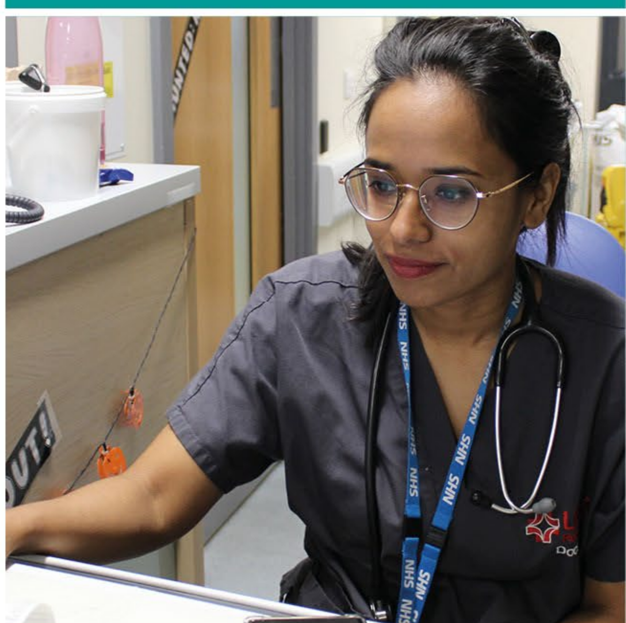
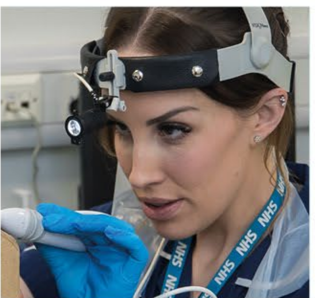
The Rotherham NHS Foundation Trust

Quality Account 2023/24

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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 2023-24. 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 patient surveys, we have selected three quality priorities for 2024-25, which we believe reflect the areas where greatest positive impact can be achieved for the patients in our care and their families. As part of our reporting process, we have also reviewed our quality priorities for 2023-24. Although some of the priorities did not completely meet their ambitious targets, significant progress was made in each area and we will continue to build on these improvements in the coming year.

Although we saw a vastly reduced number of patients with COVID-19 this year, in line with the wider NHS, we continue to recover from the impact, particularly within elective care for planned procedures. This has been further compounded by the impact of multiple episodes of industrial action throughout the year. Our position has improved during the year but we acknowledge that patients are still waiting too long for some procedures and we have set an ambitious target for 2024-25 to reduce this significantly. We will also be continuing to work towards achieving national targets for treating patients within 4 hours within our Urgent and Emergency Care Centre and building upon the achievements already seen this year in reducing ambulance handover delays.

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

- Although we have not received any external inspections from the Care Quality Commission (CQC) this year, we have implemented an Exemplar Accreditation programme to strengthen our monitoring processes and provide assurance of the quality of our services. Going forward, this will provide valuable evidence of the quality of care being provided in different wards and departments.
- The Trust has sustained improvements to the Learning from Deaths programme and has embedded a process in line with national expectations to review all deaths and identify learning. Mortality levels have remained within the expected range for the organisation. In the coming year, we will focus on how we use the information from mortality reviews to further improve patient safety and outcomes.
- The full rollout and expansion of our virtual ward capacity has demonstrated how we can use our resources differently in order to provide the care patients need, and the bringing together of some of our community based services into our Care Coordination Centre has enabled more effective community resource allocation and a more direct access to community services for our partners.
- The Quality Improvement Programme has continued to expand with more than 120 team members completing Quality, Service Improvement and Redesign (QSIR) training during the year under the leadership of our expanded Qi team. The culture of the Trust as a continually improving organisation is evident in a wide range of projects. The largest of these, our Discharge Planning event, has contributed to a reduction in our average length of stay in some areas.

- Nursing and Healthcare Support Worker recruitment and retention has continued to be hugely successful. Through a range of evidence based, targeted interventions we have reduced vacancy and leaver rates which supports the delivery of high quality patient care. This led to the Trust being a finalist in the Nursing Times Workforce Awards in 2023 for Workforce Innovation.
- Education and Development of our teams has been a key feature supporting our retention strategy and there has been a focus on developing compassionate leadership skills for nursing staff. We have participated in a successful Infection Control training programme for Health Care Support Workers and three of our Support Workers have received a national Chief Nursing Officer Award for their contributions to patient care.
- The Trust have also received national accreditation for our preceptorship programme for Nurses, Midwives and Allied Health Professionals and been awarded the Pastoral Care Quality Award for providing a supportive induction programme for internationally educated nurses.
- 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.
- I am delighted to report that the annual staff survey showed an improved position for a third consecutive year. These results are very positive and demonstrate the progress that TRFT continues to make, particularly in relation to the three advocacy questions where the Trust now ranks in the top 3 most improved organisations across England.
- Partnership working with Barnsley Hospital NHS Foundation Trust has continued to strengthen over the last year leading to benefits for patients. Of note, collaboration within gastroenterology and haematology services is proving beneficial for both organisations and we look forward to developing other close working relationships 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.

- Although we have worked hard to reduce the number of patients with long waits for elective care, there is still a need to improve further. Whilst delivery of the Referral to Treatment (RTT) constitutional standard itself has not been identified as a national objective for 2024-25, we recognise the impact that extended waiting times have on our communities, and are determined to continue our journey of improvement in 2024-25.
- We recognise that too many of our patients accessing our Urgent and Emergency Care Centre continue to wait for too long before they are admitted or discharged. The almost 50% reduction in ambulance handovers over an hour in 2023-24 compared to the previous year is evidence of our ability to deliver significant improvements over a relatively short time-period within our urgent care pathways, and 2024-25 will be the year where we accelerate this work and drive a direct impact on 4-hour performance.
- Although the Trust scored well in the maternity patient survey, the results for the Urgent and Emergency Care Centre and for adult inpatient wards showed that we need to make further improvements in these areas. In response to these surveys, detailed improvement plans were developed and enacted and I am confident that the focus we have placed on this will lead to improved feedback from our service users this year. During the coming year, we will 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 2023-24. We are refreshing our five-year strategy to reflect changes seen in the

NHS in recent years but will maintain our previous focus on being ambitious to deliver safe, high quality care with positive outcomes for patients. Our approach to continuous Quality Improvement is now well embedded and this will help us with our ambition to become an outstanding organisation. I look forward to us achieving even greater success in 2024-25 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, clinical effectiveness and quality improvement.

R. Jenkins

Dr Richard Jenkins
Chief Executive
June 2024

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

2.1 Priorities for improvement during 2024/25

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. The Quality Improvement programme at the Trust has continued to grow over 2023/24, with 112 Quality Improvement Practitioners now successfully completing training. The new AMaT system is utilised to register and track progress of all quality improvement initiatives. There have been 93 projects registered through the system over the past year.

The team has expanded and there is now a Quality Improvement Facilitator and Practitioner in post to support the Head of Quality Improvement. The expansion of the Qi team will now provide resource to be able to review the impact of quality improvement throughout the Trust. 2024/25 plans will include a look back of projects and what measurable improvements we have identified.

The Patient Safety Incident Response Framework (PSIRF) has now been implemented at the Trust. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents to learn and improve patient safety.

- A new way of responding to patient safety incidents – unintended or unexpected events in healthcare that could have or did harm one or more patients
- A data-driven approach to patient safety incident response
- Focused on learning and improvement
- Focused on systems, processes and human factors

Incident responses are the systematic approaches taken to address and manage patient safety incidents effectively. The key components are, reporting and recording incidents, investigating and analysing, learning and improvement, communication and transparency and monitoring outcomes. The responses create a safer healthcare environment by learning from past mistakes, implementing proactive measures, and fostering a culture of continuous improvement.

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 2024/25, 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 2024/25 are:

Patient Safety

- Diabetes Management

Patient Experience

- Acute Pain Management

Clinical Effectiveness

- Frailty Assessment

Patient Safety

Diabetes Management Improve the management of Diabetic patients admitted to the Acute Trust	Early identification of Diabetic patients admitted into hospital, with screening and rapid referral for those most at risk of developing complications. Structured programme of staff training on the safe use of insulin. Training to be provided for every healthcare professional who dispenses, prescribes and/or administers insulin, appropriate to their level of responsibility, including an assessment of competency. Clear, audited perioperative pathways for people with diabetes, broadly in line with the recommendations in the recent NCEPOD report Highs and Lows. Ensure there is a self-management policy, which supports patients who want to self-manage their diabetes to safely do so while in hospital, as clinically appropriate. Patients with a diabetic foot care emergency requiring admission should be assessed the same day by the MDFS (multi-disciplinary foot care service), and if vascular impairment is identified, they should have same day access to a vascular opinion. If the MDFS is not available, they may need to be transferred to a vascular service. Diabetes teams to work closely with coders to ensure diabetes is coded consistently and accurately – and ensure all inpatients who have diabetes are identified on admission to hospital. Consider an electronic system, integrated with web-linked blood glucose meters which provide an alert system for staff when any out-of-range reading is recorded.	GIRFT and National Diabetes Audit recommendations (2020, 2022-23).

Patient Experience

Acute Pain Management	All people with acute pain must have an individualised analgesic plan appropriate to their clinical condition that is effective, safe and flexible with planned review. All in patients with acute pain must have regular pain and functional assessment using consistent and validated tools, with results recorded. There should be clear guidelines for communication with the pain team. For people in severe pain, action must be taken immediately and an intervention must take place within 30 minutes. The effectiveness of the intervention must be reassessed after an appropriate interval. People with complex pain must be referred to the pain team and must be reviewed in a timely fashion. Hospital to community transition after surgery. On discharge from hospital, the discharge letter must include accurate details of all analgesia provided. The prescription of any opioid analgesia for use post-discharge must be included.	Derived from the Faculty of Pain Management (RCoA) core standards 2021.

Clinical Effectiveness

Frailty Assessments Frailty is a key priority for the NHS to identify frailty in a person early and for them to be seen at the right time by the right team in order for needs to be identified and managed.	There are a number of publications of national publications covering Frailty Assessments https://www.england.nhs.uk/long-read/frail-strategy/ CQUIN – CCG5 – Identification and response to frailty in Emergency Departments outcomes highlight poor compliance in frailty assessments and concern has been raised around the quality of completion Frailty is a theme for improvement in a number of National Clinical Audits; • National Clinical Audit of Dementia • Falls & Fragility Audit Programme NHSE Right Care Frailty Toolkit – based upon NICE and GIRFT recommendations offers a self assessment and guidance to improve care and services to support people living with frailty from patients accessing ED to providing care in patients own homes	NICE Guidance *implementation* fully achieved with metrics to evidence achieving full *compliance* Continuous improvement being achieved and sustained - evidenced within the National Clinical Audit Outcomes and the CQUIN – CCG5 Self Assessment completed, an improvement plan agreed and in progress of implementation for frailty assessments and personalised care across the organisation

2.2: Statements of Assurance from the Board of Directors

During 2023/4 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 2023/24 represented 91.7% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2023/24.

Clinical Audit

Information on Participation in Clinical Audits during 2023-24:

During 2023-24, 50 national clinical audits and 10 national confidential enquiries covered NHS services that The Rotherham NHS Foundation Trust provides.

During that period, the Trust participated in 93% of national clinical audits and 80% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust were eligible to participate in, and for which data collection was completed during 2023-24, 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.

