people with a learning disability and or Autism. These are to support our general teams on all wards and departments to facilitate better care for this patient group
- Sensory boxes, containing light therapy aids are available for all wards and departments. These help to reduce anxieties for some people with a learning disability and or autism when coming into hospital
- The team engages with quarterly regional meetings for acute Trusts who have specialised teams for the care of people with a learning disability and or autism. These are important arenas to share best practice and look to directly improve our services at TRFT
- The team supports the data gathering required for the NHSE Annual Learning Disability standards for acute Trusts. This also involves gathering responses from 100 people with a learning disability and or autism who have used the Trusts facilities within the last 12 months and the views of 50 staff members within the Trust around the care of both these patient groups

<u>Future plans:</u>

- To expand the use of Nurse Associates within the Learning Disability Team working throughout the Trust
- The team works closely with a consultant anaesthetist, who offers medical oversight and a vast level of experience around complex patients who have a learning disability and autism.
- Looking at different ways of working and increasing the capacity of the Learning Disability team in order to more effectively meet the needs of people with a Learning Disability and/or Autism within the Trust. This may include an on-call system for out of hours work and weekend working
- Explore further Learning Disability specific roles with Health Education England
- Continue to encourage the role of the Learning Disability Champion on all wards and departments
- To work with the Trust's Equality and Diversity Steering Group to look at how the Trust can actively encourage people with Learning Disabilities and/or Autism to take on voluntary or paid roles at the Trust
- Focusing on specific care planning tools for people with Learning disabilities and/or Autism, to help improve individual patient pathways and the responsiveness of the Trust

- The Learning disability and autism team provide interventions to reduce unnecessary admissions to hospital for people with Learning Disability and autism. This utilising the nurse prescribing aspect of the team and works alongside GPs and Trust Community Practitioners
- To engage the Trust in the Autism accreditation process, through the National Autistic Society, on all appropriate wards and department. To ensure the Hospital moves forward to be more inclusive and accessible to this patient group
- Continued work around the Learning Disability Mortality Review (LeDeR) programme and how this works within the Trust's Structured judgement review and Death processes. This process from February 2022 will also include the reviews of deaths of people with Autism. Continued work aims to fully embed the learning from our local LeDeR report
- For the learning disability and autism team to be involved with the Structured judgement review process, which occurs following the death of a person with a learning disability and or autism
- The implementation of the mandatory Oliver McGowan Learning disabilities and Autism awareness training, which is hoped to be embedded by the end of 2023
- To implement the use of Hospital Passport magnets – which are highlighted with the Traffic light symbol. They will go on the back on the board above the patient bed. This will highlight the person has a learning disability and the need to read the Hospital passport. This initiative came from a complaint within the Trust, which identified how we could improve our learning
- The Trust is currently reviewing their discharge pathways for our most complex patients, which include some people with a learning disability and or Autism, to prevent prolonged stays in hospital when the individual is medically well enough to leave hospital
- Potential to implement an electronic flag for Reasonable adjustments. This is a national flag which has been created and is being trialled by NHSE

Staff Experience and Engagement

We committed to continue to support our colleagues as we moved out of the pandemic phase into recovery and beyond. The demand on staff remains consistent and we are mindful of the need to address the treatment backlog faced across the NHS whilst continuing to support the workforce to be well and at work.

To this end, increased focus on the importance of wellbeing and self-care, improving the clinical environment, break out areas, changing facilities and provision of hot food has continued as an ambition to support staff. We have also continued to develop meaningful activities and health initiatives to promote colleagues to take care of their own health to enable them to care for others.

We have seen a consistent use of staff accessing our Employee Assistance Programme services, support through occupational health and ICB led initiatives and training both physical and online.

We have worked hard to embed good practice in line with the NHS People Promises such as our approach to supporting flexible working, to be compassionate and inclusive, understanding our colleague voice though emphasising the importance of the National Staff Survey.

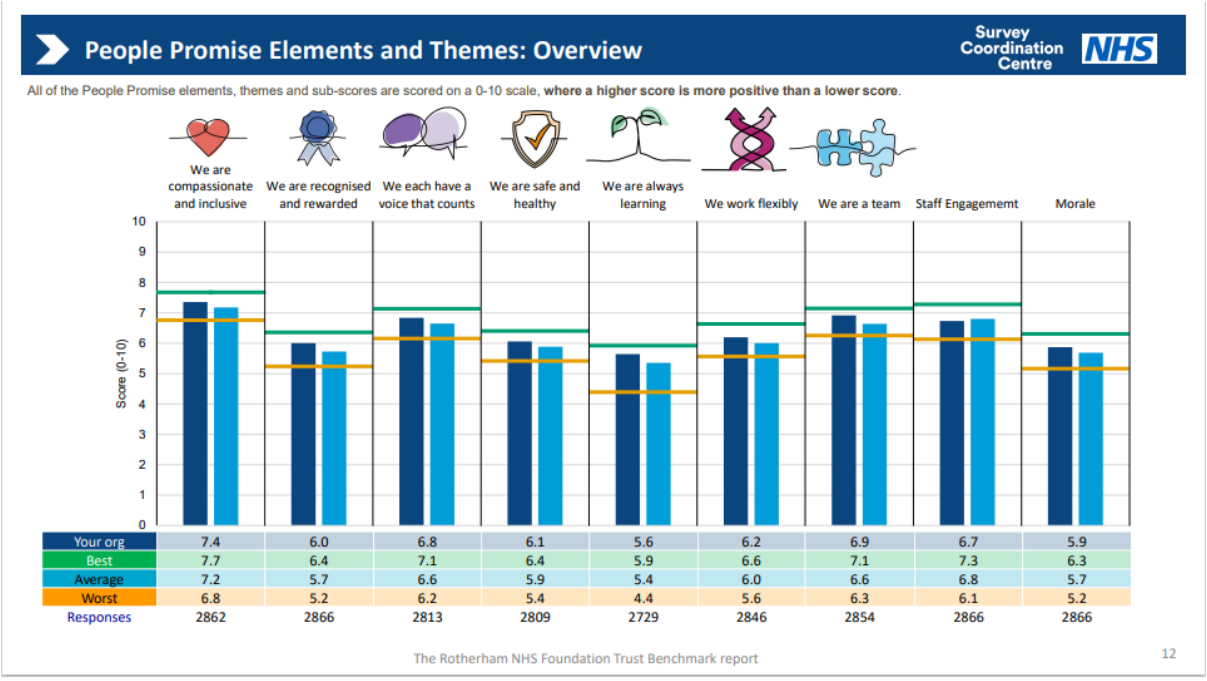
We have worked with a number of regional stakeholders to showcase and recognise talent in the borough to plan for future healthcare roles and opportunities.

National Staff Survey 2022

The NHS staff survey is conducted annually. The table below provides a high-level overview of the National Staff Survey results; seven domains linked to the NHS People Promises, which were introduced last year in addition to questions related to staff engagement and morale.

Staff engagement scores are derived from questions looking at three areas; motivation, involvement and advocacy.

Morale scores are collated from questions relating to the following areas; thinking about leaving, work pressure and stressors.



Improvements have been seen in all seven of the people promises and in the morale category. A lower performance has been seen in the staff engagement category in particular the advocacy domain.

A consistent improvement has been seen in staff engaging with the National Staff Survey. The Trust's ambition to increase the survey response rate to enable a broader and more representative workforce view has been achieved with its highest response rate of 61%.

The table below shows the incremental increase in response rates from 38% in 2018 to 61% 2022 which is a positive trend when compared nationally.

NHS Response Rate

The table below highlights the Trust performance in relation to wider NHS organisations.

	2018	2019	2020	2021	2022
Best	71.6%	76.0%	79.8%	79.4%	60.9%
TRFT	38.5%	48.0%	52.2%	59.7%	61.0%
Median	43.6%	46.9%	45.4%	51.1%	44.5%
Worst	24.6%	27.2%	28.1%	36.5%	26.2%

Areas of Improvement

Top 5 scores vs Organisation Average	Org	Picker Avg
q21a. Received appraisal in the past 12 months	92%	80%
q30b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	81%	72%
q18d. Feedback given on changes made following errors/near misses/incidents	67%	59%
q9i. Immediate manager helps me with problems I face	71%	65%
q9b. Immediate manager gives clear feedback on my work	69%	63%

Most improved scores	Org 2022	Org 2021
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	46%	34%
q30b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	81%	72%
q9i. Immediate manager helps me with problems I face	71%	66%
q20. Feel organisation respects individual differences	71%	66%
q9f. Immediate manager works with me to understand problems	73%	68%

Key Areas for Improvement and Future Priorities

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation	50%	61%
q23a. Care of patients/service users is organisation's top priority	69%	73%
q22b. There are opportunities for me to develop my career in this organisation	50%	54%
q23c. Would recommend organisation as place to work	54%	57%
q2a. Often/always look forward to going to work	51%	53%

Most declined scores	Org 2022	Org 2021
q4c. Satisfied with level of pay	27%	35%
q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation	50%	52%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76%	76%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	84%	85%
q23c. Would recommend organisation as place to work	54%	54%

- The Trust will place particular focus on the continued wellbeing support of its workforce and create a metrics dashboard to monitor improvement
- Build on the improvements made in relation to compassionate leadership to ensure that this embeds across the organisation
- Prioritise getting underneath the National Staff Survey Advocacy questions about working at the trust, receiving care and organisational care priorities

Monitoring arrangements - future priorities and how they will be measured

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

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

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

National Quarterly Pulse Survey

Our ambition to improve the response to the National Quality Pulse Survey saw a significant increase in response rates. Unfortunately, this was not sustained in Quarter 4 and the Trust started to see a decline. This was in part due to survey fatigue and challenges around reporting. Steps have been taken to improve the reporting and transparency of information and the Trust will continue to prioritise gathering feedback as part of the overall response to all staff survey data.

Freedom to Speak up (FTSU) Guardians

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

Since the appointment of a National Guardian there has been increased direction from the National Office regarding the role of FTSUG. As a result of COVID the regional network now meets virtually every two months and the annual national event was also held virtually; our FTSUG has been supported to attend. The Rotherham NHS Foundation Trust remains one of the only Trusts in the country to have FTSU training as a MaST subject with a three yearly refresher period as recommended by the National Guardians office.