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Participated	% cases submitted
1	1	Adult Respiratory Support Audit	No	Yes	No	NA	NA
2	2	BAUS Urology Audits - BAUS Nephrostomy Audit	No	Yes	Yes	Yes	100% (7/7)
3	3	Breast and Cosmetic Implant Registry	No	Yes	Yes	Yes	Data not available on registry *
4	4	British Hernia Society Registry	No	Yes	Yes	No***	NA
5	5	Case Mix Programme	No	Yes	Yes	Yes	100% (580/580)
6	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme						
	6	Juvenile Idiopathic Arthritis	Yes	Yes	Yes	No eligible cases for the sample	
	7	Testicular torsion	Yes	Yes	Yes	No eligible cases for the sample	
7	8	Cleft Registry and Audit NEtwork (CRANE)	No	Yes	No	All local identified cases are referred to Trent Regional Cleft Network at Nottingham University Hospital, who notify CRANE of all cases	
8	9	Elective Surgery (National PROMs Programme)	No	Yes	Yes	Yes	45% (70/156)
9	Emergency Medicine QIPs						
	10	Care of Older People – year one	No	Yes	Yes	Yes	100% (105/105)
	11	Mental Health (Self-Harm) – year one	No	Yes	Yes	Yes	100% (267/267)
10	12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People1	Yes	Yes	Yes	Yes	100% (62/62)
11	Falls and Fragility Fracture Audit Programme						
	13	Fracture Liaison Service Database (FLS-DB)	Yes	Yes	Yes	Yes	94.6% (1070/131)
	14	National Audit of Inpatient Falls (NAIF)	Yes	Yes	Yes	Yes	100% (8/8)
	15	National Hip Fracture Database (NHFD)	Yes	Yes	Yes	Yes	100% (291/291)
12	16	Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory	No	Yes	Yes	No***	NA

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Partici pated	% cases submitted
		Bowel Disease (IBD) Audit]					
13	UK Renal Registry						
	17	Chronic Kidney Disease Audit	No	Yes	No	NA	NA
	18	Acute Kidney Injury Audit	No	Yes	Yes	Yes	100% (3235/3235)
14	19	Learning disability and autism Programme - Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	No	Yes	Yes	Yes	100% (12/12)
15	MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme						
	20	Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	Yes	Yes	Yes	100% (1/1)
	21	Maternal mortality confidential enquiries	Yes	Yes	Yes	Yes	100% (1/1)
	22	Maternal mortality surveillance	Yes	Yes	Yes	Yes	100% (1/1)
	23	Perinatal mortality and serious morbidity confidential enquiry	Yes	Yes	Yes	Yes	100% (13/13)
	24	Perinatal Mortality Surveillance	Yes	Yes	Yes	Yes	100% (13/13)
16	NCEPOD Medical and Surgical Clinical Outcome Review Programme						
	25	Community Acquired Pneumonia	Yes	Yes	Yes	Yes***	Organisational questionnaire only submitted
	26	Endometriosis	Yes	Yes	Yes	No***	0%
17	NCISH Mental Health Clinical Outcome Review Programme						
	27	Real-time surveillance of patient suicide	Yes	Yes	No	NA	NA
	28	Suicide (and homicide) by people under mental health care	Yes	Yes	No	NA	NA
	29	Suicide by people in contact with substance misuse services	Yes	Yes	No	NA	NA
18	National Adult Diabetes Audit (NDA)						
	30	National Core Diabetes Audit	Yes	Yes	Yes	Yes	100% (390/390)*
	31	National Diabetes Footcare Audit (NDFA)	Yes	Yes	Yes	Yes**	100% (28/28)*

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Participated	% cases submitted
	32	National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Yes	Yes	100% (1/1)
	33	National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Yes	Yes	100% (35/35)
	34	NDA Integrated Specialist Survey	Yes	NA	Yes	Annual Organisational Survey	
19	National Respiratory Audit Programme (NRAP)						
	35	Adult Asthma Secondary Care	Yes	Yes	Yes	Yes**	39.2% (75/191)*
	36	COPD Secondary Care	Yes	Yes	Yes	Yes**	58.5% (100/171)*
	37	Paediatric Asthma Secondary Care	Yes	Yes	Yes	Yes	100% (62/62)
	38	Pulmonary Rehabilitation	Yes	Yes	Yes	Yes	100% (266/266)*
	39	National Respiratory Audit Programme (NRAP) - Wales Primary Care Audit	Yes	Yes	No	NA	NA
20	40	National Audit of Cardiac Rehabilitation	No	Yes	Yes	Yes	100% (624/624)*
21	41	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPREVENT)	Yes	Yes	No	NA	NA
22	42	National Audit of Care at the End of Life (NACEL)	Yes	Yes	Yes	Yes	No data has been collected during 2023. Commenced Jan 24 and remains open currently.
23	43	National Audit of Dementia - Care in general hospitals	Yes	Yes	Yes	Yes	100% (78/78)
24	44	National Audit of Dementia - Spotlight audit in community-based memory assessment services	Yes	Yes	No	NA	NA
25	45	National Audit of Pulmonary Hypertension	No	Yes	No	NA	NA
26	46	National Bariatric Surgery Registry (NBSR)	No	Yes	No	NA	NA
27	47	National Cancer Audit Collaborating Centre - National	Yes	Yes	Case ascertainment to be published in 2024-25		

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Participated	% cases submitted
		Audit of Metastatic Breast Cancer					
28	48	National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Yes	Case ascertainment to be published in 2024-25		
29	49	National Cardiac Arrest Audit (NCAA)	No	Yes	Yes	No***	NA
30	National Cardiac Audit Programme (NCAP)						
	50	Myocardial Ischaemia National Audit Project (MINAP)	No	Yes	Yes	Yes**	100% (311/311)*
	51	National Adult Cardiac Surgery Audit (ACS)	No	Yes	No	NA	NA
	52	National Audit of Cardiac Rhythm Management (CRM)	No	Yes	Yes	Yes	100% (237/237)*
	53	National Audit of Mitral Valve Leaflet Repairs (MVLR	No	Yes	No	NA	NA
	54	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	No	Yes	No	NA	NA
	55	National Congenital Heart Disease Audit (NCHDA)	No	Yes	No	NA	NA
	56	National Heart Failure Audit (NHFA)	No	Yes	Yes	Yes**	38.6% (177/458)*
31	57	The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	No	Yes	No	NA	NA
32	58	National Child Mortality Database (NCMD) Programme	Yes	Yes	Yes	Yes	100% (13/13)
33	59	National Clinical Audit of Psychosis (NCAP)	Yes	Yes	No	NA	NA
34	60	National Clinical Audit of Psychosis (NCAP) - 2023 EIP audit (bespoke data) 2024 EIP audit (bespoke data	Yes	Yes	No	NA	NA

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Partici pated	% cases submitted
35	National Comparative Audit of Blood Transfusion						
	61	2023 Audit of Blood Transfusion against NICE Quality Standard QS138	No	Yes	Yes	No***	NA
	62	2023 Bedside Transfusion Audit	No	Yes	Yes	Deferred nationally until April 24	
36	63	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Yes	Yes	70% (69/98)*
37	64	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Yes	Yes	100% (102/88)
38	65	National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)	Yes	Yes	Yes	Yes	100% (198/198)
39	66	National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	Yes	Yes	100% (59/59)
40	67	National Joint Registry	No	Yes	Yes	Yes	100% (803/803)
41	68	National Lung Cancer Audit (NLCA)	Yes	Yes	Yes	Yes	100% (449/449)
42	69	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Yes	Yes	*Data extracted by RCOG from NHSE.
41	70	National Neonatal Audit Programme (NNAP)	Yes	Yes	Yes	Yes	100% (270/270)
42	71	National Obesity Audit (NOA)	Yes	Yes	No	NA	NA
43	72	National Ophthalmology Database Audit (NOD) - National Cataract Audit	No	Yes	No**	NA	NA
44	73	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Yes	Yes	100% (131/131)
45	74	National Prostate Cancer Audit (NPCA)	Yes	Yes	Yes	Yes	100% (189/189)
46	75	National Vascular Registry (NVR)	Yes	Yes	No	NA	NA

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Participated	% cases submitted
47	76	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	No	Yes	No	NA	NA
48	77	Paediatric Intensive Care Audit Network (PICANet)	Yes	Yes	No	NA	NA
49	78	Perinatal Mortality Review Tool (PMRT)	No	Yes	Yes	Yes	100% (13/13)
50	79	Perioperative Quality Improvement Programme (PQIP)	No	Yes	Yes	Yes	65.6% (180/247)
51	Prescribing Observatory for Mental Health						
	80	Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	No	Yes	No	NA	NA
	81	Monitoring of patients prescribed lithium	No	Yes	No	NA	NA
52	82	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Yes	Yes	A 90%+
53	83	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	No	Yes	Yes	Yes	100% (41/34)
54	84	Society for Acute Medicine Benchmarking Audit (SAMBA)	No	Yes	Yes	Yes	100% (72/72)
55	85	The Trauma Audit & Research Network (TARN)	No	Yes	Yes	Yes	Unable to report on case ascertainment due to the closure of the TARN submission portal in June 2023
56	86	UK Cystic Fibrosis Registry	No	Yes	No	NA	NA

**Data for projects marked with * require further validation. Where data has been provided these are best estimates at the time of compilation. Data for all continuous projects and confidential enquiries continues to be reviewed and validated during April, May or June 2024 and therefore final figures may change.*

* **Supporting Statements – data not available**

Quality Accounts - **Breast and Cosmetic Implant Registry (BCIR)** – data unavailable as Breast and Cosmetic Implant Registry is mid-migration to NHSE Outcomes registries platform
* **NCAPOP - National Maternity and Perinatal Audit (NMPA)** - data unavailable as the RCOG states that there have been delays in receiving the data from NHS England for the last 2 years.

****Supporting Statements – lower than expected case ascertainment**
NCAPOP – National Respiratory Audit Programme (NRAP) - Adult Asthma - There is no dedicated resource allocated to the collection of data for this audit, due to capacity within the Specialty. Discussions are being held with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment. The asthma and COPD discharge bundles are being created on Meditech, which will also support automisation of data and reduce the data burden. The Medical Division continue to find a solution for increasing resources to effectively participate.

NCAPOP – National Respiratory Audit Programme (NRAP) - COPD - There is no dedicated resource allocated to the collection of data for this audit, due to capacity within the Specialty. Discussions are being held with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment. The asthma and COPD discharge bundles are being created on Meditech, which will also support automisation of data and reduce the data burden. The Medical Division continue to find a solution for increasing resources to effectively participate.

NCAPOP – National Early Inflammatory Arthritis Audit (NEIAA) – National Clinical Audit Provider aware of and acknowledged the Trust's workforce challenges in Rheumatology impacting on case ascertainment. Additional support from the Clinical; Effectiveness Team has enabled further cases to be submitted during 2023-24 but lower than expected case ascertainment. Sustainable approaches for supporting the NEIAA are being agreed and it is expected that case ascertainment will significantly increase in 2024-25.

NCAPOP – National (Diabetes) Foot Care Audit (NFCA) - Workforce challenges within Podiatry has impacted on case ascertainment. In October 2023, the data collection tool was created in SystmOne, enabling the clinicians to record the data fields required for the audit electronically in real time. This can now be extracted electronically and uploaded to the Clinical Audit Platform. With this new way of working now embedded, an increase in case ascertainment should be seen during 2024-25.

Quality Accounts – National Cardiac Audit Programme (NCAP) - National Heart Failure Audit (NHFA) - Workforce challenges have impacted on case ascertainment for the NHFA. Discussions are being held with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment. A one day a week post has been secured for 6 months to undertake data collection whilst a sustainable approach is agreed and embedded going forwards.

*****Supporting Statements – non participation**
NCAPOP – National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) – Endometriosis – non submission of organisational questionnaire – local work to be undertaken and will review national report & recommendations when published.

NCAPOP – National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) – Community Acquired Pneumonia – NCEPOD team missed the Trust from the case sample and no patients were allocated. The Trust are currently reviewing the published national recommendations for improvements locally.

Quality Accounts – National Cardiac Arrest Audit (NCAA) - The data gained from the NCAA can be replicated in an interrogatable database stored locally without incurring any cost. Within the database, the data fields are limited and with the database created locally, far more information can be gained to understand and inform local improvements.