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

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

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

During 2022/23, the FTSUGs have received 24 concerns. The majority of the concerns have related to attitudes and behaviour (12), with colleagues being directed to HR or union support for further advice. The number of concerns shows a decrease on previous years, however responses to the relevant questions in the staff survey show a year on year increase which may be linked to the increased time dedicated to the role and staff experience from those who have accessed the service. It may also be due to The Rotherham NHS Foundation Trust being one of the only Trusts nationally to have FTSU as a mandatory training subject; this training ensures staff are aware of FTSU and what to do if they suffer a detriment and how to escalate it, if it does indeed occur. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors.

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

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

In 2022, the Trust's annual Proud Awards returned to an in-person event in July and celebrated our dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

More than 430 nominations were received for the 2022 Proud Awards. Held at Magna, the 2022 ceremony was the first in-person event since November 2019 due to the COVID-19 pandemic. The event was hosted by Heart Yorkshire's Dixie with around 400 colleagues in attendance, alongside partner organisation representatives and sponsors. The award categories were announced by members of the Executive Team, Chairman and representatives from the Council of Governors.

The 2022 winners are:

<u>Values Award</u>
Nikhil Nanavati – Orthopaedics

<u>Governor's Award for Outstanding Colleagues</u>
Rachel Quinn – Workforce Development

<u>Safe and Sound Award</u>
HPV Vaccination Team

<u>Diversity and Inclusion Award</u>

Roma Nursing Team

Innovation and Improvement Award
Orthopaedic Planned Care Panel

Clinical Team of the Year
Pathology

Non-Clinical Team of the Year
IT 2nd Line

Public Recognition Award
Alison Buck – Specialist Nurse Practitioner and Alex Marinov – Specialist Breast Surgeon

Inspiring Leader Award
Sally Short – Keppel

Apprentice of the Year Award
Bryony Drewett-Noone – Respiratory and Sleep Services

Outstanding Volunteer of the Year Award
UECC volunteers

Unsung Hero Award
Sue Grundy – Procurement

Chief Executive's Award
Sarah Petty - Maternity

Chairman's Award
Acute Medical Unit (AMU)/Same Day Emergency Care (SDEC)

Excellence Award - Team of the Year
Trauma and Orthopaedics Theatre Team

Excellence Award - Individual of the Year
Jen Hilton – Infection Prevention Control

Excellence Award – Public
Urgent and Emergency Care Centre (UECC)

Implementing the priority clinical standards for 7-day hospital services

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

Management of Rota Gaps – Doctors in Training

Gaps in junior doctor rotas occur for various reasons. Often these are training gap vacancies, but also, we are seeing a higher number of trainees working less than full

time. The current vacancy rate for training grades is 6.77%; the equivalent of 10.8 posts out of an establishment of 159.6 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. The Trust utilises a centralised rota co-ordination function, currently covering rotas across Medicine, General Surgery, Urology and the UECC. This provides business resilience in terms of rota co-ordination across the Divisions.

Management of gaps occurs on a daily basis with Rota Co-ordinators taking a pro-active approach to ensure gaps are filled in a timely manner. If a gap is not filled by a substantive member of staff, the process is to look to fill from the Trust's Internal Bank. In June 22 the Executive Team signed off approval for the Trust to join Care1Bank, which is the regional bank solution across a number of Trusts, and which is the preferred option over advertising to agency. If cover cannot be sourced internally or via Care1Bank, agency cover can be sought. Other staff can also be utilised, such as an Advanced Nurse Practitioner for an F1 gap, and it is evident that our clinical workforce is now trending towards a more integrated approach. 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 adopted Good Rostering Guidance, produced jointly by NHS Employers and the British Medical Association in May 2018, along with adherence to contractual requirements of the 2016 Doctors in Training contract. Rota issues are a standing agenda item at the monthly Junior Doctor Forum, chaired by the Director of Medical Education, and attended by junior doctors across the Trust, along with various management representatives as well as representatives from the Rota Co-ordination Team.

External Agency Visits, Inspections or Accreditations

During 2022/23 there have been 13 external agency visits. Details of these visits are included in Appendix 3. Action plans are developed, where required, and monitored through the Clinical Effectiveness Committee.

3.2 Performance against relevant indicators

The Rotherham NHS Foundation Trust is reporting against the five following indicators:

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

Reporting categories will be updated for the 2023/4 report.

18 weeks from point of referral to treatment (RTT)

The Trust remained in the top quartile for Referral to Treatment performance when benchmarked nationally.

The table below shows the maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

% of patients waiting less than 18 weeks - Incomplete	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=92%													
2021/22	**81.10%**	82.42%	84.45%	85.12%	84.72%	83.21%	82.46%	83.18%	81.93%	80.44%	77.17%	76.20%	74.80%
2022/23	**69.60%**	73.88%	76.72%	74.00%	72.66%	70.06%	66.83%	68.27%	67.77%	66.44%	66.00%	67.00%	67.90%

(Source: Meditech and SystmOne)

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

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

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

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

Given the ongoing challenges around ensuring activity is restored to pre-pandemic levels, along with increased volumes of referrals above 2019/20 levels, performance against the Referral to Treatment time standard declined nationally in 2022/23. At the Trust, progress against recovery from earlier in the pandemic also declined, with the end of year performance at 67.9%, down from 74.8% a year earlier. This reflected a more than 50% increase in the number of patients waiting over 18 weeks for their treatment following a referral. The Trust saw an increase in patients waiting at least 52 weeks for treatment, from over 60 in March 2022 to just over 300 at the end of the year. However, focussed efforts to ensure the very long waiters were treated were successful, with the Trust meeting the national ask to ensure there were no patients waiting over 78 weeks at the end of the year and remaining in the top quartile due to a nationally challenged picture.

Number of patients waiting more than 52 weeks													
Target = 60	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	**62**	405	332	260	163	124	67	47	44	35	48	59	62
2022/23	**315**	73	79	117	151	183	217	244	259	253	289	285	315

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

During 2022/23, the Trust remained one of 14 field test sites who were piloting new national standards for urgent and emergency care. The field test sites commenced in May 2019 and have been ongoing since then. The new metrics were intended to replace the 4 hour waiting time standard for emergency care, however, earlier this year NHS England confirmed that they had agreed with the government that the 4 hour standard would remain. As a result the Trust will be returning to managing and reporting against a 4 hour standard for urgent and emergency care in 2023/24.

As part of the field test pilot, the urgent and emergency care standards focused on within the Trust were:

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

ED New Indicators - Time to Initial Assessment in A+E													
Target = 15	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2021/22	**24**	18	19	18	26	23	27	25	28	25	24	23	26
2022/23	**35**	25	27	26	26	25	33	38	37	60	36	37	26

ED New Indicators- Time to be seen by a Clinician													
Target = 60	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2021/22	**161**	122	142	144	190	162	171	170	174	169	162	175	164
2022/23	**183**	173	191	196	201	182	201	194	203	213	151	159	145

ED New Indicators - Mean Total Wait in A+E													
Target = 200	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2021/22	**306**	235	258	266	325	317	317	324	338	336	319	324	334
2022/23	**357**	340	342	348	348	343	371	366	373	409	337	340	303

Work has been ongoing through the Acute Care Transformation Programme throughout the year to deliver improvements in urgent care pathways and ensure more timely treatment for patients.

In line with the national expectation set out in the operational planning guidance, the Trust will return to reporting against the 4 hour standard in 2023/24. The national target is to achieve 76% of patients being seen, treated and admitted or discharged within 4 hours by March 2024, with further improvement expected in 2024/25.

Cancer National Waiting Times

Trust performance against national waiting times for cancer services 2015/16, 2016/17, 2017/18, 2018/19, 2019/20, 2020/21, 2021/22 and 2022/23:

Metric	Target	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	95.12%	95.89%	95.1%	93.8%	93.2%	92.6%	93.6%	81.2%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	97.43%	94.98%	90.9%	85.7%	87.1%	74.7%	89%	90.4%
Cancer 31 day wait from decision to treat to first treatment	96%	98.82%	99.21%	97.6%	97.6%	97.5%	95.4%	95.6%	97.6%
Cancer 31 day wait for 2nd or subsequent treatment – surgery	94%	98.67%	96.85%	98.8%	98.5%	95.5%	94.9%	98%	100%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	88.46%	86.93%	84%	81.3%	76.9%	64.8%	73.9%	69.3%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	98.20%	96.28%	90.8%	94.9%	92.5%	86.8%	88.3%	91%
Consultant Upgrade	TBC	94.72%	91.95%	92.8%	88.5%	87.3%	89.2%	88.1%	89.8%

(Source: InfoFlex/Open Exeter)

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

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

Cancer Standards 62 Day 2022/23	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	83.5%	69.1%	64.9%	70.8%	71%	61.8%	75.2%	62.5%	68%	67%	67.9%	69.9%
Numerator	43	57	48	40	46.5	53.5	57.5	42.5	52	37.5	56	47.5
Denominator	51.5	82.5	74	56.5	65.5	86.5	76.5	68	76.5	56	82.5	68

Performance Against Targets

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

Screening

Screening targets were met in three out of four quarters with colleagues working hard to ensure patients are seen in a timely manner as per the national requirements. This was only possible given the significant improvement of our endoscopy waiting times delivered the year before, such that the bowel screening backlog was eliminated. Achieving screening targets can be challenging due to the small numbers of patients within the screening programme – the under-performance in the final quarter related to a total of four patients across the three months.

62 Day Cancer Waiting times:

Timely management of patients referred onto the cancer pathway is an important focus for the Trust. Following the significant reduction in some key cancer activity in 2020/21 based on national guidance, there has been a backlog of activity to manage within our cancer pathways. In 2022/23 the key national ask within the National Operational Planning Guidance was for us to focus on patients waiting over 62 days and ensure these were reduced to 56 or fewer, which the Trust achieved, with only 42 patients waiting over 62 days at the end of the year. This shift in focus nationally was in part to recognise that the pre-pandemic standards may be unachievable in the medium term, but a focus on shorter waiting times is critical to longer-term recovery. The Trust remained non-compliant with the 62-day standard of 85% of patients being treated within that timeframe following urgent referral from their GP.

The Trust monitored performance against the new national 28-day cancer Faster Diagnosis Standard throughout the year. This new standard requires patients to be given a confirmed diagnosis within 28 days of referral, in order to ensure more patients with and without cancer receive this confirmed diagnosis much faster. The Trust is not yet consistently meeting this standard, and that will need to be a major focus for 2023/24, A small Cancer Improvement team was recruited in Quarter 3 2022/23, in order to support the Trust's pathway improvement work within the most challenged tumour sites (in particular Lower Gastrointestinal and Urological cancers), with the aim to improve our performance against this standard. This small team helped ensure we delivered a steady improvement against the Faster Diagnosis standard over the last few months of the year, such that the standard was met in March 2023. A number of other additional roles have been supported by non-recurrent Cancer Alliance monies, which will enable positive pathway changes to take place and ensure closer connections with our cancer patients in order to deliver more timely access to care.

Incidence of C.Difficile

Number of reported cases of C.diff													
Target = <24 Target <19 in 2022/23	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2021/22	**26**	2	1	3	2	0	1	2	2	6	3	2	2
Target =<19	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2022/23	**37**	4	0	3	3	0	5	5	2	4	5	2	4

(Source: Trust Winpath System)

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

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

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

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	2020/21		2021/22		2022/23	
			*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	22	>26	26	-	37	>19
Number of cases - MRSA	x	x	0	0	1	0	0	0
Delayed transfers of care	x	x	not reported	3.50%	not reported	3.50%	not reported	No longer an indicator
Infant health & inequalities: breastfeeding initiation	x	x	66.90%	66%	67.60%	66%	Indicator changed in 22/23	
Babies with a first feed of breast milk (percent)							57.50%	70%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	91.00%	95%	95.40%	95%	96.59%	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	61.20%	90%	71.50%	90%	52.20%	90%
Non - Admitted	x	x	82.00%	95%	81.10%	95%	73.90%	95%
Incomplete	x	x	65.23%	92%	81.10%	92%	69.60%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	46.50%	Less than 1%	18.20%	Less than 1%	9.80%	Less than 1%
Cancelled operations for non-medical reasons	x		0.83%	0.80%	1.79%	0.80%	2.02%	
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		92.90%	90%	92.90%	90%	91.60%	90%
Patients who spend at least 90% of their time on a stroke unit	x		25.61% (end Oct)	80%	not reported	80%	No longer an indicator	
Higher risk Transient Ischaemic Attack cases who are scanned and treated within 24 hours	x		75% (end Oct)	60%	not reported	60%	No longer an indicator	
Elective Adult patients 18years and over readmitted to hospital within 30 days of discharge from hospital	x		2.32%	6%	2.29%	6%	2.26%	6%
Non-Elective Adult patients 18 years and over readmitted to hospital within 30 days of discharge from hospital	x		12.08%	12.50%	11.66%	12.50%	11.68%	12.50%
Elective patients 0-17 years readmitted to hospital within 30 days of discharge from hospital	x		1.22%	3%	0.96%	3%	0.88%	3%
Non-Elective 0-17 years patients readmitted to hospital within 30 days of discharge from hospital	x		11.99%	10.40%	9.93%	10.40%	10.04%	10.40%
Ensuring patients have a positive experience of care (Pt survey overall score)	x	x	2020 Survey results to be published November 2021	-	Awaited	-	Awaited	-
Patients waiting no more than 31 days for second or subsequent cancer treatment					Cancer data April - Dec 2021		Cancer data April 2022 – March 2023	
Anti-Cancer Drug Treatments - Chemotherapy	x		100%	98%	100%	98%	100%	98%
Surgery	x		94.90%	94%	98.00%	94%	100%	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		86.80%	90%	88.30%	90%	91%	90%
Urgent GP Referral	x		64.80%	85%	73.90%	85%	69.3%	85%
31-Day Wait for First Treatment (Diagnosis to Treatment)								

All cancers	x		95.40%	96%	95.60%	96%	97.6%	96%
Two week wait from referral to date first seen								
All cancers (%)	x		92.60%	93%	93.60%	93%	81.2%	93%
For symptomatic breast patients (cancer not initially suspected)	x		74.70%	93%	89.00%	93%	90.4%	93%
SHMI	x							

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

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

Statement on behalf of the Council of Governors

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

We believe that the report is an accurate and true reflection in terms of actions taken by the Trust during the year 2022/23 and provides some clear objectives for quality improvement in the near term.

In 2022 the Trust once again welcomed the Care Quality Commission who carried out inspections at the Trust. The Governors were concerned that enforcement action was taken against the Trust during the previous year and that more conditions were applied in 2022.

The Governors are very pleased that because of the work of colleagues across the Trust, led by our Chief Nurse, all of the conditions that were put in place have now been lifted and there are no sanctions against the Trust. We are hopeful that the Trust can meet its aim to be an outstanding Trust in the near future.

The Governors know that the most important asset of TRFT are our colleagues and so staff health and wellbeing and morale are key to driving continual quality improvement. The recent staff survey results from 2022 showed an improvement in that regard. It is an area that the Governors continue to take an interest in and monitor.

We are also pleased that over time the SHMI mortality measurements for the Trust have dropped and have stabilised.

Performance against national indicators for cancer referrals have again improved overall. However, there are still areas where the national targets are not met including the 2 week wait for all urgent referrals which is concerning to the Governors.

The numbers of patients that wait more than 18 weeks for treatment has also increased substantially.

The Governors are aware that a number of changes and initiatives have been implemented to address previous issues and that overall, the Quality Improvement Programme is developing well, with a clear plan that is being delivered and resulting in some positive outcomes.

We are assured that there is a clear, continued focus on the quality improvement plan across TRFT as we develop our collaboration further with the ICS partners.

The Council of Governors want to take this opportunity to again thank the NHS staff within the Trust and the community, for their dedication, hard work, compassion and diligence in continuing to help and support our patients in challenging times.

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

Gavin Rimmer
Lead Governor, The Rotherham Foundation Trust

Statement from NHS South Yorkshire ICB

South Yorkshire Integrated Care Board
Rotherham Place
Oak House
Moorhead Way
Rotherham
S66 1YY

4 May 2023

Helen Dobson
Chief Nurse
TRFT

Dear Helen

TRFT Annual Quality Account

2022/23 continued to see all the NHS push and strive for "business as usual" following the pandemic. NHS South Yorkshire Integrated Care Board (ICB) Rotherham PLACE, commend The Rotherham NHS Foundation Trust (TRFT) for the continuous commitment that they have shown in delivering safe and effective care to patients throughout the year.

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

The ICB are particularly keen to highlight a few of TRFT's achievements: -

- Due to the conditions placed by CQC following previous Inspections the ICB are incredibly pleased that following significant and continued work by the Trust these conditions were removed from the Trust's Certificate of Registration at the end of March. This means that for the first time since 2015 they do not have a regulated sanction against them and supports their journey towards an Outstanding Trust.
- Continued improvement for the reduction in HSMR and SHMI mortality scores over the past year demonstrating a picture of not above national average.

- The Trust's drive to understand Learning from Deaths and the robust processes aligned to the Medical Examiners' role and Structured Judgment Reviews.
- The Trust has reported no Never Events.

The ICB is supportive of TRFT's vision to become an outsanding trust by delivering excellent care across inpatient and commuinty settings. TRFT are taking their entire workforce on the journey with each and everyone having a role and repsonibility to achive their Quality Improvement outcomes. The key quality priorities for 2023/2024 which sit under Patient Safety, Patient Experience and Clinical Effectieveness have been developed via a consultation process with communcations involving collegues and governors married with the triangulation method of outcomes from complaints/compliments, patient feedback, incidents and risks thus ensuring a reflection of the current patient need.

Yours sincerely

Sue Cassin
Chief Nurse
NHS SY ICB Rotherham Place

Jason Page
Medical Director
NHS SY ICB Rotherham Place

Statement from Healthwatch Rotherham

The Rotherham Foundation Trust (TRFT) Quality Account 2022/23

These comments are provided on behalf of Healthwatch Rotherham.
This year, Healthwatch Rotherham is excited about the chance to participate in the Rotherham Foundation Trust Quality Account. Though there are still some things that could be done better, given how the pandemic has affected the healthcare system as a whole, the accomplishment of TRFT is still a commendable step forward. Healthwatch Rotherham would like to congratulate the Trust for their efforts to achieve and maintain quality.

This report demonstrates the Trust's desire to ensure the quality and safety of the services provided, as well as its commitment to a framework for quality improvement that values the opinions of patients, families, carers, and co-workers and actively seeks to understand them. It is admirable that efforts are being made to provide 24-hour assistance for patients who have dementia or delirium and to collaborate with community organisations to provide care for patients who have learning disabilities and autism. A major step towards ensuring a better patient experience at the TRFT Hospital goes hand in hand with Trust's efforts to ensure the staff's health and well-being in this post-pandemic environment.

Based on the comments we hear from patients during outreach campaigns, we are confident that The Rotherham Foundation Trust is paying attention to what patients want and is acting to deliver it, enabling patients to make informed choices about their care and treatment. Furthermore, Healthwatch Rotherham is eager to see the development of a solid system to track progress and make adjustments in response to patient feedback. We appreciate the chance to participate in the Patient Experience Group and the Patient Information Group, where we can see how services are being improved, and we look forward to working with The Rotherham Foundation Trust in the future to make sure that patient voices are heard and no community feels left out.

Eldho Baslin Rajan
Service Manager
Healthwatch Rotherham

Health Select Commission Stakeholder Statement

The Health Select Commission members would like to express their appreciation for the opportunity to provide feedback on the draft Quality Account for 2022/23. We acknowledge the ongoing improvement journey of the Trust, particularly in the urgent and emergency care domain, and we remain confident in its progress. The commitment to continuous improvement aligns with the priorities of Rotherham Residents, which is highly valued.

After reviewing the draft, our members observed evidence of learning from serious incidents. We understand that quality accounts do not include narratives about processes that sit behind and respond to quality measures are not included in a quality account. However, we would welcome more information on how the Trust is monitoring progress towards quantifiable goals. We intend to explore these questions further in our ongoing dialogue with the Trust's leadership, who have demonstrated active and consistent participation in public scrutiny.

While we acknowledge that the draft may not reflect prevention work related to promoting physical activity and smoking cessation, we believe this work is essential due to its positive impact on lives. Our members emphasise the importance of pursuing a higher quality of life for patients within the health sector, with the objective of promoting healthy living rather than solely focusing on the flow of people through services.