Quality Accounts – Improving Quality in Crohn's and Colitis (IQICC) - Non-participation in this audit is due to workforce challenges during 2023-24. The IQICC dataset is substantial, with data being collected and submitted manually overtime for each patient contact, including review and follow up, making this very resource intensive. A local database is maintained by the Gastroenterology team, which can be used for local quality improvement work. The IBD Registry – IQICC is closing as of 31 March 2024.

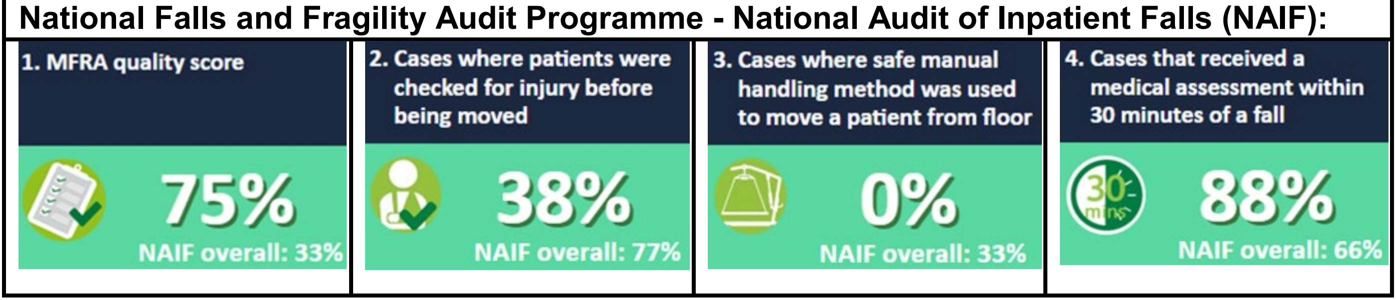
Quality Accounts - 2023 Audit of Blood Transfusion against NICE Quality Standard (QS138) – Workforce challenges impacted on the ability to collect and submit the data to the National Clinical Audit Provider before the data submission period closed. The National Report will be reviewed locally and recommendations for improvement considered alongside local data.

Quality Accounts - National Ophthalmology Database Audit (NOD) - National Cataract Audit – data submission requires Medisoft software, and the Trust have not procured this system. The Trust have approved non participation and internally local practice is audited to benchmark against the national outcomes when published.

Quality Accounts – British Hernia Society Registry – a new addition to the Quality Accounts for 2023-24 and the Trust were not participating previously. Consideration is currently being given to the dataset and participating for 2024-25.

The reports of 20 National Clinical Audits, published in the calendar year of 2023, were reviewed by the provider in the financial year 2023-24. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which are detailed below;

NCAPOP - National Falls and Fragility Audit Programme (NFFAP) - National Audit of Inpatient Falls (NAIF)
Falls remain one of the leading causes of harm in hospital settings. The NAIF measures care given to patients who fell while they were in hospital and sustained a hip fracture. NAIF data is discussed at the Trust Falls Prevention Group, where areas for focussed improvement projects are agreed. The Trust has undertaken further work to improve the quality of care delivered:



Mobility Assessment - A review of the length of time taken for a referral to therapy services for patients identified as being at risk of falls was undertaken. The process for referral to therapy services has now been integrated into the falls risk assessment in Meditech. Once a patient has been identified as requiring assessment, an automatic pop up appears for the referral to be completed at the point of identification.
A snapshot review of 16 patients referred to therapy services where referrals were completed using the new pop up showed that:

- 11 were identified earlier as not requiring input
- 4 had therapy referrals completed within 48 hours
- 1 referral was completed within 24 hours

Previously on average referrals took 3-4 days.
Lying & Standing Blood Pressure – The revised RCP guidelines have been added to Meditech to improve compliance with completing Lying & Standing blood pressures

Safely moving patients - Trust wide communications on the locations and how to access flat lift equipment was circulated in the ibulletin September 2023
Patient Safety 5in5 was circulated Trust wide on the safe use of and access to flat lift equipment September 2023
TRFT Slips, Trips and Falls Policy is being reviewed and updated to reflect the requirement of the use of flat lift equipment for patients with suspected fractures (February 2024)
TRFT Falls Prevention Competency package has been amended in-line with the Policy to demonstrate the national requirement. It will be uploaded and available on ESR. This enables local and Divisional management and Trust wide oversight of compliance
A business case is in development for the purchase of 2 new flat lift air systems to increase availability and access
The NAIF data and case studies of post falls care is shared in training and on the Nurse Preceptorship Programme
Trust wide manual handling training continues to include the safe use of flat lift equipment

What Next - Participation in the NAIF enables the Trust to stay abreast of common national themes and areas for focussed Quality Improvements projects, the Trust maintains an ‘everybody’s responsibility’ approach to falls prevention, which is reflected in the increased divisional representation at the falls prevention group.

The NAIF annual report has highlighted the areas for improvement and KPI’s for the 2023 data submitted - these include:

- KPI 1 - High-quality multi-factorial risk assessment (MFRA)
- KPI 2 – Check for injury before moving
- KPI 3 – Flat lifting equipment used to move the patient from the floor
- KPI 4 – Medical assessment within 30 minutes of the fall

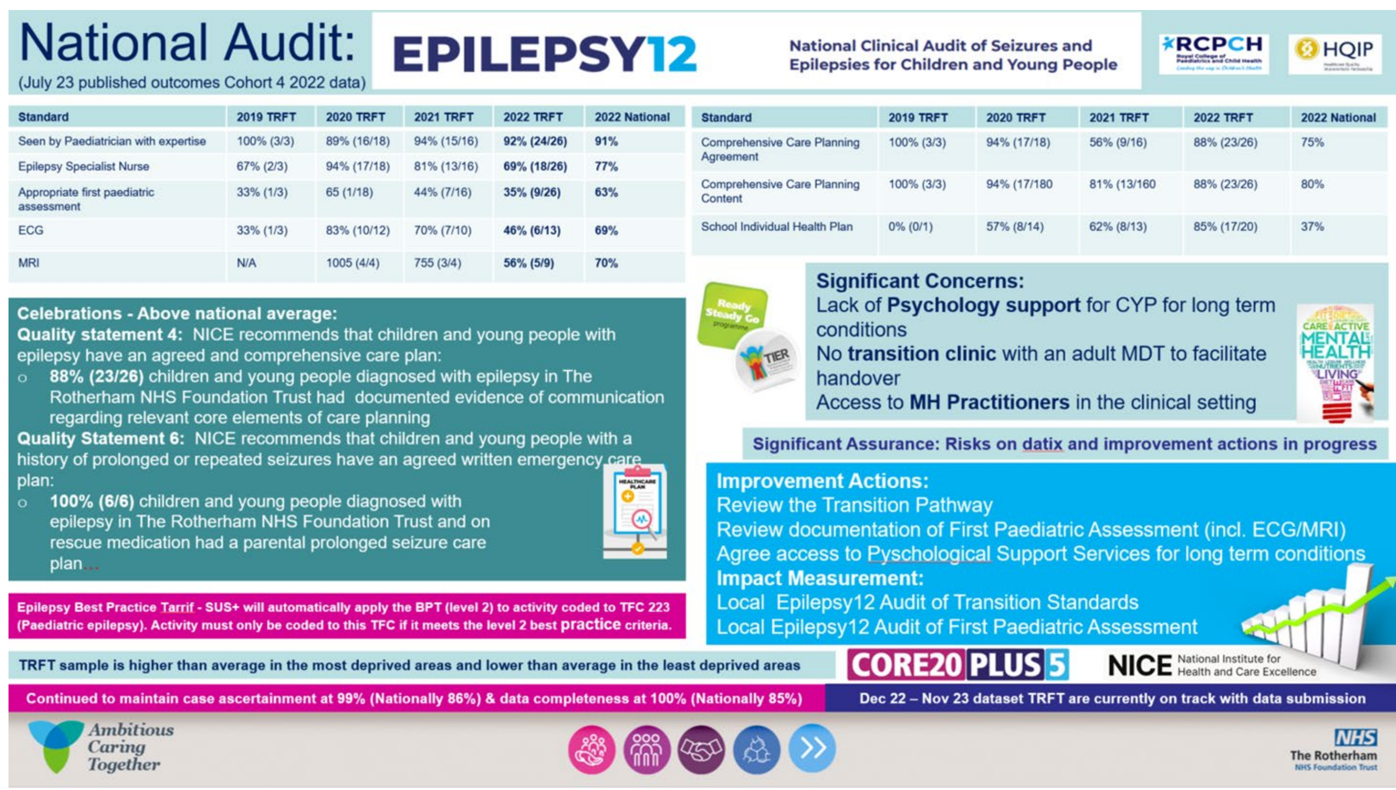
There is currently improvement work taking place throughout the organisation as mentioned above around KPI 1 & 3, there remains areas for improvement around KPI’s 2 & 4. The falls Prevention Group continue to meet quarterly to review the NAIF data and annual report to ensure quality improvement projects are focussed around areas of concern.

KPI’s 2 & 4 there is a planned review due to take place, looking closely at the post fall care our patients receive. This includes our average time for medical assessment to take place once a

patient has fallen and the length of time taken to administer analgesia. The NAIF data reported an increase in the average time for the administration of analgesia for patients post fall. This is an area of concern that the falls prevention group will be addressing in next month's meeting.

Inpatient falls dashboard - Currently the number of falls within each inpatient area are reported on a monthly falls dashboard which is circulated to divisions at the end of each month. The dashboard is a representation of the number of falls within each area by harm only, it does not allow further analysis or the identification of themes and trends. A new PowerBI. dashboard is in development which will reflect the falls data in more depth, with various components and fields lifted from Datix and available on the dashboard. This will allow for greater thematic analysis into inpatient falls within particular areas.

Epilepsy12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People



Standard	2019 TRFT	2020 TRFT	2021 TRFT	2022 TRFT	2022 National
Seen by Paediatrician with expertise	100% (3/3)	89% (16/18)	94% (15/16)	**92% (24/26)**	**91%**
Epilepsy Specialist Nurse	67% (2/3)	94% (17/18)	81% (13/16)	**69% (18/26)**	**77%**
Appropriate first paediatric assessment	33% (1/3)	65 (1/18)	44% (7/16)	**35% (9/26)**	**63%**
ECG	33% (1/3)	83% (10/12)	70% (7/10)	**46% (6/13)**	**69%**
MRI	N/A	1005 (4/4)	755 (3/4)	**56% (5/9)**	**70%**

Standard	2019 TRFT	2020 TRFT	2021 TRFT	2022 TRFT	2022 National
Comprehensive Care Planning Agreement	100% (3/3)	94% (17/18)	56% (9/16)	88% (23/26)	75%
Comprehensive Care Planning Content	100% (3/3)	94% (17/180	81% (13/160	88% (23/26)	80%
School Individual Health Plan	0% (0/1)	57% (8/14)	62% (8/13)	85% (17/20)	37%

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Patient Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure

<table>
<tr><td colspan="3">Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure
A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure. The national report identified that action could be taken at all points of the patient pathway. The Trust are taking the following actions to improve the quality of care;</td></tr>
<tr><td></td><td>Have a system in place which enables emergency medicine/admitting clinicians to communicate with the patient’s usual epilepsy clinical team (wherever the team is based) when the patient presents to hospital with a seizure</td><td>Communication by UECC and AMU with Neurology:
For emergency advice - this is with the RHH On Call Neurology Service by telephone via RHH Switchboard. For routine advice - this is via the epilepsy nursing services
To obtain latest correspondence letters with management plans - this is via the secretary of the Epilepsy Clinical Team
To ensure epilepsy clinical team aware of a recent discharge from hospital, this requires AMU to send a copy of the discharge summary to the epilepsy specialist nurses</td></tr>
<tr><td></td><td>Arrange follow-up plans before the patient is discharged from a hospital admission following a seizure</td><td>UECC and AMU to follow the First Fit Referral Pathway and Guidelines to book a patient with first seizure presentation into the correct Neurology OPD
Attach a copy of the discharge summary with the First Fit Referral form
For patients known to a clinical epilepsy team, discharge summary to be copied to the epilepsy specialist nurses</td></tr>
</table>

Review of Local Clinical Audits

The outcomes of 123 Local Clinical Audits were reviewed by the provider in 2023-24. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which can be seen in Appendix 1.