Additionally, we have concerns about the response of local services to the inverse relationship between a person's willingness to seek medical attention and their urgent need for it. It is disheartening to witness deteriorating wait times for services related to cancer. We hope the Trust will address these concerns and work towards improving access to timely care.

We have taken note of the staff survey returns, which indicate that the Trust's performance is above average on all headline measures. We encourage the Trust to continue collaborating with Healthwatch Rotherham to monitor the experiences of residents and ensure their voices are heard.

Finally, on behalf of the people of Rotherham, we extend our sincere gratitude for your hard work and dedication in caring for residents during their times of need. Your efforts are deeply appreciated.

Sincerely,
Taiba K. Yasseen
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 England 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 2022/23
- 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 2022 to 31 March 2023
    - papers relating to quality reported to the Board over the period April 2022 to 31 March 2023
    - feedback from governors dated 15 May 2023
    - feedback from NHS South Yorkshire ICB received 4 May 2023
    - feedback from local Healthwatch organisation dated 11 May 2023
    - feedback from Health Select Commission received 16 May 2023
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2023
    - the national patient survey published September 2022
    - the National Staff Survey 2022 published 9 March 2023
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated June 2023 (approved at Audit Committee on 20 June 2023)
    - CQC inspection report dated 29 September 2021

- the Quality Account presents a balanced picture of The Rotherham NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Account has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account

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

By order of the Board

Chairman
June 2023

Chief Executive
June 2023

Appendix 1: Review of Local Clinical Audits

The reports of 114 clinical audits were reviewed by the provider in 2022-2023 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, Radiology	Polytrauma computerised tomography waiting time 2019	A re-audit will be undertaken to ascertain status after the remarkable events and changes to practise due to the COVID-19 Pandemic	R1225
Anaesthetics	Assessing compliance of perioperative blood transfusion protocol in patients undergoing surgery for fracture neck of femur	Re-circulate the updated 'Protocol for anaesthetic management of patients undergoing surgery for fractured neck of femur' within the department. Liaise with Theatre recovery staff to ensure consistent availability of working equipment. All patients undergoing surgery should have an immediate postoperative point-of-care Hb check in the post anaesthesia care unit, making adequate plans for appropriate blood transfusion if necessary. Disseminate audit findings within the anaesthetics, trauma and orthopaedics department and the anaesthetic team.	S2107
Anaesthetics	Prophylactic use of Antacid in Caesarean Section patients	Audit showed that overall compliance with national and local guideline is good. Results showed that sodium citrate need not be used regularly. It can be taken out of local guidelines, but still needs to be available if required.	S2003
Anaesthetics	An audit to see if the Fractured Rib Trust guidelines are being followed	A meeting with the Frailty Team to be arranged to discuss requirements and review the referral process. Ensure that the focus is on the assessment of pain scores for assurance of pain control. Review patients presenting at A&E in real time with a follow up on admission and continue to educate staff focussing on the safe use of non-steroidal anti-inflammatory drugs	S2078

Anaesthetics	Assessing compliance of postoperative blood transfusion protocol in patients undergoing surgery for fracture neck of femur	Presentation and discussion of audit findings with the anaesthetics and post anaesthesia care unit (PACU), in order to discuss availability of appropriate point-of-care devices in theatre recovery. This re-audit showed some improvement in PACU haemoglobin checks, which improved from 45% to 57%, however the rate of compliance to PACU Hb-check was still lower than expected local standards.	S2155
Community Adult Services	Quality of Radiographs in Barnsley, Doncaster and Rotherham Community Dental Service July 1st 2021 - December 31st December 2021	Contact all Practitioners to ensure awareness of the required standards and care in completion of radiographs. Encourage the software company to create more reports to allow analysis of a larger sample for the next annual audit. Share results and learning at next joint service staff meeting.	R1360
Community Adult Services	Audit of the quality of paediatric new patient referrals to Doncaster Community Dental Service	To standardise paediatric referrals from across all three areas, Rotherham, Barnsley & Doncaster. To contact all General Dental Practitioners in the Doncaster area to inform as to what should be included in the referral including date of x-rays and school attended.	R1364
Community Adult Services	Is accurate periodontal screening being undertaken in children and adolescents under 18	To ensure that treatment required was accurately documented, together with any follow up treatment. To be re-audited in a year to ensure that changes have been embedded in practice.	R1321
Community Adult Services	Community Dental Service Antibiotic Prescribing Re-audit 2021	The audit showed that antibiotic prescribing had increased, but this was deemed to be understandable since the data had been collected during the pandemic. No other concerns noted, and no further training was indicated.	R1326
Community Adult Services	Audit of the quality of paediatric new patient referrals to Rotherham Community Dental Service from Bassetlaw	The contents of the referral form will be reviewed. Details of x-rays and school attended should be added. A letter should be sent out to all Dental Practitioners in the Bassetlaw area summarising findings of the audit and standards	R1362

		for what should be included in referrals.	
Community Adult Services	Audit of the quality of paediatric new patient referrals to Rotherham Community Dental Service	The contents of the referral form will be reviewed. Details of x-rays and school attended should be added. A letter should be sent out to all Dental Practitioners in the Rotherham Community Dental Service summarising findings of the audit and standards for what should be included in referrals.	R1363
Community Adult Services	How well is frailty identified and Do Not Attempt Cardiopulmonary Resuscitation discussed within care homes in Rotherham	Frailty scores must be completed, and patients triaged accordingly together with appropriate medication review.	S2095
Community Adult Services	Patient Notes Audit - Rotherham Ear care and Audiology Service	Audit findings will be discussed with all members of staff within Audiology and Ear care. Any improvement plans within relevant areas will be rolled out to staff as part of staff development and training.	S2128
CYP Service	Audit of Midwife to Health Visitor handover template 2021	Midwifery Team Leaders to disseminate audit findings to their staff at Midwifery team meetings and Midwives reminded to complete the template as per the Standard Operating Procedure.	R1252
CYP Service	Audit of 'Was not brought' policy 2021	Renew & review the 'Was Not Brought policy' in line with current guidelines & procedures. To produce a template to use on Meditech for professionals to use.	R1319
CYP Service	UNICEF Baby Friendly Initiative Audit of Staff Education (Q3 2021-22)	An updated training programme to be delivered in 2022, to increase staff knowledge and skills in the areas not meeting UNICEF Baby Friendly Initiative standards. All new staff to complete 2-day Infant Feeding Training within 6 months of employment. Recruit at least 1 champion for each 0-19 Team. Establish regular meetings to disseminate information and discuss infant feeding initiatives. Champions to have access to further training. 0-19 Team Managers to support Champions role development. Use of	R1329

		Breastfeeding Assessment Tool and Feeding checklists to be incorporated into all training curriculum. 0-19 Infant Feeding newsletter to inform on current issues to be collated and distributed to all staff every 2-3 months	
CYP Service	Re-audit of the use of the Ante Natal SOP in 0-19 service	Ante Natal exception reports to include all non-completed Antenatal assessment templates. Staff to be reminded to ensure effective and robust liaison with midwifery services especially where safeguarding issues have been identified	R1370
CYP Service	Adherence to NICE guidelines on management of Nocturnal Enuresis	Offer regular health promotion / prevention activities for hospital Paediatric staff, 0- 19 service, GPs and schools. To establish a training programme to Special Educational Needs Co-Ordinator staff. To continue to offer regular training for the 0-19 service. Enuresis admin staff to attach a copy of the management of nocturnal enuresis pathway to the GP, together with the referral form.	R1375
CYP Service	Audit of paediatric contacts of Tuberculosis referred for screening	Develop local Tuberculosis Pathway SOP for management of referral.	S1980
CYP Service	Safe Sleep Assessment in 0-19s Re-audit 2022	Audit results to be shared with service staff who will be reminded to follow the Safe Sleep Standard Operating Procedure. 0-19 Service staff to be reminded to complete Safe Sleep Questionnaires, and to repeat the assessment if any concerns are identified. Results to be presented at the Clinical Effectiveness Forum. The audit to be repeated in January 2023. Data collection methodology to be reviewed before this to facilitate a larger sample.	R1388
CYP Service	Re-audit of the use of the Young Persons Team SOP in 0-19 service	To determine if the Friends and Family questionnaire can be sent electronically to young parents. To review the current staffing against the caseload numbers to	R1399

		ensure that the appropriate amounts of staff are within the service.	
CYP Service	Was not brought to children's out-patients audit (Quarter 1, 2022-23)	Amend questions on the audit template in line with the new 'Was not Brought' policy. To ensure 'Was not Brought' template is accessible on Meditech. Staff to have access to the database of 'Was not Brought' children.	R1424
CYP Service	Audit of Bleeps during teaching and handovers	To raise awareness of medical staff teaching and handover times amongst all clinical staff, ensuring non urgent issues do not interfere with these times. Junior staff to check in with ward areas before attending scheduled teaching and handover periods. To allocate a junior doctor to the re-audit when appropriate.	R1426
CYP Service	Evaluation of neonatal parenteral nutrition prescribing on special care baby unit	Total Parenteral Nutrition guideline to be produced.	R1365
CYP Service	Fostering and Adoption Clinic: Re-audit of Action Plans (2022)	Talk to Doctors who undertake looked after children medicals to inform them that all health recommendations should be completed in a SMART way and by specific date. This will be monitored via a Quality Assurance tool which is completed by the Looked After Children Designated doctor who can raise the issues with the individual doctor.	R1366
CYP Service	Audit of Jaundice CG98 Guideline: Jaundice in Newborn Babies Under 28 days	Head of Midwifery to be contacted regarding the joint bilirubin chasing responsibility (senior house officer (SHO)/Midwife). A bleep number will be added to the Meditech request for Bilirubin and this recommendation will be added to the local guideline.	R1443
CYP Service	Re-audit of Paediatric Child Protection Medical Assessment done in Clinics/ wards 2022-23	Develop an electronic Child Protection Medical Assessment Provisional Report proforma, the contents of which to be agreed with the Consultant Paediatricians and Rotherham Safeguarding Partners. Develop and agree the process for completion and signing off by Consultant. Use standard	R1433

		template to obtain written consent from Parent/Carer for the Child Protection Medical Assessment and ensure this is scanned to Meditech and disseminate this process with all new starters. Review Child Protection Medical Assessment medical proforma to ensure chaperone documented and request amendments with Information Technology. Develop competencies for new starters to the Trust to complete for completion of Child Protection Medical Assessment to sign off by clinical supervisor and disseminate the competencies with the training programme.	
CYP Service	Re-audit of Antimicrobial Stewardship in Paediatrics	Discuss the correct documentation regarding the time given, to improve prompt antibiotics administration, with the nurse educators/ward manager. To show colleagues how to access the antibiotic guideline via email and advise regarding documentation of deviations from the policy.	R1392
CYP, Safeguarding	Safeguarding Documentation Audit on the children's ward (voice of the child, evidence of practitioner thinking check and Think Families approach)	Recirculate genogram reference guide and tools and reinforce at safeguarding supervision and training with medical colleagues. Develop Meditech documentation to include Think family prompts for medical colleagues. Promote Think family training for nursing and medical teams to increase knowledge and promote professional curiosity.	R1345
CYP, Safeguarding	Monthly Re-audit of body maps in Children and Young People (CYP) (2021/22)	Add checklist sticker including body map reminder. Disseminate draft of complete body map and training. Discuss body map with named consultant for the case and include a copy body map with final report to External Agency	S2075
CYP, Safeguarding	Re-audit of Paediatric Child Protection Medicals in clinics/Wards	Standardise the Child Protection Medical Assessment to ensure adherence to record keeping and written communications policy. Create SOP/guide for completing	S2091

		Child protection Medical on Meditech and embed digital proforma for use during an annual review of Child Protection Medical Assessment next year.	
Dermatology	Psoriasis Audit for Patients on Systemic Therapy	Dermatology Nurse Consultant to write proformas for education and to increase working of day to day procedures for the treatment and management of certain dermatological conditions. Education sessions will be run to support the team, together with presentation of lessons learned at local Clinical Governance meeting.	S1913
Dermatology	Audit of 2 week wait referrals for primary care	Restart Rotherham's 'Skin Matters' meetings where training is provided to GP/primary care colleagues.	R1408
Dermatology	Audit of quality of documentation related to 2 week wait referrals - initial appointment	Develop new referral clerking proforma to ensure ease of documentation.	R1409
Endoscopy	Audit of Post Colonoscopy Cancer diagnosis 2020	Remind endoscopists at 6 monthly appraisal of Key indicators of good performance. Prepare business case for video capture in endoscopy theatre.	S1990
Endoscopy	Audit of all Key Performance Indicators - July - December 2021	To discuss Key Performance Indicators with all endoscopists in appraisals.	S2063
Endoscopy	Audit of unplanned Admissions within 8 days (January 2021 – Dec 2021)	Present deaths and re admissions in a timely manner using Power BI.	S2071
Endoscopy	Audit of unplanned Admissions within 8 days (Jan 2020 - December 2020)	Individual cases should be analysed to identify learning outcomes, which will likely be done through governance and other meetings. Set up Power BI for monthly re-audit as per Joint Accreditation Group.	S2012
Endoscopy	Audit of Patient Comfort Scores	Modify the questionnaire to be used in a future re-audit to include session, endoscopist and date and explore ways to improve patient capture.	S2066
Endoscopy	Re-audit of Polypectomy Surveillance (July - December 2021)	Create and display a poster of new Polypectomy Surveillance guideline, and also disseminate via e-mail. Creation of validation pathway for polypectomy	S2067

		surveillance and documentation about intention of follow up and justification for deviance from guideline if applicable.	
Endoscopy	Audit of the World Health Organisation (WHO) safety checklist/Team brief (Q3 2021-22)	Reminded staff to remain compliant with filling out the WHO checklist. Create Team Brief proforma and ensure Team Brief takes place before every endoscopy list.	S2070
Endoscopy	Re-audit of Repeat endoscopy within 12 weeks for gastric ulcer	Create posters with standards and recommendations to ensure that all endoscopists are aware of guidelines. Create a mandatory checklist for patients diagnosed with gastric ulcer with following tick boxes: - has the patient been informed of diagnoses and need to repeat scope - does the patient agree - if yes has an ambulance order been completed for repeat Oesophago Gastro Duodenoscopy in 12 weeks. If a repeat Oesophago Gastro Duodenoscopy is not recommended due to comorbidities ensure this is recorded. If a repeat Oesophago Gastro Duodenoscopy is needed ensure a letter is sent to the GP by the consultant.	R1414
Endoscopy	National audit of Post Colonoscopy Colorectal Cancer (2022)	To implement complex polyp pathway and monitor outcomes. To audit the quality of the bowel preparation and make sure that patients with poor preparation are booked for repeat colonoscopy. To undertake a Bi-annual appraisal of endoscopists key performance indicators and provide individual feedback. Surgery Governance and Clinical Support Unit (CSU) leads to be informed formally of governance issues related to patient management identified during this audit.	S2119
Endoscopy	A Re-Audit Examining the Incidence of Post-colonoscopy Colorectal Cancers Among Patients	Implement complex polyp pathway and monitor outcomes. Surgery Governance and Clinical Support Unit leads to be informed of the issues related to patient	R1396

	Diagnosed with Colorectal Cancer in 2021.	management identified during the audit.	
General Surgery	Management of Sigmoid Volvulus in Frail Patients	Devise CSU guidelines of how to deal with sigmoid volvulus	S2039
General Surgery	Assessing quality standards of upper Gastro Intestinal endoscopy at The Rotherham Foundation Trust (TRFT)	Photo recommendations showing British Society of Gastroenterology and Association of Upper Gastrointestinal Surgeons Guidance to be located in every room. Consider mucolytics (N-acetylcysteine), defoaming agents (Simethicone) and pump-controlled jet for mucosal visualization with clear photos for Medicolegal purposes. Staff to be reminded to document Time (start to finish not entry to exit time), J-manoeuvre details and any other findings, including nothing abnormal detected. To ensure Barrett's reporting and biopsy according to Prague criteria, and Barret's diagram to ensure accurate biopsy sampling-add on timing. In normal dysphagia cases take oesophageal biopsies to exclude eosinophilic oesophagitis. Undertake Gastro-Oesophageal Junction length (Z-line) and diaphragm pinch for Hiatus Hernia. Display the 'Biopsies in Iron Deficient Anaemia' recommendation on a laminated sheet in clinical areas. To share the guidance document with department staff and all stake holders and discuss in Endoscopy User Group. To re-audit in 6 months.	R1413
General Surgery	Audit of pre-operative iron infusion for colorectal cancer patients	To update the Local Guideline and educate pre-operative assessment staff with reference to the threshold for iron infusion, with intravenous iron being the first line treatment unless contraindicated. The protocol regarding further iron infusion if the repeated haemoglobin after first infusion does not meet target of 130g/dL will also be clarified.	R1432

General Surgery	Same day emergency care waiting times	Consideration to be given to the introduction of a triage system and a dedicated trolley space for SDEC patients to facilitate prompt IV availability	R1459
Genitourinary Medicine	British Association for Sexual Health & HIV 2021 national Audit – Post Exposure Prophylaxis pathways	Individuals attending for Post Exposure Prophylaxis should be issued with the complete course as opposed to 5-day starter pack.	R1343
Genitourinary Medicine	Monitoring Fracture Risk Assessment Tool scores in people with HIV aged over 50	All staff to be reminded to complete fracture risk assessment scores, calculated using the British HIV Association tool. An audit of compliance to be undertaken.	R1368
Genitourinary Medicine	Assessing Human papillomavirus vaccine provision for men who have sex with men (MSM) aged 45 and under at the Rotherham Sexual Health Services clinic	Clinical and administrative staff have been informed of ways to improve provision of Human papillomavirus vaccine at the Rotherham Sexual Health Service clinic. Wrongly coded and declined vaccinations have been coded appropriately.	R1454
Haematology	Consolidation and improvement of Chemotherapy Initiation documentation with customised systemic cancer consent forms	Re-assess practice to ensure that consent forms and pre-prescription checklists are completed and filed consistently with patient notes. Re-educate staff in improved practice and repeat audit following change to ensure implementation.	R1296
Haematology	Haematology Phone Assessment Record against evidence-based UK Oncology Nursing Society's rapid assessment and access	Following patient phone contact Haematology will contact Urgent & Emergency Care Centre (UECC) staff to make aware of planned attendance by patient forwarding patient summary and anticipated intervention plan i.e. possible neutropenic sepsis. A copy of the completed phone assessment record is then emailed to UECC reception whereupon it will be attached to the patients' electronic record. Staff training will embed this process followed by re-audit to provide assurance that the new process is effective.	S2001
Haematology	Standardising Practice for Venesection patients with Hemochromatosis and Erythrocytosis	Medical Teams will continue to work to British Society for Haematology 2018 guidelines & Venesection Best Practice Guidance Standard Operating Procedure. Patients will complete	S2103

		a hemochromatosis assessment on Meditech. More patients will be encouraged to donate blood once within the maintenance phase. Improved provision of patient information on self-management and updated training packages for Clinicians will lead to an improvement in the level of patient care and outcomes.	
Lab Medicine	NHS Blood and Transplant 2019 National Comparative Re-audit of the Medical Use of Red Cells	Include hotlink tile on trust intranet to NHS Blood Transfusion patient information leaflet as additional electronic format, and reference to direct patient if electronic version preferred.	R1134
Lab Medicine	Annual Re-audit of Integrated Care Pathway 2021	Transfusion team to continue to promote culture of Haemovigilance with specific focus on the Safe Bedside Checklist, Consent, Competency Compliance and Observation Completion. The importance of quality and accuracy of all documentation to be stressed to all staff. To utilise Meditech for the scanning information into the electronic patient record, to assist with ease of access to this information. Revise the audit tool so the discharge summary question is completed to ensure compliance with 2020 recommendation for consent. Training to be monitored following the drop-in compliance identified. Scheduled audits to be continued.	R1403
Medicine	Outpatient Management of Pulmonary Embolism in the Same Day Emergency Care Department	Liaise with Information Technology to implement improvement in documenting Wells score requirement when ordering ultrasound scans in order to become compliant with NICE guidance. Propose and design a pilot flow chart incorporating Pulmonary Embolism Severity Index scores, discharge section for the management of patients with confirmed pulmonary embolism.	S2079
Medicine	Antibiotic Audit	Contact Information Technology Department to introduce a reminder for an end date when	R1383