CQUINs (Commissioning for Quality and Innovation)

In 2023/24 a total of 9 of the national CQUIN schemes were applicable to TRFT, of these TRFT selected 5 schemes against which to assign a financial incentive. Trust performance against each indicator has been submitted quarterly in line with the national CQUIN reporting timetable. The CQUIN schemes are listed below:

ID	Title	Financial incentive assigned
CCG1	Staff Flu Vaccinations	Yes
CCG2	Supporting patients to drink, eat and mobilise after surgery	Yes
CCG3	Prompt switching of intravenous antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	No
CCG4	Compliance with timed diagnostic pathways for cancer services	No
CCG5	Identification and response to frailty in emergency departments	No
CCG6	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Yes
CCG7	Recording of and appropriate response to NEWS2 score for unplanned critical care admissions	Yes
CCG12	Assessment and documentation of pressure ulcer risk	Yes
CCG13	Assessment, diagnosis and treatment of lower leg wounds	No

The final submission of the quarterly CQUIN performance is due in June 2024 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.

CQC ratings

There have been no formal inspection visits during 2023/24. 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		Requires Improvement			Requires Improvement
Children & Young People	Requires Improvement	Requires Improvement			Requires Improvement
Inpatients			Outstanding		
End of Life Care		Requires Improvement			Requires Improvement
Dental					

(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. The Trust has completed all of the actions within the CQC improvement plan and continues to provide assurance that these are embedded.

The CQC have moved to the new Single-Assessment framework. All Core Services have previously completed a Quality Assurance Review and have now started to review against the new criteria. This will continue into the upcoming year and will be supported through a peer review programme.

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. The Trust has continued to work with other organisations and share good practice.

The Trust is also required to report any breaches of the **Ionising Radiation Regulations** to the CQC. Below is a summary of the radiation incidents that were reported to the CQC from 1 April 2023 to 1 April 2024.

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

> The CQC say that:
>
> "When there is an accidental or unintended exposure to ionising radiation, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) employer knows or thinks it is significant or clinically significant, they must investigate the incident and report it to the appropriate UK IR(ME)R enforcing authority (under Regulation 8(4)."

We have reported 22 radiation incidents to our local Radiation Protection Advisor (RPA), for a dose report and recommendations.

Two of these incidents met the criteria to be reported to the CQC.

Reportable Incident 1 – nuclear medicine department incorrect patient referral meant that the patient had an injection of a radionuclide which was unintended. This has been discussed with the clinician and reflections have been made by the referrer. CQC has closed this incident after a report was submitted.

Reportable Incident 2 – Ct scanning main radiology department – a pregnant patient underwent a CT scan of chest abdomen and pelvis. There is no documentation to suggest the correct checks were completed prior to the examination. Action plan and full report has been sent to the CQC, awaiting feedback. Learning has been taken from this incident and the incident has been shared with team members to aid earning. Processes are being reviewed to mitigate the risk of this occurring again.

All Radiation incidents are recorded internally on DATIX and reported to the Radiation Protection Advisor (RPA) all radiation incidents are investigated and learning outcomes identified and shared. These are also discussed at Radiation Protection Committee meetings which are held quarterly and these feed into the Trust's Health and Safety meetings.

These incidents have been investigated and have been escalated through to the Clinical Support Services, Divisional Quality Governance Committee meetings. These are also discussed at Radiation Protection Committee meetings, which are held quarterly which feed into the Trusts Health and Safety meetings. This provides assurance as to the quality of the investigation and the robustness off the remedial actions taken.

Special Reviews and Investigations

The Trust has not participated in any Specialist Reviews during 2023/24.

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% (99.8% for 2023/24) for admitted patient care
- 100.0% (100.00% for 2023/24) for outpatient care
- 99.8% (99.5% for 2023/24) 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 2023/24) for admitted patient care
- 100% (100% for 2023/24) for outpatient care
- 100% (100% for 2023/24) 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 2022/23 was 'Substantial Assurance' and Toolkit 'Standards Met'.

The Trust will submit again by 30 June 2024 and is aiming for full compliance – assurance will also be sought from the auditors prior to the end of May 2024.

Payment by Results

The Trust was not subject to the Payment by Results clinical coding audit during 2023/24 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 England Data Quality Dashboards.

The Trust was subject to the mandatory Clinical Coding Information Governance audit in December 2023, during the 2023/24 reporting period as required by NHS England. 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 97.74% 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 the 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 England Data Quality Dashboard perspective. Any fluctuations in performance are identified and actions are put in place to resolve. If aide memoires, for staff understanding, are required the Data Quality Team will work with the Training Team to put the best possible processes in place to resolve these issues. The Data Quality Team also works closely with the Reporting Teams to ensure that they are aware of any errors that may be present from a submission perspective to ensure these are rectified at source, thus ensuring the Trust maintains its high standards with regards to the integrity of our data.

Clinical Coding

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

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	97.00%	98.16%	98.16%	99.03%

(Source: The Rotherham NHS FT Information Governance Audit Report 2023/2024)

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 2022/23 the Trust worked with the following actions to improve clinical coding and data quality and these continued throughout 2023/24:

- 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 2024/25 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 2023-24	Qtr 2 2023-24	Qtr 3 2023-24	Qtr 4 2023-24	YTD 2023-24	Progress
IMPROVING DATA QUALITY	IDQ-1 DQMI ECDS	2021-22 **	69.2	Increase	85.5	85.3	84.9	84.9	84.7	
	IDQ-2 DQMI APC	2020-21 **	98.9	Increase	97.0	96.9	96.9	99.2	99.2	
	IDQ-3 DQMI CSDS	2020-21 **	93.0	Increase	94.1	94.0	94.0	94.1	94.2	
	IDQ-4 DQMI MSDS	2020-21 **	99.6	Increase	99.5	99.7	99.8	99.9	99.9	
	IDQ-5 DQMI OP	2020-21 **	99.2	Increase	98.6	98.7	98.7	98.6	98.6	
	IDQ-6 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015-16	99.8%	Increase	99.8%	99.8%	99.9%	99.8%	99.8%	
	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	99.4%	99.6%	99.6%	99.5%	99.5%	
	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 Summary Hospital-level Mortality Indicator (SHMI) data each month at the Trust's Mortality Group meeting. This data includes reports which alert the Trust when modelling has determined that there is a statistically significant level of excess deaths in a diagnostic group. The

Mortality Group will use this information alongside past information, to determine how to investigate the alert. Investigations comprise of coding reviews, review of completed SJRs or the request of additional SJRs deaths in the diagnostic group.

Learning from Deaths - Medical Examiner Scrutiny

This service provides independent scrutiny of all Trust non-coronial deaths. Part of this scrutiny involves escalating deaths to the Trust which should be considered for a 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. These processes are being put in place for 2024/25. The scrutiny of all non-coronial deaths is proposed to become mandated in law at some point during 2024/25.

For 2023/24 the Service just fell short of its target of a 100% completion rate for scrutinies of Trust deaths. 99% were completed. The service has a target for Trust scrutinies to be completed within 5 days of death. Whilst there will be circumstances when this is not possible, the rate for completions within 5 days is high at 89%.

Medical Examiner Scrutiny Figures for 2023/24:

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-23	89	89	100%	99%
May-23	79	79	100%	100%
Jun-23	83	83	100%	96%
Jul-23	52	52	100%	94%
Aug-23	81	81	100%	70%
Sep-23	87	87	100%	90%
Oct-23	88	88	100%	94%
Nov-23	88	88	100%	98%
Dec-23	113	113	100%	88%
Jan-24	124	124	100%	73%
Feb-24	96	96	100%	100%
Mar-24	110	94	85%	75%
2023/24	**1090**	**1074**	**99%**	**89%**

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. The Trust estimates that 10% of death will be identified for SJR from Trust coded data or from national mortality indicator data, and therefore not close to the time of death. Therefore, for 2023/24 a 90% target was set.

87% of SJR for deaths in 2023/24 have been completed. 55% were completed within 60 days. This represents a significant improvement on 2022/23 figures of 45% and 25% respectively. This is a result of the new SJR process for 2023/24. Improvement was seen during the year and ongoing work is continuing to improve the timeliness figure.

SJR Figures for 2023/24:

Discharge Date	Adult Inpatient & UECC Deaths	SJR Requested	Completed	Outstanding	% Completed	Overall Care Score < 3	Preventa-bility Score < 4
2023/24	1070	220	192	28	87%	36	3
Q1	247	41	41	0	100%	9	2
Q2	214	48	48	0	100%	11	0
Q3	286	63	60	3	95%	10	1
Q4	323	68	43	25	63%	6	0

Discharge Date	% Completed < 60 Days
2023/24	55%
Q1	41%
Q2	50%
Q3	73%
Q4	51%

Preventability score	6 – Definitely not	5 – Slight evidence	4 – Possibly: less than 50:50	3 – Possibly: greater than 50:50	2 – Strong evidence	1 – Definitely preventable

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

All SJRs where the overall care has been judged to have been poor or likely preventable are added as incidents and reviewed following the Trust Governance processes. In addition these SJR are recommended for presentation at the appropriate Clinical Support Unit Clinical Governance meeting.

Intelligence and Learning

Thematic Analysis Reports have been produced quarterly 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 – Reviewing Deaths for those with Learning Disabilites, Autism and Serious Mental Illness

In line with national guidelines, TRFT completes SJRs for all of these deaths. The Trust has a robust system for identifying these.

Deaths for these patients are identified by using Trust clinical coded data and alert data, recorded in the patient's electronic patient record. The Medical Examiner will also flag these patients if they are identified during a scrutiny.

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

All LeDer requests go to the Trust Matron for Learning Difficulties and Autism, who will assist the Integrated Care Board LeDer Team with the review. This can involve arranging on-site visits with the LeDer Review Team, to enable them to review appropriate Trust-held medical records. TRFT will supply the team with a completed SJR, or request one if the patient died within 14 days of a Trust discharge, or longer if appropriate.

Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding and to the requesting Integrated Care Board LeDer Team.

SJR Figures for Adults with a Learning Disability, Autism or Serious Mental Illness

Month of Discharge	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
Apr-23	2	2	0	1	0
May-23	2	2	0	0	0
Jun-23	1	1	0	0	0
Jul-23	1	1	0	0	0
Aug-23	3	3	0	1	0
Sep-23	4	4	0	1	0
Oct-23	1	1	0	1	0
Nov-23	3	3	0	1	0
Dec-23	5	5	0	0	0
Jan-24	4	2	2	0	0
Feb-24	1	0	1	0	0
Mar-24	6	2	4	1	0
2023/24	**33**	**26**	**7**	**6**	**0**

All SJRs have been allocated for 2023/24 deaths. The SJRs not completed are for deaths in the final quarter, and are expected to be completed in the first quarter of 2024/25.

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-22	Dec-22	Mar-23	Jun-23	Sep-23
SHMI	105.1	107.3	107.5	103.4	102.4
Banding	As Expected	As Expected	As Expected	As Expected	As Expected
% of Deaths with Palliative Care Coding - TRFT	45	44	46	48	49
% of Deaths with Palliative Care Coding - England	40	40	40	41	42

The table above tells us that the Trust's SHMI has consistently been 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).

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

Patient Related Outcome Measures (PROMS)

DOMAIN	Indicator Title	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Domain 3 - Helping people to recover from episodes of ill health or following injury	**Primary hip replacement surgery (EQ-5D Index) - health gain**							
	1st April 2021 - 31st March 2022	18	0.319	0.821	0.502	15 (83.3%)	3 (16.7%)	0 (0.0%)
	1st April 2022 - 31st March 2023	1	-0.074	0.760	0.834	1	0	0
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2021 - 31st March 2022	29	0.228	0.768	0.540	27 (93.1%)	2 (6.9%)	0 (0.0%)
	1st April 2022 - 31st March 2023	5	0.153	0.542	0.389	4	0	1
	On the 1st October 2017, PROMs data for varicose veins and groin hernia surgery ceased collection, following on from the NHS England Consultation on the future of PROMs							

Please note: Results in this document are finalised for April 21 - March 22. Figures for April 2022 - March 2023 are Provisional. Casemix-adjusted figures are calculated only where there are at least 30 modelled record.
Data source = https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms

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

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

Domain5: Treating and Carng for people in a safe place.	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
	*Percentage of patients admitted to hospital and risk assessed for VTE	Apr 22 - Mar 23	94.91%	national data not available		
		Apr 23 - Mar 24	95.76%	national data not available		
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over (total cases)	Apr 21 - Mar 22	27.8	43.72	138.4	0
		Apr 22 - Mar 23	32.5	43.5	133.64	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 23 - March 24	0.28%	national data not yet available		
		Apr 23 - Dec 23	0.30%	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 2024 for April 2023 to March 2024**

*** 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
2022/23	**96.59%**	97.31%	97.29%	96.41%	95.83%	95.36%	96.42%	97.49%	96.67%	96.61%	96.70%	96.89%	96.60%
2023/24	**95.90%**	95.11%	94.72%	94.67%	94.89%	95.30%	95.65%	95.81%	97.05%	96.69%	96.85%	97.10%	96.20%

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

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

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
12a. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period.	Data validated and published by NHS Digital. The Trust's SHMI value has been consistently in the As Expected band.	The Trust has a Trust Mortality Group (TMG), which holds meetings each month. Divisional Mortality Leads hold monthly mortality meetings in their respective Division and feed into the TMG. The TMG in

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:
		turn reports to the Clinical Effectiveness Committee, chaired by the Deputy Medical Director. SHMI Data, intelligence from SJRs 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 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.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 30 days of discharge from the Trust (as per national reporting and benchmarking consistency).	Internal Trust data is used for reporting of re admissions for the performance reports for the Board of Directors, the Divisions, the CSUs and for the Service Line Monitoring 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. Readmissions 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 2022. Full results are available later in this report.	The CQC published the 2022 patient survey results in September 2023. Picker were invited to deliver a facilitated feedback session with all divisions participating. From this, a Trust wide Quality improvement plan was developed with Divisions which included safe staffing, discharge, nutrition, hydration and pain management.
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.	58% of colleagues would be happy with the standard of care that the Trust provided to their family or friends, as detailed in the National Staff Survey. This is the largest increase in England, (up 8% from 2022).

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:
21.1 The national change to the Friends and Family Test (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. 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 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 is no longer possible because there is now no limit upon how often a patient or service user can give their feedback.	Numerical data is no longer comparable between NHS organisations; this was also a factor in the ending of national reporting on the percentage response rates achieved. Positive feedback, areas of improvement and actions taken as a result of feedback are discussed and recorded as part of Divisional governance meetings. Divisions have robust mechanisms in place to ensure that the feedback via the FFT dashboard is reviewed and acted upon where required. Following the introduction of the electronic survey, the FFT dashboard and Power BI has been used to provide data to the divisions, Patient Experience Group and Patient Experience Committee. Activity and learning 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.

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:
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 Post Infection Review presented at the Harm Free Care panel and the Infection, Prevention and Control Group and Committee.
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 2023 to March 2024. This was the latest reporting period where the Trust has submitted its data and it has been validated by the NRLS Team. Number of NRLS reportable incidents occurring in this period was 9476. The percentage of severe harm or death was 0.28%.	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures, shared learning events and patient safety bulletins. As the Trust continues to transition 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.

(Source: Trust Information System)

His Majesty's Coroner's Inquests 2023/24

During the relevant period the Trust received 72 referrals from His Majesty's Coroner, compared with 54 referrals from the previous year, which represents a significant increase. These included both confirmed inquests and preliminary investigations.

His Majesty's Coroner heard 46 inquests during the last financial year, 16 of which required attendance by the Trust, 15 as Interested Parties and 1 where a clinician gave evidence as a witness of fact. The majority of the attended inquests were listed for 1-2 days. A total of 37 inquests were documentary (i.e. evidence was read under Rule 23). External solicitors were instructed to represent the Trust's interests.

The Trust is expected to attend approximately 26 inquests in 2024/25 which are referrals received during 2023/24.

His Majesty's Coroner issued one Prevention of Future Death Report in 2023/24 following an inquest heard in October 2023, pursuant to Schedule 5 of Coroners and Justice Act 2009 which imposes a statutory duty on Coroners to request for action to be taken to prevent future deaths.

The continued focus in the next financial year will be on divisional management oversight of inquests at an early stage 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 2023/24

A summary of the Trust's nine quality priorities for 2023/24 is provided below.

Patient Safety

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

Patient Experience

- Holistic Needs Assessments for Cancer Patients
- End of Life Care
- Reducing Health Inequalities – Digital Weight Management/Tobacco Treatment Services

Clinical Effectiveness

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

Details of the achievement against these in the year are included below. In summary we have made significant progress against each of these priorities although we did not meet the ambitious targets we set for ourselves in all areas. Work will continue in each of these areas over the coming year to make further improvements.

Quality Priorities	**Achieved/Partially Achieved/Not achieved**
Prevention of Pressure Ulcers	Achieved
Management of Sepsis	Achieved
Learning from Deaths	Partially Achieved
Holistic Needs Assessment for Cancer Patients	Achieved
End of Life Care	Partially Achieved
Reducing Health Inequalities – Digital Weight Management/Tobacco Treatment Services	Partially Achieved
Virtual Ward	Partially Achieved

Quality Priorities	Achieved/Partially Achieved/Not achieved
Getting it Right First Time (GIRFT)	Achieved
Clinical Audit and Effectiveness	Partially Achieved

Domain: Patient Safety

***Title* – Prevention of Pressure Ulcers**

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. Treating pressure damage costs the NHS more than £3.8 million every day and is a significant cause of both physiological and psychological harm.

There were 47 SDTIs (suspected deep tissue injury), 144 deep unstageable pressure ulcers, 10 category 3 or 4 pressure ulcers and 559 category 2 pressure ulcers reported at the Trust (acute and community combined) in the year 2022/23.

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

The aim of the quality priority was to ensure that our staff were trained and able to give high quality, personalised wound care for adults, children and young people. This will improve patient experiences, save money, reduce the number of wounds and the chance of them coming back.

The objectives were identified as:

- There will be a 20% reduction in Category 3, 4, unstageable and SDTI pressure ulcers from April 2023/ March 2024
- There will be 10% reduction in Category 2 pressure ulcers from April 2023/March 2024

There were a number of identified actions which the Trust has completed to support this work;

1. There will be a review of Datix information to establish a baseline of incidents across pressure ulcer categories of the past 2 years.
2. Implementation of the national wound care strategy and framework.
3. Review of current RCA documentation to be in line with the patient safety incident response framework.
4. Guidance and SOP for managing pressure ulcers.
5. Establishment of a harm free care panel for oversight and sign off of all pressure ulcer incidents at category 3, 4, unstageable and SDTI.
6. Utilisation of the SEIPS approach, identifying themes to drive quality improvement programmes of work.
7. Tissue viability education strategy for the Trust.
8. Monitoring of personalised care planning compliance via Tendable.
9. Action plans to be integrated into the OLAF framework.

What did we achieve?

All of the actions have been completed throughout the year and have contributed to the success in the overall reduction of harms from pressure ulcers at category 2 by 18%. There has been a 22% reduction of pressure ulcers at category 3, 4, SDTI and unstageable for patients in the Acute site and a total reduction of numbers in Community.

How was progress monitored and reported?

Throughout the year progress was monitored through data collection, Tendable assurance, datix events and audit. This was reported to the Patient Safety Committee and Quality Committee.

What further actions need to be undertaken?

An important part of pressure ulcer prevention is undertaking an assessment of the risk of a patient developing a pressure ulcer. This enables an effective pressure ulcer prevention/treatment plan to be developed and ensures effective use of resources.

An effective pressure injury risk assessment requires a structured approach that considers factors including but not limited to mobility, existing pressure injuries, co-morbidities such as diabetes, circulatory status, body temperature and nutrition.

The current pressure ulcer risk assessment in use in the Trust is the Waterlow Risk Assessment tool with the exception of UECC, Intensive Care Unit and Paediatrics who have service specific risk assessment tools. The Waterlow risk assessment tool has previously been the leading tool used within the NHS. However the limitations of the Waterlow have been documented as being:

- Poor sensitivity accuracy
- Inadequate inter-rater reliability
- Lack of clear definitions within the categories
- Over prediction of risk and consequently over prescription of pressure relieving equipment

The Pressure Ulcer Risk Assessment Tool that is now recommended for use in NHS settings by the National Wound Care Strategy is the PURPOSE-T Risk Assessment Tool developed by The Leeds Teaching Hospital Foundation Trust in conjunction with Leeds University.

The advantages of PURPOSE-T

- Purpose-T has a screening stage allowing rapid identification of those who are not at risk preventing the need for a more detailed full assessment which saves time and clinical hours
- Colour is used to aid decision-making
- Includes pain as a risk factor and key indicator of pressure ulcer development
- Clearly distinguishes between primary and secondary prevention, so patients with an existing pressure ulcer or scarring are immediately allocated to a secondary prevention pathway, facilitating escalation of treatment and promoting healing
- Developed based on a systematic review of the risk factor evidence and pain cohort study, involving international and interdisciplinary experts and in partnership with service users

The Trust will adopt the Trust wide use of the PURPOSE-T risk assessment tool with the exception of the Intensive Care Unit, UECC and Paediatrics who have service specific risk assessment tools.

Aims

- To improve the accuracy of the assessment of the risk of patients developing pressure ulcers
- To reduce patient harm caused by the development of avoidable pressure ulcers

***Title* – Management of Sepsis**

Executive Lead – Medical Director
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. It occurs when the body's immune system – which normally helps to protect us and fight infection – goes into overdrive. It can lead to shock, multiple organ failure and sometimes death, especially if not recognised early and treated promptly. 5 people die with sepsis every hour in the UK (Sepsis UK, 2021).

Although the Trust has a low number of deaths associated with Sepsis, we remain committed to improving the response to patients who are showing signs of physiological deterioration with a possibility of developing sepsis to improve their outcomes.

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

The aim for the quality priority was to ensure that all patients showing signs of possible sepsis will get a senior clinical review earlier. This will then ensure they were on the right medications earlier, so that patients will get better faster.

Metrics:

- Baseline data intelligence for initial starting point and ongoing progress
- >90% of all adult patients with a NEWS score >5 will have a sepsis screening completed
- >90% of patients screened as high risk of sepsis will be escalated for a senior clinical review and this will be completed in 1 hour alongside appropriate diagnostic investigations
- >90% of all patients receiving treatment for suspected sepsis should have early diagnostic testing, review of antibiotic requirement and targeted treatment to ensure best clinical outcomes and support antimicrobial stewardship

The Actions associated with this priority are:

1. Review and revise the Sepsis policies (Adults, Paediatrics and Maternity)
2. Review and revise the NEWS 2 policy
3. Update the Sepsis and Deteriorating patient Power Bi dashboards
4. Establish the Sepsis Quality Improvement Group
5. Commission audit cycle and capture actions through the Sepsis Quality Improvement Group

What did we achieve?

Across all admission areas, UECC and an in-patient medical ward with the highest acuity of patients, it was demonstrated that >90% of patients showing signs of sepsis had sepsis screening completed, had early senior clinical review within 1 hour and have treatment started. The metric for diagnostic

testing was unable to be collected consistently in the audit, however appropriate management plans were completed in 96% of cases.