		prescribing antimicrobials. Use coloured posters as a reminder for the appropriate antibiotic prescription in the Acute Medical Unit doctors' office. Contact all TRFT Doctors to consider stop/review date when prescribing antibiotics and to consider reviewing intravenous antibiotic prescriptions.	
Medicine	Re-audit of Management of Acute Kidney Injury patients in Acute Medical Unit (AMU)	All acute kidney injury patients to be discussed at the renal departmental team meeting. All patients must have urine dip stick, midstream specimen of urine, input/output charting started by nursing staff and an ultrasound of the kidneys, ureters and bladder ultrasound for all stage 3 patients.	S1866
Medicine	Quality of Dementia care in TRFT	After dementia screening and review of past medical history, staff should ensure the “forget me not” scheme is activated in the patient summary in order to denote dementia diagnosis. Ensure that information is cascaded to electronic patient record and SEPIA. New staff to be educated in the use of “This is Me” and established staff to be reminded to ensure document is used. Discharge plans to be completed and prepared in a timely manner and doctors to be encouraged to consider Advanced Care Planning.	S2083
Medicine	Re-Audit on care of Diabetic Foot Care in AMU (TRFT)	Ensure that a poster is displayed in the doctor's office within the acute medical unit to highlight referral of diabetic patients to multidisciplinary team foot care services within 24hours of examination of a diabetic foot.	S2117
Medicine	Audit of management of Patients with New Atrial Fibrillation in TRFT	Anticoagulation should be offered to patients with paroxysmal atrial fibrillation if indicated by scores. CHA2DS2-VASC score will be calculated and documented for all patients with new atrial fibrillation. For female patients, if the CHA2DS2-VASC score is 1 then	S2139

		anticoagulation should not be given for stroke prevention. ORBIT score will be calculated and documented for all patients with a new diagnosis of atrial fibrillation. Anaemia will be investigated as necessary and treated if identified.	
O&G	Management of massive obstetric haemorrhage	Disseminate information on Labour Ward via Learning Points to: Effectively communicate with the appropriate staff at appropriate times – Senior staff to be involved early if haemodynamic instability even if the blood loss is not 1.5 lit. Inform Consultant at 1000 mls and Consultant to attend at 1500 mls if ongoing or earlier if unstable. Accurately measure of blood loss in room and in theatre - check on any blood loss prior to transfer to theatre. Weigh all swabs as soon as blood loss >500 mls. Crib sheet to be completed, scanned and uploaded onto Meditech Teaching sessions on: 1. Difficult delivery at C sections at full dilatation 2. Management of Massive Obstetric Haemorrhage	R1359
O&G	Re-audit of the Management of Maternal Anaemia and Iron Deficiency a Global assessment -	Discuss changing the protocol for borderline HB of 105 - 110 at 28 weeks, to review at 32-34 weeks, to improve management of late onset anaemia.	R1302
O&G	Audit of infant Safe sleep in hospital based paediatric and maternity services (Sept – Dec 2021)	Dissemination of Learning Points to promote the fact that safe sleeping is a process which begins from birth not from discharge, and reiterate the importance of providing guidance to parents as soon as possible following birth so that questions can be raised prior to discharge.	R1334
O&G	Midwife 0-19 service handover antenatal (Quarter 2 July 2021)	Target work with identified midwives not completing the antenatal handover template	R1354
O&G	Personalised Care Plan and Risk Assessment Ockenden Audit	Make ‘Risk Assessment’ Tab Mandatory; Add ‘Intended place of Birth’ into the Risk Assessment at subsequent appointments; Re - model Personalised Care Plans	R1393

		with co-production of service users and Community/Greenoaks midwifes. Lead midwives in Community, Greenoaks and the Acute to relaunch Personalised Care Plan in all areas. Improve staff engagement to improve compliance. Matron to put Ockenden audits onto Tendable for Community.	
O&G	Audit on Obstetric Anal Sphincter Injury	Discuss ways to use Pelvic floor funding to improve Obstetric Anal Sphincter Injury detection and postnatal care. Improve swab count process by implementing second count by a different person.	S2048
O&G	Elective caesarean section audit	Staff education regarding documenting evidence of information leaflet being given on consent form. Sticker to go in notes or leaflet to give patients, outlining risks and benefits of e.g. antenatal steroids and C-section. Write a reminder on whiteboard reminding staff of requirement of population, intervention, comparator and outcomes for Body Mass Index>35 and indications for post-op antibiotics. Change local guidelines to say 'if opioids are prescribed, laxatives should be prescribed concurrently'. Discuss laxative prescription with opioids with Meditech staff regarding adding laxatives as a suggested prescription when opioids are prescribed (similar to how oxygen is suggested)	S2121
O&G	Clinical Negligence Scheme for Trusts (CNST) Assurance - Perinatal Mortality Review Tool	Facilitate increased access to the Maternal, Newborn and Infant Clinical Outcome Review Programme database to complete the notification, surveillance and inputting of data.	R1333
O&G	Audit of babies under transitional care throughout 2021 (CNST, 3)	Introduce and embed a daily neonatal huddle with maternity staff, paediatric Senior House Officer (SHO), registrar, consultant	R1341

		and nurse in charge on Special Care Baby Unit and Wharncliffe Ward.	
O&G	Re-audit the risk assessment of venous thromboembolism (VTE) in pregnancy	Midwives to reweigh all women at 28 weeks/postpartum and a mandatory VTE assessment to be carried out and documented. All women to be risk scored for postpartum haemorrhage. For all caesarean section cases, low molecular weight heparin to be given 4 hours after spinal anaesthesia (if no risk of bleeding).	R1358
O&G	Audit of babies under transitional care throughout 2022 (CNST, 3)	Re-Introduce and embed a daily neonatal huddle with maternity, paediatric SHO, Registrar and Consultant and the nurse in charge on Special Care Baby Unit on Wharncliffe Ward.	R1412
O&G	Carbon Monoxide monitoring in pregnancy (CNST, 6.1)	To provide in-house training within the maternity unit for midwives, support workers and medical staff; 'Stop the Shift' training – completing Carbon Monoxide monitoring, understanding relevance of smoking in pregnancy on the health of the mother and baby, and 'very brief advice' – to be completed by the smoking in pregnancy Team Midwives (rolling programme). Electronic patient records to be adapted to ensure ease of recording Carbon Monoxide monitoring, plus mandatory fields amended to 'drop down' fields to ensure full completion.	R1423
O&G	Fetal Anomaly Screening Programme Audit	Ensure that most up-to-date trisomy checklist sticker is available and in use by all Midwives conducting bookings. Staff to be informed of the importance of this in newsletter, emails and mandatory training.	S1833
O&G	Audit of Instrumental delivery	To ensure that the appropriate position and station of the fetal head prior to forceps/ventouse application is ascertained and documented. To initiate routine training of midwives and new	S1976

		doctors to ensure cord gases are taken at every forceps delivery, especially for sequential and abandoned deliveries and to add a mandatory cord gas recording box to the Meditech delivery record template. To further develop the electronic documentation of instrumental deliveries in Meditech to reduce errors in birth data. To produce a list rationalising the terminology of indication for instrumental delivery in order to facilitate the consistent and complete documentation of all aspects of the delivery by obstetricians and midwives. To re-audit when recommendations have been implemented.	
O&G	Re-audit of Management of Ectopic Pregnancy	As part of their induction to the Trust, all medical staff should be made aware of (1) The risks associated with ectopic pregnancies and should seek to exclude these as part of their assessment. (2) The requirement to discuss their plans following a 3rd beta Human Chorionic Gonadotrophin or if not following guidelines with a consultant. Early Pregnancy Assessment Unit staff should be empowered to ensure that this happens where possible, including feeling they are able to directly request consultant review if needed. (3) That patients undergoing salpingectomy require follow-up, with either repeat beta Human Chorionic Gonadotrophins or Urine pregnancy testing in 3-weeks. (4) To consider carefully whether scan findings are indicative of tubal ectopic or an adnexal mass adjacent to the ovary and moving separately. Staff to offer and jointly plan follow-up in Gynaecology Outpatient Department for all “complex” cases.	S2126

O&G	Trust Consent audit 2022 (Gynae)	Communicate to medical staff to ensure that clinicians and patients sign and date in the appropriate section of the consent form. Improve documentation about patients' consent regarding multimedia, by informing medical staff to complete this section and delete where not appropriate. Medical staff to specifically document in the medical records that the relevant patient information leaflet was given to the patient prior to the procedure. Roll out pre-populated consent forms in select clinics which will be filled out during outpatient clinics and given to patients with relevant information leaflets as a pre-op packet.	S2152
O&G	Audit of Dilapan use for the Induction of Labour	Refresher training sessions to be arranged regarding Doctors insertion techniques to improve success rates. Continue current use of balloon and propess as first line with Dilapan as alternative where appropriate	R1328
O&G, Safeguarding	Safe Sleep Assessment Re-audit 2021, (Community Midwifery)	Inform and work with Maternity staff members to ensure they have the repeat the safe sleep questionnaire when indicated and to inform the 0-19 service when this has triggered	R1259
O&G, Safeguarding	Documentation of who accompanies women during labour	Findings in Subjective, Objective, Assessment and Plan format, supported by a power point presentation are to be presented at Maternity Governance and Safeguarding Operations meetings. The information to be shared within clinical areas; to also consider adding an audit to Tendable for annual review, to ensure compliance.	R1373
O&G, Safeguarding	Adherence to NICE guidelines on management of Nocturnal Enuresis	Advise staff to ensure they have access to systm 1 to complete checks and to liaise with the Children's ward for help if they cannot access the system.	R1401
OMFS	Are Emergency Department (ED) GP letters being completed by	OMFS Team should be educated at the audit meeting about the importance of Emergency	R1355