The policy for Sepsis and Deteriorating patient has been updated to reflect the changes to national guidance. The work that is associated with sepsis improvement is now coordinated through the Sepsis Quality Improvement Group and an audit cycle for the acute Trust has been commissioned and started in 2 ward areas.

How was progress monitored and reported?

Progress against the metrics has been monitored monthly through the sepsis quality improvement group and report to the Patient Safety Committee and Quality Committee.

What further actions need to be undertaken?

The commissioned audit programme has started in 2 areas and will be ongoing throughout the 2024/25 financial year. The outcome of the audit will determine the work that is required to support improvement.

The success demonstrated in the admission areas and UECC will be monitored through a quarterly audit cycle and reported in the Sepsis Quality Improvement Group, Patient Safety Committee and Quality Committee.

***Title* – Learning from Deaths**

Executive Lead – Medical Director
Operational Lead – Learning from Deaths and Mortality Manager

Current position and why is it important?

A major component of the Learning from Deaths programme 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 hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

From April 2023, a new SJR completion process started at TRFT. This will ensure that the Trust has good quality, complete and timely SJRs. This will provide the Trust with good intelligence from the Learning from Deaths programme, in order to allow the better identification of themes and trends, for both good and poor care.

The new process for 2023/24 has emerged from the Trusts Learning from Deaths Improvement Programme with NHSE/I's Better Care Tomorrow Team and follows advice and best practice. The process has SJRs completed by a small team of trained SJR Reviewers who have protected time and complete reviews regularly. The SJR Review team be will trained in and use NHSE/I's national SJR+ system. SJR+ also provides the Trust with additional analytics.

2022/23 was about creating a process which produces good quality SJRs. 2023/24 will be about making sure the new process delivers and critically that the Trust has processes in place to make

sure that this intelligence is viewed by the right groups within the Trust who can devise changes which reduce/prevent problems and promote good care for future patients.

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

Aim:

To have a Learning from Deaths Programme that creates a rapid cycle of learning by producing good timely intelligence from SJRs which can be used by the Trust to devise and implement changes to procedures/processes which reduce/prevent problems and promote good care for future patients.

Objectives:

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

- Ensure that the Trust is selecting and completing appropriate SJRs
- Enhancing & improving the quality, and consistency and completeness of its SJRs.
- Have timely SJRs which can highlight potential good or bad care close to the time that the care was delivered
- Be able to analyse and determine trends and themes from SJRs
- Using intelligence gathered from the SJRs to deliver learning, improvement and change

Metrics:

- Quality & Consistency of SJRs: All SJRs will have supportive freetext for care scores. 2023/24 Target = 100% (2022/23 attainment 21%)
- SJR Timeliness: SJRs to be completed with 60 Days of Death 2023/24 Target = 90% (2022/23 attainment 25%)
- Learning Dissemination: A Thematic Analysis report to be produced & distributed quarterly. 2023/24 Target = 100% (2022/23 attainment 2 per annum)

What did we achieve?

Ensure that the Trust is selecting and completing appropriate SJRs:

In 2023/24 there were 1070 adult Inpatient and UECC deaths at the Trust. 21% of these deaths had SJR requested. This is in line with the number expected and comfortable above the 15% recommended nationally. Cases are selected for SJR if they meet the criteria for any of the 6 national categories.

Cases are identified after a Medical Examiner Scrutiny and from searches of patient's electronic medical record data. These data searches has been enhanced during 2023/24 including the addition of a search for deaths of patient with a Serious Mental Illness, based on their diagnosis coding for their final admission.

TRFT is confident it has a robust systems and processes for its case selection process to identify deaths requiring a SJR.

Enhancing & improving the quality, and consistency and completeness of its SJRs:

Metric: Quality & Consistency of SJRs: All SJRs will have supportive freetext for care scores.

The target of 100% was reached for 2023/24. The Trusts SJRs are now completed by a team of trained SJR Reviewers. They are of a much higher quality and completeness. All care scores are backed up by supportive freetext, which is providing the Trust with more and better intelligence.

Have timely SJRs which can highlight potential good or bad care close to the time that the care was delivered

Metric: SJR Timeliness: SJRs to be completed with 60 Days of Death

The attainment figure for 2023/24 is 55%. This represents significant improvement on the previous year's figure (25%), however does not meet the 90% standard. This is in part due to more than 10% of deaths not being requested for SJR close to the time of death. Most of these are unavoidable such as those identified through national mortality indicator data or coded Trust data. This may mean that the 90% target is reduced. The biggest cause however is the timeliness of reviewers completing their allocated SJRs. Reviewers are encouraged to complete SJRs within 4 weeks of allocation and this has increased throughout the year.

Be able to analyse and determine trends and themes from SJRs:

Metric: A Thematic Analysis report to be produced & distributed quarterly.

The target figure of increasing the frequency of Thematic Analysis Report production and dissemination, from twice a year to quarterly has been reached.

Using intelligence gathered from the SJRs to deliver learning, improvement and change:

Individual SJRs

All completed SJRs are sent to the respective Division. The Divisional Mortality Leads selects SJRs with learning points, both good and bad, and sends these, together with SJRs that are judged to have had poor care or been preventable, to the appropriate Clinical Support Unit (CSU). These SJRs are then discussed individually at the CSU Clinical Governance meeting or separate CSU Mortality meeting.

All completed SJRs that are judged to have had poor care or been preventable are now entered as incidents onto the Trust's Datix system. These are reviewed by representative from the Patient Safety Team, staff from the clinical area and any colleagues for whom the incident is relevant. Learning points and actions are discussed. Actions can include instigating a Patient Safety Incident Investigation and referring the SJR and its learning points to the appropriate CSU Clinical Governance meeting or directly to the Clinical Team involved in the care.

Thematic Analysis Reports (grouped SJRs)

The Trust's objective is to use intelligence from the Learning from Deaths programme to drive improvements. This means disseminating the intelligence to Trust Groups/Individuals, who have the expertise to devise and implement changes to care processes and procedures.

Most completed SJRs do not require or meet a criteria for further investigation or review. However, the majority of these do contain comments relating to good or poor care. This intelligence is much more valuable when this is grouped into themes.

One isolated incidence of an issue i.e. delay in antibiotic prescribing, suggests an issue for that individual case. If several instances of an incident are identified, then it suggests there may be a system or process problem.

TRFT produces a Thematic Analysis Report each quarter which groups the free texts comments into themes. These reports are distributed widely within the Trust to groups and individuals.

<u>How was progress monitored and reported?</u>

Progress is monitored monthly by the Trust Mortality Group. Monthly reports are produced which include monitoring of the 3 performance metrics. These reports and their discussion are standing agenda items for this group.

The Trust Mortality Group reports progress to the Trust's Patient Safety Committee, Quality Committee and Board of Directors via a quarterly Learning from Deaths report.

<u>What further actions need to be undertaken?</u>

A new process for completing SJRs commenced in April 2023. The objective was to provide the Trust with good quality and timely SJR, providing valuable intelligence for the Trust. On the whole the objectives have been achieved. The process delivers much higher quality SJRs and closer to the time of death, when the clinical care was delivered.

2023/24 was about establishing this new process and delivering the intelligence from SJRs to the right people and groups with the Trust. The Trust now has robust processes to respond to SJRs where that individual case needs further review or investigation. Thematic Analysis Reports are now delivered to a wide range of Trust groups with responsibility for patient safety and clinical effectiveness. In addition, some Trust groups are requesting groups of SJRs that relate to their area of interest.

Processes are in place, which means good intelligence for the Learning from Deaths programme is flowing within the Trust. This will be built on in 2024/25, and there are still improvements with regard to the timeliness of SJR completion. There are unlikely to be wholesale changes to the SJR process. Focus now must move how the Trust uses and responds to this information.

How Intelligence from SJRs is being Used

As a result of big improvements in 2023/24, the focus for 2024/25 and beyond is now able to move to the ultimate goal of the programme. This is for intelligence from the programme to be used as a learning tool by the Trust, to devise and implement changes to care processes and procedures, which will reduce the occurrence of poor care for future patients and spread best practice of good care.

Intelligence from the Learning from Deaths SJR programme will have positive effects by adding to and strengthening already known intelligence available to the Trust. This will increase awareness and may give strength and further evidence to changes that are being or proposed to be made. This effect is difficult to measure when there are multi sources identifying the same issue. There will be

some changes where they are derived or expedited directly as a result of intelligence from the Learning from Deaths SJR programme. These changes will be easier to measure.

A feedback process will begin in 2024/25. This will ask recipients of the Thematic Analysis Reports to inform how their Groups responds to these reports. Questions such as:

- Are these reports routinely discussed/reviewed
- What is the format for these discussions, full report/selected parts, routine agenda item
- Are the reports identifying any new issues?
- Have the reports highlighted some that some problems thought to be rare or solved are more common place?
- Have the reports led to any new initiatives for change or given further evidence for initiatives already being undertaken?

In addition, a feedback process will begin in 2024/25 to ask how can the Thematic Analysis be improved to help Trust groups derive benefit from them.

In essence, these feedback processes will ask two questions for the Trust, how it is using the current Thematic Analysis Reports and how they can be improved to be used better. Whilst improvement suggests to reporting will always be considered and made, it is essential that the main focus has to be with the first part of this feedback process.

Domain: Patient Experience

***Title* – Holistic Needs Assessments for Cancer Patients**

Executive Lead – Chief Nurse
Operational Lead – Lead Cancer Nurse

Impact Statement

The National Personalised Care and Support Programme across all cancer pathways is based on having conversations around “what matters” to people and identifying their individual strengths and needs. Through offering patients newly diagnosed with cancer, the opportunity to complete a Holistic Needs Assessment (HNA), to facilitate a discussion around what their individual concerns are, will begin the process of embedding personalised care into the care we deliver to our patients. The Trust will demonstrate that 85% of all patients newly diagnosed with cancer will be offered a Holistic Needs Assessment. This will improve the patient’s experience of care by enabling them to more fully engage in their care and facilitate choice and enables the patient to take greater control of what happens to them and supports them to self-manage their condition.

Objective

- There will be an increase in the overall numbers of HNA’s offered to patients newly diagnosed with cancer to 85% across each individual cancer pathway by March 2024
- A planned trajectory will be to increase from 32% - 64% by September 2023 then from 64% - 85% by end of March 2024
- Where these objectives may not be met for each team to understand why this might be the case and to put plans in place to ensure objectives met

Metrics

- Baseline data intelligence for initial starting point and ongoing progress for all tumour sites as a collective
- Baseline data intelligence for initial starting point and ongoing progress for each individualised tumour site teams
- Quarterly data to be analysed against proposed trajectory as a collective and for each individual tumour site
- Patients experience of personalised care both at the beginning of the time period and the end

Validated data for Q4 2024 of numbers of HNA's offered

Breast - 87%
Gynaecology - 90%
Head and Neck - 100%
Lung - 96%
UGI - 96%
Brain - 100%
CUP - 100%
Haematology - 89%
LGI - 98%
Skin - 79%
Urology - 94%

Total number of newly diagnosed patients with cancer in quarter 4 2023/2024 = 421 with 92% being offered/discussed an HNA

Feedback from Patients

"Going through this process (HNA) and being asked about what I was concerned about helped me to be reassured that the staff who were looking after me really cared which built my confidence with the team and the NHS."

"When I was first asked I didn't know what to say I had just been diagnosed with cancer so my mind was a "shed" and didn't know what was concerning me. Sitting with the nurse and filling in the tick box really helped me to think about what I was really concerned about. I was then referred onto another service who really helped me to sort stuff out. I never realised that the medical team would be able to help me sort out some money problems I had but they did. Seeing this on the checklist gave me the ok to bring it up and talk about it."

"Felt it was too soon but after a few weeks had loads of things I needed sorting but thought I had missed having had this discussion until the nurse mentioned this again so asked if I could discuss this at that point."

"You have so much to think about it is really good that the staff who are looking after you think about more than just the medical treatment but think about all the other things that are going in in my life."

Actions Completed

- Guidance and SOP for the Holistic Needs Assessment process
- Training needs analysis to be conducted around the HNA process with a Learning and Development package to be in place
- Establish a quarterly Personalised Care and Support working group who will select two patients per speciality for case notes review and spot check on the value of the assessment for the patient and to provide peer review of the process. Share good practice
- Recruit to a dedicated Personalised Care and Support Project Manager to support the process

- Recruit to the Macmillan Information and Support Service Manager and Cancer Support Worker role as these will be pivotal at extending the HNA offer
- To seek patients feedback on the offer of HNA and the provision of personalised care

The next steps are designed to answer the following questions

- Is there any themes/trends with patients who accept the HNA conversation?
- Is there any themes/trends with patients who decline the HNA conversation?
- How many of the HNA conversations that take place result in the development of a personalised care plan?
- What is the quality of these care plans?
- What are common concerns raised by our Rotherham patients and which services do we have available to sign post the patient to for support?
- What do patients feel regarding the experience of being offered a HNA and a Personalised Care plan?
- Develop a secure web based means to providing a HNA to patients to allow them to complete at home
- Utilising behavioural science "nudges" to promote the HNA process and empower patients to ask to complete
- To develop a Cancer Patient Engagement Group

***Title* – End of Life Care**

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position

The Supportive Care Team is supported by a Consultant in Palliative Medicine and Clinical Nurse Specialists in Palliative and End of Life Care. The Lead Nurse for the Supportive Care Team left the Trust in July 2023. Recruitment for a new Lead Nurse was successful with an experienced, compassionate Lead Nurse starting in the Trust in January 2024.

The aim and objectives

The aim of the team is to pick up referrals through Meditech or SystmOne, Monday – Friday between 08.00–18.00 hours. Patients, families and clinical teams then seen and supported with their individualised needs to receive Person Centred Palliative and End of Life Care.

The Trust launched the six ambitions for Palliative and End of Life Care Strategy in May 2024 and this was ratified at the Board of Directors in summer 2024. There is now wider place and system work to build on the six ambitions and work collectively across South Yorkshire.

The team are also responsible for ensuring Role Specific Training across the Trust is delivered to the clinical workforce, ensuring there is a culture of learning and professional curiosity around end of life care.

What did we achieve?

Throughout 2023/4 there were 950 adult deaths in the Trust (excluding deaths in UECC) of these, 559 patients were given tailored care through the individualised plan of care (average 58.8%).

The team have delivered end of life education through the Person Centred Care study day to almost 400 Trust and place staff. Additional training to medical colleagues was delivered by the Consultant in Palliative Care.

The Rotherham Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) was also implemented across Rotherham place and this is being used well.

Every year, people around the country use Dying Matters Awareness Week as a moment to encourage communities to get talking in whatever way, shape or form works for them. In 2023, Dying Matters Week took place from 8 – 14 May and the team arranged a week of promotions to support these messages.

How was progress monitored and reported?

This year, End of Life was a Quality Priority so a performance dashboard was set up to start to collect data on referrals to the team and some outcomes. This work will evolve further with the new Lead Nurse working with informatics to continue to provide good data in the performance of the team.

In January 2024, the new National Audit for End of Life (NACEL) was launched. This includes a revised ongoing audit around the care patients have received, family feedback and staff feedback on their confidence for giving End of Life Care.

We currently have submitted 40 case note reviews and received 18 surveys back from relatives.

What further actions need to be undertaken?

The team are leading on several quality improvements, including Organ and Tissue donation, new bereavement books, guides to staff on how to care for people at the end of life and how to spread the new bereavement boxes introduced on Ward A5.

The family and staff feedback published by NACEL will further help to shape our services and this will be shared with all clinical teams.

***Title* - Reducing Health Inequalities – Digital Weight Management/Tobacco Treatment Services**

Executive Lead – Chief Nurse
Operational Lead – Healthy Hospitals Programme Manager

Current position and why is it important?

Reducing smoking and promoting healthy weight are two of the most effective ways we have to tackle inequalities of health outcomes among our patients. The performance of the QUIT team in identifying smokers and supporting them in managing their tobacco addiction remains strong, despite a recent drop in performance precipitated by staffing shortages and technical issues. Take-

up of the digital weight management pilot opportunity continues to grow, and is offering patients a new avenue of support in getting fit for surgery.

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

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.

Objectives:

- To increase the number of TRFT patients who quit smoking
- To provide enhanced tobacco treatment services to aid the reduction of local smoking prevalence and associated health care burden
- To reduce weight management pre-operatively to improve recovery, wound healing, shorter hospital stay and reduce need for critical care
- To establish secondary care access to the Digital Weight Management Programme for NHSE agreed surgical pathways - hysterectomy, laparoscopic cholecystectomy, hernia repair and hip/knee replacements

Established metrics for QUIT programme: ICB KPIs and targets

90% of inpatient spells with LOS ≥ 1 day have smoking status recorded electronically within 24 hours of admission

45% of ALL inpatients smokers with LOS ≥ 1 day have NRT prescribed within 24 hours of admission

Local pilot metric: digital weight management

A numeric increase in the number of patients signing up for the Digital Weight Management programme.

What did we achieve?

89% of inpatient spells with LOS ≥ 1 day had smoking status recorded electronically within 24 hours of admission
However, 95% of inpatient spells with LOS ≥ 1 day had smoking status recorded electronically during admission

28% of ALL inpatients smokers with LOS ≥ 1 day had NRT prescribed within 24 hours of admission
44% of ALL inpatients smokers with LOS ≥ 1 day had NRT prescribed during admission

412 (60%) of the 716 eligible patients triaged over the first ten months of the programme accepted digital weight management
This represents both a numeric and a proportional increase compared to 49% at the previous quarter checkpoint

(NB - the Digital Weight Management Programme did not start at the beginning of the financial year)

How was progress monitored and reported?

Progress is monitored through our local business intelligence systems and monitored and reported internally to Clinical Effectiveness Committee and the Patient Experience Committee before being reported for external scrutiny to: the SYICB in the case of our QUIT programme outturns, and to NHSE in the case of DWM pilot returns.

What further actions need to be undertaken?

The work described here is subject to a continuous service improvement plan. Now that a new Healthy Hospitals Programme Manager has been recruited, the focus of this plan is broadly to:

- Recover staffing levels and improve the quality of electronic production of patient lists to enhance prompt interactions with inpatient smokers
- To collaborate more closely with the community stop smoking service to ensure that patients have a strong chance of sustaining quit attempts once they leave hospital
- To reach more outpatients, staff and visitors with support and signposting to quit smoking
- To broaden the offer of the Healthy Hospitals team to tackle a wider range of health inequalities and develop a coherent approach to preventative intervention, for example through the development of enhanced 'making every contact count' training
- To feed in our experiences of the digital weight management pilot programme to the national evaluation team and ensure that lessons are learned and opportunities are taken to further develop our approach once the pilot concludes

Domain: Clinical Effectiveness

***Title* – Virtual Ward**

Executive Lead – Medical Director
Operational Lead – Divisional Director - Division of Therapies, Dietetics & Community Care

Current position and why is it important?

The essence of the Virtual Ward is to offer care in the sanctuary of a patient's home, a setting that is often more conducive to recovery than a hospital or community bed setting. This innovative model employs a multidisciplinary team (MDT) to deliver acute care to patients with complex medical needs, particularly those on respiratory or frailty pathways, directly in their home environments. The Virtual Ward's mission is to reduce unnecessary hospital admissions and support early discharges, ensuring patients receive optimal care through a collaborative approach involving senior clinicians, nurse consultants, Advanced Clinical Practitioners, therapists, support workers, social care, pharmacy, NHS 111, and the Yorkshire Ambulance Service. Referrals are triaged, with care plans tailored and adjustable to meet the evolving needs of each patient. The team's commitment to 24/7 availability via the Urgent Community Response Service and daily patient interaction underscores the Virtual Ward's dedication to a patient-centred care model.

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

The primary aim of our Virtual Ward is to enhance patient care quality and efficiency outside traditional hospital settings. The goal of the Virtual Ward is to provide acute care and treatment in patients' homes, as an alternative to hospital admission, utilising remote technology and existing multidisciplinary teams. This service is crucial for reducing hospital admissions and facilitating early discharges, particularly for patients on frailty and acute respiratory infection pathways.

Objectives include maintaining patient safety, improving health outcomes, and increasing the capacity for at-home care. Since its inception 12 months ago, metrics for success involved maintaining 80% for the scheduled trajectory of patient occupancy, patient satisfaction rates, maintaining a 14 day maximum length of stay whilst on the Virtual Ward, monitoring the number of avoided hospital admissions, and the effectiveness of remote monitoring technologies.

What did we achieve?

Throughout the last year, our Virtual Wards have showcased an exemplary commitment to providing patient-centred care, with a capacity firmly set at 100 patients. We have achieved a peak occupancy of 89 patients, which reflects our ability to deliver substantial and effective care remotely across various patient demographics. Maximum length of stay targets have always been maintained unless the patient becomes End of Life with only days to live.

How was progress monitored and reported?

All metrics have been monitored and reported via the VW Power BI Dashboard and fortnightly Situation Report has been submitted in line with national expectations for benchmarking.

What further actions need to be undertaken?

To continue improving clinical effectiveness, actions such as expanding service offerings to include more specific pathways (e.g. heart failure), implementation and integrating remote monitoring technologies, and enhancing patient and wider healthcare provider education on Virtual Ward practices are needed.

Domain: Clinical Effectiveness

***Title* – Getting it Right First Time (GIRFT)**

Executive Lead – Medical Director
Operational Lead – Business Manager

Current position and why is it important?

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. The GIRFT programme is designed to improve medical care by reducing unwarranted variations.

GIRFT is part of an aligned set of programmes within NHS England. The programme has the backing of the Royal Colleges and professional associations.

The GIRFT Programme was identified as one of the Quality Priorities for 2023/24 and will be key to identifying the impact on patient care as a result of the changes in practice that have been made through the programme.

Delivery of the GIRFT programme is integral to the Trust achieving improved Use of Resources as well as other key efficiency directives.

In January 2024 the Trust also became part of Cohort 3 for the Further Faster Programme. The Further Faster Programme was launched to deliver rapid clinical transformation with the aim of eradicating 52 week waits by April 2024.

The GIRFT Support days scheduled in November 2023 unfortunately had to be stood down owing to Industrial Action. With the impact of Industrial action and operational pressures throughout December-March a decision was taken to stand down formal support days. These are due to restart in May 2024 as we work through the action plans of the Further Faster Programme.

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

Objective:

- 50% of all specialities will have undergone a GIRFT review (16 specialities in total)
- All current GIRFT actions plan reviewed and updated to reflect new best practice guidance
- Clinical reviews linked to Quality Improvement Initiatives

Metrics/Targets:

1. Utilising Model System to provide baseline position for individual specialities
2. In-depth service review to benchmark against peers
3. Speciality deep dive programme to be piloted

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

- Establishment of Trust-wide GIRFT oversight group
- Relaunch of GIRFT programme
- Created a rolling programme of GIRFT reviews and action plans
- 8 speciality GIRFT Reviews with action plans in place and ongoing monitoring

<u>How was progress monitored and reported?</u>

The progress of the quality priority was monitored through the newly established GIRFT Oversight Group. Each speciality would provide regular updates on their 5 point action plans. The GIRFT Oversight Group also oversees the progress of the Further Faster Programme.