	Oral and Maxillofacial surgery (OMFS) Dental Core Trainees (DCTs) after discharging patients in ED?	Department discharges. Ensure all Dental Core Trainees' 'Favourite list' on Meditech includes the Emergency Department GP letter	
OMFS	Do our OMFS handover documents provide adequate information?	Ensure existing guidance is available in the OMFS Dental Core Trainee induction booklet, and present information at Clinical Effectiveness meeting to make DCTs more aware of the recommendation of a good handover and the information required.	R1369
OMFS	OMFS compliance of ordering appropriate investigations upon admission of patients with orofacial infections	OMFS team should be educated at the audit meeting about the need for appropriate investigations to be carried out for every patient with an orofacial infection, unless contraindicated. Discuss with fellow DCT colleagues to implement changes to favourites list. Reformat the DCT handbook for next year's cohort to ensure it is clear which investigations should be carried out for patients with orofacial infections.	S2104
OMFS	OMFS clinical staff awareness of emergency medical equipment and drugs (AED), and identifying medical emergencies.	Ensure SHO's are aware of the location of emergency equipment in the outpatient department. A clear label was ordered highlighting where the AED location and the crash trolleys. Do, Check, Ask poster and educational campaign launched, as without this in place it will be difficult for any other initiatives to improve practice.	R1267
OMFS	Audit of the appropriateness of General Dental Practitioner (GDP) extraction referrals for patients at risk of Medication-related osteonecrosis of the jaw	Develop a proforma for use during an annual review of patients with type II diabetes. Formulate a leaflet that can be forwarded to local GDP's. Improve General Dental Practitioners' awareness of Scottish Dental Clinical Effectiveness Programme guidelines to allow for the safe management of patients at risk of Medication-related osteonecrosis of the jaw in primary care.	R1344
OMFS	Complications following minor oral surgical	To use chlorhexidine mouth rinse for 1-minute pre operatively for all	R1331

	procedures - a prospective audit	extractions (both surgical and non-surgical)	
OMFS	Reasons for change in the treatment plan received by Poswillo Services from referring clinician for exodontia under general anaesthesia	To design a letter directed to Dental trainees to make them aware of required imaging and discussions before referral, to include: • Ensure that appropriate x-rays are taken before and attached with referral. Discuss the x-rays and possibility of change in treatment plans at time of pre assessment.	S2116
OMFS	Re- audit: Are Emergency Department GP letters being completed by OMFS Dental Core Trainees (DCTS) after discharging patients in ED?	Educate the new Dental Core Trainees regarding the importance of GP letters and how to complete them	R1395
OMFS	Re-audit of Electronic Venous thromboembolism (VTE) assessment and prescribing. Are we doing it correctly?	Educate the DCTs regarding the importance of VTE assessment and prescribing and the use of the Meditech admission summary, which should be used on patient admission and which prompts a VTE assessment.	R1309
OMFS	Trust Consent Audit 2022 - OMFS	Leaflets to be made available in consultation rooms to provide to patients. Update the British Association of Oral and Maxillofacial Surgeons (BAOMS) leaflets to make more relevant to patients.	S2143
OMFS	An Audit to identify compliance with the Royal College of Surgeons guidelines relating to wisdom teeth extractions 2020	Raise awareness of the contraindication of coronectomy and documenting appropriate discussions in notes regarding coronectomy and cone-beam computed tomography systems (cbct)	S2123
Ophthalmology	Retinopathy of prematurity screening audit	Special Care Baby Unit referral to retinopathy screening to be made in advance to allow the infant to receive first screening exam before 5 completed weeks postnatal age.	S2097
Ophthalmology	Cataract surgery outcome for all surgeons at The Rotherham NHS Foundation Trust (TRFT) 2020-21	Audit the cases with and without comorbidity separately. Reduce the number of wet age-related macular degeneration referrals expected not to meet the target to cataract clinic (This	R1349

		recommendation was not agreed by all consultants).	
Ophthalmology	Emergency eye clinic audit	All referral letters to be scanned onto MEDITECH. GPs and Opticians will be encouraged to examine the patients first (especially cold cases) before referral. General Clinic patients to be followed up in consultant clinic slots. Retain a clinic slot for the discussion and triage of external referral letters. Facilitate triage training and ensure only appropriately trained triage staff take patient enquiries. Cases seen by Emergency Staff are discussed with the on-call Ophthalmologist to ensure correct grading. Emergency Staff to receive training in common ophthalmology emergencies.	R1350
Orthopaedics	Re-audit of S1917: Getting it Right First Time (GIRFT) Best Practice for knee and hip arthroplasty surgery documentation.	All Lower limb arthroplasty consultants should review operation note templates to ensure they are satisfied with the key information highlighted by the GIRFT guidance that is included in the templates	S2074
Orthopaedics	Prospective audit investigating the compliance of Venous-Thromboembolism prophylaxis (VTEp) prescribing for patients post-operative from lower limb arthroplasty surgery	Surgeons performing total hip and knee arthroplasties to amend operative note templates in order to provide standardisation and clarity when prescribing appropriate venous thromboembolism prevention.	R1382
Orthopaedics	Re-audit of early management of paediatric forearm fractures	Re-audit data showed that there was almost 90% compliance with the British Orthopaedic Association guidelines compared with only 30% in the first audit cycle showing an improvement to patient outcomes.	R1417
Pharmacy	Prospective audit of adult patients on medicine and surgical wards to determine appropriateness of antimicrobial therapy based on local guidelines and expert opinion form Consultant microbiologist	Review how mycoplasma and chlamydia tests are ordered on Meditech and re-issue communications regarding how to order these. Ensure sample type in Adult antimicrobial policy matches current guidance to ensure the correct tests are being	R1298

		used and that the policy reflects this. Consider additional Microbiology ward rounds on AMU, if Microbiology workload allows to have a proactive review of patients, provide on the spot education and training	
Safeguarding	Audit and assurance of TRFT compliance with Child Death Review Statutory and Operational Guidance (England) HM Gov 2018	Review SOP 096 with senior managers from Special Care Baby Unit and Labour Delivery Suite and identify where gaps in knowledge and information are. Update SOP as necessary and provide necessary briefings/ learning events Share learning from audit in all relevant forums. Review SOP 117 for Infant and Child Death in Children's and Adult Services and SOP 096 Child Death Review Process with Consultant Paediatricians and key professionals to ensure role and responsibilities are understood when attending a child death in TRFT. Provide bespoke training to Consultant Paediatricians re completion of the Immediate Decision Making Proforma.	R1262
Safeguarding	Quarterly independent Audit of body maps in the Urgent and Emergency Care Centre (UECC)	Independent audit to take place on daily admission data collection May 2022. Feedback to UECC practitioners where body map not used and recirculate. Consider National standards for body mapping - bench marking	S2099
Safeguarding	UECC identification of vulnerable adults with dependent children safeguarding referrals (CQC 4H2)	Task and finish group to be set up to review the IT processes to support identification of safeguarding in UECC, to review and update the safeguarding Huddle SOP so this reflects identification and discussion of all safeguarding cases. Continue to reinforce child safeguarding processes when adults with dependent children attend at Stop the Shift sessions, including the safeguarding mandatory questions in triage template. Safeguarding Think Families training programme level 3 for UECC staff is a full day	S2098

		course and will be a rolling programme for UECC staff to be rostered into to attend. Review and develop some additional focused communications to send out for the UECC newsletter	
Safeguarding	In depth Audit of body maps in the Urgent and Emergency Care Centre (UECC)	Body mapping to be included at the induction of all new UECC doctors. Missed body mapping to be highlighted to lead Consultant for individual feedback. Review local guidance document for body mapping in UECC. Review practical application of the use of paper body maps for children in UECC and uploading these to the Meditech system to improve practitioner compliance.	S2125
Safeguarding	Audit to monitor and review possible missed safeguarding opportunities in UECC	Review and amend Manchester triage safeguarding section of the Meditech template to improve the clarity of documentation for safeguarding checks and safeguarding assessment.	R1419
Safeguarding	Audit of Quality of One to One Children's Safeguarding Supervision	To organise supervision with 0-19 team leaders. To ensure ongoing training for supervisors to make sure that as staff leave, or move to a role where they will not be delivering supervision, 2 sessions a year will be planned to ensure there will be sufficient supervisors across the Trust to support the supervision requirements.	R1330
Safeguarding	Re-Audit Safeguarding 16 & 17 year olds pathway when presenting to Rotherham Hospital.	Provide feedback and learning opportunities to staff where safeguarding checks have been missed. Raise awareness at safeguarding champions meetings of the importance of safeguarding checks.	R1402
Safeguarding	Re-audit the effectiveness of safeguarding huddles - consideration given to discharge planning on Children's Ward 2022	Communications memo to be sent to social care managers to reinforce the requirement of discharge planning minutes to be received in TRFT and also make ward staff aware of this requirement, by cascading a summary page to the ward manager for distribution to ward staff.	R1377

Trust wide	National Early Warning Score (NEWS) 2 audit to ensure the correct monitoring of vital signs in clinical wards	Nursing staff require additional training on the rationale for completing observations as per policy. NHS improvement project will look further at the reasons why observations are not completed as per the policy. Changes are required in Meditech to ensure scheduling observations is a more efficient process. Roll out of the deteriorating patient proforma to all Clinicians.	S2093
Trust wide	Review compliance of theatre teams with the WHO safety surgical checklist	Work to improve the engagement of the surgical and anaesthetic teams with respect to checklist completion. Regular training to be done in theatres around the use of the surgical safety checklist. A rolling training programme to be established involving all theatre staff. Audit results to be discussed at the Surgical Divisional Governance and Anaesthetic weekly meeting and shared with the Family Health teams.	S2100
Trust wide	Duty of Candour	Implementation of electronic letter templates and electronic checklists for clinicians in order to monitor all factors required to comply with Duty of Candour as per Regulation 20 with respect to Care Quality Commission. Additionally, an information booklet will be available to patients for clarification.	S2127
Urology	Quality of operative notes	Ensure complete documentation is included within patient notes, including a management action plan in order to comply with the cystoscopy audit	S2054
Urology	Surveillance cystoscopy following trans urethral resection of bladder in bladder cancer patients	To embed knowledge of NICE guidelines by displaying a poster in Endoscopy outlining the required recommendations for service provision. To include a plan in the operation notes for the management of the patients' condition.	S2086

Urology	Urology VTE Prophylaxis	All elective or emergency admissions should have a venous thromboembolism (VTE) assessment. All the new staff should be educated in how to perform the assessment and existing staff should have refresher training.	R1410

Appendix 2: Readmissions within 28 days

Emergency Re admissions within 30 days of discharge from Hospital		
Age Bands	**1st April 2021 – 31st March 2021**	**1st April 2022 – 31st March 2023**
Age 0- 15 years	8.15%	11.79%
Age 16 years and above	7.81%	10.48%

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 reports.

The internal TRFT data has been aligned to the National Benchmarking reports - in this case Model Hospital. Model Hospital is an NHSI tool that uses HES (Hospital Episode Statistics) Data and contains some additional methodology on how they report readmissions. In 2020 the reports were re-written to align to National data, the reports include INO, same day readmissions and reporting within 30 days. We are also picking up if a patient has had multiple readmissions in the reporting period if within the time frame. This is all as per the National Methodology. - The report does however report readmissions - Same Treatment Function code back to Same Treatment Function Code. In 2022 we have amended the data to excluded all Day Cases from the Denominator, something that was included up to Mar 2022.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2022/23

Detail of Visits	Date of Visit
UKAS Full Assessment Visit to Laboratory Medicine	8 February 2022, 3 March 2022, 9-13, 16, 18 & 25 May 2022
Police Counter Terrorism Security Advisor visit to Laboratory Medicine	12 April 2022
British Standard Institute inspection of Sterile Services	25 April 2022
SQAS virtual review of Newborn and Infant Physical Examination screening programme	04 May 2022
The Regional Ockenden Support Visit to Maternity Services	25 May 2022
Environment Agency visit re: Radioactive Substances Regulation to Nuclear Medicine	12 September 2022
Regional Gateway Review Ophthalmology for South Yorkshire & Bassetlaw system	27 October 2022
Endocrinology Gateway Review Pilot -South Yorkshire and Bassetlaw ICB	07 November 2022
GIRFT Virtual Deep Dive: Orthopaedic Trauma Surgery	10 November 2022
GIRFT Anaesthetics and Perioperative Medicine visit	24 January 2023
GIRFT Adult Critical Care Deep Dive	02 February 2023
UKAS Surveillance Visit 1 to Laboratory Medicine	W/C 06 February 2023 and W/C 27 February 2023
NHS South Yorkshire ICB - GIRFT/High Volume Low Complexity Clinical Gateway Review for General Surgery	16 February 2023

References

Accessible Information standard (NHS England, 2015). Available at: https://www.england.nhs.uk/ourwork/accessibleinfo/ (Accessed: 27 March 2023)

Care Act (2014). Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (Accessed: 27 March 2023)

Counter-terrorism Strategy (CONTEST) (Home Office, 2018). Available at: https://www.gov.uk/government/publications/counter-terrorism-strategy-contest-2018 (Accessed: 27 March 2023)

Deprivation of liberty safeguards: Supreme Court judgments. Available at: https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-supreme-court-judgments (Accessed: 27 March 2023)

Good Rostering Guide (NHS Employers, 2018). Available at: https://www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide (Accessed: 27 March 2023)

Gosport Independent Panel Report (2018). Available at: https://www.gosportpanel.independent.gov.uk/ (Accessed: 27 March 2023)

Governance Arrangements for Research Ethics Committees (published 20 July 2021). Available at: https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/governance-arrangement-research-ethics-committees/ (Accessed: 27 March 2023)

Governance Arrangements for Research Ethics Committees GAfREC (Department of Health, 2011). https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/governance-arrangement-research-ethics-committees/ (Accessed: 27 March 2023)

Health Act (2009). Available at: https://www.legislation.gov.uk/ukpga/2009/21/contents (Accessed: 27 March 2023)

Health and Social Care Act (2008). Available at: Health and Social Care Act 2008 (legislation.gov.uk) (Accessed: 27 March 2023)

Ionising Radiation (Medical Exposure) Regulations 2017. Available at: https://www.legislation.gov.uk/uksi/2017/1322/contents/made (Accessed: 27 March 2023)

Liberty Protection Safeguards: what are they (Department of Health and Social Care 2021). Available at: https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-what-they-are (Accessed: 27 March 2023)

Macmillan Quality in Information and Support Services Standard. Available at: https://learnzone.org.uk/courses/course.php?id=93 (Accessed: 27 March 2023)

Macmillan Volunteering Quality Standards. Available at: https://learnzone.org.uk/courses/course.php?id=243 (Accessed: 27 March 2023)

Mental Capacity Act (2005). Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents (Accessed: 27 March 2023)

Never Events Policy & Framework Revised 2018 (NHSI 2015). Available at: Revised-Never-Events-policy-and-framework-FINAL.pdf (england.nhs.uk) (Accessed: 27 March 2023)

NHS Foundation trust annual reporting manual (FT ARM) 2020/21 (NHS England). Available at: https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/ (Accessed: 27 March 2023)

Quality Standard [QS86] updated 2017 (National Institute for Health and Care Excellence 2015). Available at: https://www.nice.org.uk/guidance/qs86 (Accessed: 27 March 2023)

Report of the Mid Staffordshire NHS Foundation Trust Enquiry (2013). Available at: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry (Accessed: 27 March 2023)

The Ionising Radiation Regulations, 2017. Available at: https://www.legislation.gov.uk/uksi/2017/1075/contents/made (Accessed: 27 March 2023)

The Rotherham NHS Foundation Trust – Public Panel. Available at: https://www.therotherhamft.nhs.uk/Get_Involved/Public_Panel/ (Accessed: 27 March 2023)

DA Languages Interpreting Services. Available at: https://intranet.xrothgen.nhs.uk/TeamCentre/CorporateServices/Pages/translation.aspx (Accessed: 27 March 2023)

Acronyms

A&E	Accident & Emergency Department
AMU	Acute Medical Unit
APC	Admitted Patient Care
CCG	Clinical Commissioning Group
C-DIFF	Clostridium Difficile
CHKS	Comparative Health Knowledge System
CMP	Case Mix Programme
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CPE	Carbapenemase Producing Enterobacterales
CSDS	Community Services Data Set
CSU	Clinical Support Unit
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
DCT	Dental Core Trainee
DIPC	Director of Infection Prevention and Control
DoLS	Deprivation of Liberty Safeguards
DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
ECDS	Emergency Care Data Set
E.Coli	Escherichia coli
ED	Emergency Department
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GAfREC	Governance Arrangements for Research Ethics Committee
GDP	General Dental Practice
GIRFT	Getting it Right First Time
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
IDQ	Improving Data Quality
IPC	Infection Prevention and Control
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
LeDeR	Learning Disabilities Mortality Review
LPS	Liberty Protection Safeguards
MaST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSDS	Maternity Services Data Set
NABCOP	National Audit of Breast Cancer in Older People
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme
NCAP	National Cardiac Audit Programme
NEWS	National Early Warning Score
NHS	National Health Service
NHSE	NHS England

NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OMFS	Oral and Maxillofacial Surgery
PACU	Post Anaesthesia Care Unit
PET+	Patient Experience Toolkit
PIR	Post Infection Review
PLACE	Patient-led Assessment of the Care Environment
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
QI	Quality Improvement
QIP	Quality Improvement Programme
QR	Quick Response
QSIR	Quality, Service Improvement and Redesign
RCA	Root Cause Analysis
RTT	Referral to Treatment
Shh	Sleep Helps Healing
SHMI	Summary level Hospital Mortality Indicator
SHO	Senior House Officer
SJR	Structured Judgement Review
SOP	Standard Operating Procedure
SQAS	Safety & Quality Assessment for Sustainability
SQL	Structured Query Language
SUS	Secondary Uses Service
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent and Emergency Care Centre
UKAS	United Kingdom Accreditation Service
VTE	Venous Thromboembolism
WHO	World Health Organisation
YTD	Year To Date

Glossary

Acute Services	Include treatment for a severe injury, period of illness, urgent medical condition, or to recover from surgery. In the NHS, it often includes services such as accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery.
Care Quality Commission	The independent regulator of all health and social care services in England
CHA2DS2-VASc	CHA2DS2-VASc score, are clinical prediction rules for estimating the risk of stroke in people with non-rheumatic atrial fibrillation
Clinical Coding	The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.
Clinical Commissioning Group	Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Commissioning for Quality and Innovation (CQUIN)	A payment framework where commissioners reward excellence, by linking a proportion of income to the achievement of agreed quality improvement goals.
Data Quality Maturity Index	A monthly publication about data quality in the NHS
Datix	incident reporting and risk management software
Data Security and Protection Toolkit	An online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards
Duty of Candour	A statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.
Employee Assistance Programme	An Employee Assistance Programme provides around-the-clock mental health support to your workforce and their immediate family.
Friends and Family Test	A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
Healthcare Associated Infection	Infections people get while they're receiving health care for another condition.
Hospital Episode Statistics	A database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England.
Hospital Standardised Mortality Ratio	Broad system-level measure comparing observed to expected deaths
ICE	The system allows you to see pathology and radiology results held by the hospital, including ones not requested, and means the laboratory team can see all the information it needs. ICE also keeps an electronic record in a patient's notes so that there is full accountability.
Meditech	MEDITECH is an on-premise electronic health record system that enables healthcare providers to access patient records,

	communicate with patients virtually, enable pre-registration and perform administrative tasks
NHS Digital	NHS Digital is the trading name of the Health and Social Care Information Centre, which is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England, particularly those involved with the National Health Service of England.
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.
ORBIT	The ORBIT Score estimates the risk of major bleeding for patients on anticoagulation for atrial fibrillation.
Patient Reported Outcome Measures	Questionnaires measuring the patients' views of their health status
Power BI	Power BI is an interactive data visualization software product developed by Microsoft with a primary focus on business intelligence. It is part of the Microsoft Power Platform.
Quality Account	A report about the quality of services offered by an NHS healthcare provider.
Secondary Uses Service	A collection of health care data required by hospitals and used for planning health care, supporting payments, commissioning policy development and research.
SEPIA	A viewing tool which allows health care professionals to see an integrated patient record
Structured Judgement Review	Usually undertaken by an individual reviewing a patient's death and mainly comprises two specific aspects: explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received.
Summary level Hospital Mortality Indicator	The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there
SystmOne	Clinical Software System
Tendable	Tendable is a smart inspection app that replaces the manual pen and paper audit/inspections used to assess and improve quality across clinical areas.
UK Health Security Agency	The UK Health Security Agency is a government agency in the United Kingdom, responsible since April 2021 for England-wide public health protection and infectious disease capability, and replacing Public Health England. It is an executive agency of the Department of Health and Social Care.
UNICEF	UNICEF, originally called the United Nations International Children's Emergency Fund in full, now officially United Nations Children's Fund, is an agency of the United Nations responsible for providing humanitarian and developmental aid to children worldwide.