<u>What further actions need to be undertaken?</u>

- Ongoing monitoring of action plans for pathway reviews
- Ongoing monitoring of Further Faster Programme action plans
- Continuation of support days for remaining specialities

Domain – Clinical Effectiveness

<u>Title</u> – The Trust will effectively participate in local and national audits to evaluate the quality of care delivered and promote best practice by influencing quality improvements

Executive Lead – Medical Director
Operational Lead – Clinical Effectiveness Manager

Current position and why is it important?

The organisations' NHS Standard Contract and CQC license to practice include the requirement to monitor the quality and effectiveness of our care and services that we deliver every day to patients. In particular, to agree and implement an annual Clinical Audit Programme that evidences the impact of improvements made to patient's health outcomes. The clinical audit programme must:

- Evidence effective participation in the mandated National Clinical Audit Patient Outcomes Programme (NCAPOP) audits and the wider Quality Accounts topics relevant to the services provided and any locally agreed requirements such as Commissioning for Quality and Innovation (CQUIN) audits
- Use the findings from clinical audits to ensure that action is taken to improve healthcare and be able to evidence the impact
- Ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development)
- Provide Board with the assurance they need to certify that they have effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients

The consequences of failing to deliver an effective system of monitoring and continually improving are significant and include:

- Failure to effectively participate could result in escalation to the CQC as a negative outlier (non-participation or lower than expected case ascertainment)
- Failure to evidence the impact of taking timely action to improve on clinical audit outcomes, not identifying concerns and/or risks and actions taken to address could result in CQC or Commissioner penalties being applied and at worse, licenses to practice removed

The above could result in a lack of public confidence, inability to provide a service if a license was revoked, poorer patient outcomes, failure to prevent harm and poorly reported patient experience.

Therefore, this work focussed on these main areas:

- Ensuring participation in all eligible Quality Accounts (NCAPOP and non NCAPOP) topics and CQUINs
- Utilising digital solutions for data collection and submission to reduce data burden
- Timely review of data to inform decision making and actions for improvement
- Evidence of the impact of improvements made
- Implementing an annual programme agreement process for 2024-25

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

- Ensure that the Trust has a robust clinical audit programme that can deliver on national and organisational priorities – evidenced through:
    - participation
    - reporting
    - improved clinical audit outcomes

- Roll out a new clinical audit digital system to improve the engagement of clinical audit and provide greater autonomy and ownership at divisional/local level – evidenced through:
    - a procured system with trained and registered users
    - registered audits with information entered on outcomes, improvement actions and impact

What did we achieve?

The Trust have procured and implemented AMaT, a Programme Management Software tool, which has been introduced and is in use for tracking the progress of Clinical Audits and the implementation of NICE Guidance. Clinical Effectiveness Leads and wider key roles within Divisions have attended AMaT training.

Meeting with the National Clinical Audit leads to review:

- Metrics for each dataset and identify systems for extracting the data centrally (only reverting to case notes or proformas for any metrics where an electronic solution cannot be achieved)
- The process for the audit data to be reviewed and understood so areas of concern and those of significance can be escalated and addressed
- The requirement to agree a SMART improvement action plan in response to any highlighted areas of concern for improvement

The national clinical audit progress table has been revised to include a breakdown in progress against all datasets for each topic on the national clinical audit programme. This will provide clear and concise information for the regular oversight of progression against all national clinical audits by the Clinical Effectiveness Committee and the Quality Committee through the year.

Development of a proforma for submission to gain approval for any non-participation in a Quality Accounts topic.

The Clinical Effectiveness Team have located live links to the National Clinical Audit data dashboards and reporting, sharing these widely with the Divisions and CSUs within progress reporting to facilitate discussion around review, highlighting successes, concerns and any risks where improvement is required. Further work needs to take place in strengthening these forums where this review takes place to ensure the right roles are involved to inform decision making for improvement.

Key Trust learning points resulting from National & Local Clinical Audits and wider quality measurements such as CQUINs are being shared as part of training sessions to reach a wider audience within the Trust. Alongside discussions with attendees on how best to share this information that ensures it reaches those that need to be aware in delivering patient care every day.

The 2024-25 Clinical Audit Programme Agreement process was developed and approved by the Clinical Effectiveness Committee in October 2023 to further support the Quality Priority.

A Divisional Clinical Effectiveness Committee Report Template has been developed to guide inclusion of key information such as outcomes and actions taken on National & Local Clinical Audits to further evidence effective participation. NCAPOP Outcomes continue to be presented at Clinical Effectiveness Committee within the Divisional Reports for transparency.

The agendas for the Clinical Effectiveness Meetings have been further strengthened by including wider Clinical Effectiveness information for triangulation and context to inform decision making.

The Clinical Effectiveness Leads Network Meetings have been launched with the first meeting held in December 2023 - with a focus on the 2024-25 Clinical Audit Programme Agreements and Sharing & Learning together across TRFT.

How was progress monitored and reported?

Work was undertaken at Corporate, Divisional and Specialty levels and monitored and reported through:

- Specialty Clinical Effectiveness & Governance Meetings
- Divisional Clinical Effectiveness & Governance Meetings
- Clinical Effectiveness Committee
- Quality Committee

What further actions need to be undertaken?

The 2023-24 Quality Priority to Effectively Participate in Clinical Audits has made good progress but continues to need further development. Therefore, a partially achieved has been concluded and it is proposed that the Trust should:

- Further strengthen processes within specialties for review of outcomes and agreement of improvement plans. In particular;
    - Ensuring timely review & translation of data that is triangulated with wider information for context and understanding, root cause analysis is undertaken to identify why any *non-compliance* and the escalation of concern and any risk considered of significance takes place
    - Themes for improvement identified within clinical audit outcomes are taken forward in collaboration with Safety, Experience and Effectiveness, with support from the QI Faculty to improve patient care

- SMART action planning guidance is developed and disseminated as a resource ensuring that identified metrics for evaluating the effectiveness of each action in addressing any risk or areas where improvement was required are reviewed for impact on patient care

- Further measurement is agreed:
    - Audit for continuous improvement
    - Wider QI
    - Assurance monitoring of agreed metrics

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 has an online survey via the Trust Website or via a mobile phone Quick Response (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 Trust is also undertaking a pilot within Urgent and Emergency Care using text messaging, which has seen a significant increase in feedback.

The information and data are available on the hub and is directly shared with all divisions. Power BI soft wear service also allows coherent and visually immersive and interactive insight of Friends and Family Test (FFT) data.

Divisional quarterly patient experience reports based around the framework of the Yorkshire Patient Experience Toolkit and presented to the Patient Experience Group also includes FFT data.

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. There is also an internal process for monitoring and reporting ‘pass by’ breaches of mixed sex accommodation.

In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit level 2 care to base wards, this escalation process is now well embedded and supported by the Critical Care, Operational and Site teams. However, there has been 8 mixed gender breaches between April 2023 and March 2024 (2 in July 2023, 4 in January 2024 and 2 in March 2024). This has been due to the unavailability of an appropriate ward bed within the agreed 4 hour time period because of site pressures.

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 Incident Review Panel for confirmation that this does meet the NHSI criteria.

During 2023/24 the Trust has reported 1 Never Event in Ophthalmology which related to the insertion of the wrong strength lens to a patients eye, but did not cause any harm.

Patient-Led Assessments of the Care Environment (PLACE)

The PLACE assessment was reintroduced following Covid in Autumn 2022 as part of the drive towards business as usual. The table below shows the PLACE scores for 2023.

Inspected	TRFT score – 2022 (%)	TRFT score – 2023 (%)	National average score	Highest NHS Trust score	Lowest NHS Trust score
Cleanliness	**99.32**	**99.20**	98.1%	100%	56.1%
Food overall	**94.73**	**90.48**	90.9%	100%	72.6%
Organisation (of) Food	**95.49**	**100**	91.2%	100%	67.4%
Ward food	**94.51**	**87.65**	91%	100%	55.2%
Privacy, dignity & wellbeing	**81.33**	**89.42**	87.5%	100%	13.6%
Condition, appearance & maintenance (of buildings and facilities)	96.24	**97.62**	95.9%	100%	9.6%
Dementia (meeting needs)	75.81	**84.12**	82.5%	100%	31.7%
Disability (meeting needs)	80.41	**86.31**	84.3%	100%	30%

The National CQC Patient Experience Surveys for Acute Trusts

Maternity Survey

The Maternity Survey 2023 was published in February 2024 and looked at the experience of women and other pregnant people who had a live birth in early 2023, including ethnic minorities in January and March.

Responses were received from 148 people and the Trust scored better than most other Trusts in England in a number of areas. These are; women being included in decision making during their antenatal care, partners being included in labour care, women being treated with respect and dignity, and women sharing they had confidence and trust in the staff caring for them.

Adult Inpatient Survey

The Adult inpatient survey 2022 was published in September 2023 and looked at the experiences of patients who stayed at least one night in hospital as an inpatient.

Responses were received from 492 people out of 1250 people invited to take part. Out of the 11 different sections, six were worse than expected, two were somewhat worse than expected, two were about the same and one was much worse than expected.

Urgent and emergency care Survey

The urgent and emergency care survey 2022 was published in July 2023 and looked at the experiences of people who received care from urgent and emergency care services.

Responses were received from 261 people out of 2220 people invited to take part. Out of the nine different sections, six were about the same and two were somewhat worse than expected.

Learning and improvement from patient experience surveys

Throughout 2023, divisions were 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, a Quality improvement plan was developed to ensure all areas were working towards a coordinated improvement plan. These included:

Safe Staffing on Wards – Milestones achieved in 2023/4

To support an evidence base for the setting of establishments, we signed licences for Safer Nursing Care Tool for adult inpatient wards, adult assessment areas, Children and Young People and UECC. This was run four times this year and recommended establishments presented to the Chief Nurse for approval at People Committee and Board of Directors in January 2024.

Safe Staffing Matron leads on twice daily staffing huddles to oversee decisions on daily deployment of staff to ensure clinical areas are as safe as possible.

As part of the Retention improvement plan a series of interventions were developed including Leadership programmes for;

- 26 Health Care Support Workers completed the Florence Nightingale Foundation IPC champions
- 20 Band 6/7 Registered Nurses to undertake the RCN Clinical Leadership Programme (celebration event spring 24)
- 33 RNs are now Professional Nurse Advocates (celebration event September 2023)
- 20 Matrons/senior nurse/AHP leaders are on the Florence Nightingale Foundation Matrons Development programme Reward and recognition of Health Care Support Workers with three Health Care Support Workers achieving the CNO award and celebrating national Health Care Support Workers day in November

Speciality career pathways were developed for nursing colleagues using a tree symbol and these were printed for all areas where nursing staff work.

The Preceptorship accreditation as achieved for early career Registered Nurses and expansion of team-rostering has supported giving clinical staff a voice.

The Deputy Chief Nurse completed a successful business case for changing rooms, resulting in the new Rooftop Changing Rooms being opened. All Trust staff (including learners) now have access to showers, lockers and a safe space to get changed and store belongings. This work was recognised by being shortlisted at the Nursing Times Workforce Awards.

The education offer was reviewed and shared with all colleagues for role specific training and the Pastoral Care Quality Award was achieved for Internationally Educated Nurses. The first Cultural Celebration event to celebrate our diverse workforce was help all supporting improvements in this work.

Huge improvements in the Retention of nursing workforce.

Discharge – What have we achieved?

The Chief Operating Officer commissioned a 'Rapid Improvement Discharge Event' in April 2023. This meant four days off site with average of 80 attendees per day.

Themes identified by teams for improvement included:

- Improve Person Centred Care/Reconditioning
- Standardise Board Rounds/Ward Rounds
- Implement Discharge to Assess
- Roll our Virtual Wards and develop In-reach service to facilitate early discharge
- Implement Criteria Led Discharge
- Develop Transfer of Care Hub

A multi-professional PCC/reconditioning study day has been developed with over 200 staff attended. This will continue to run in 2024/5. Improvements from this work development of the phrase 'You Look Your Best When You're Up and Dressed' regular in patient tea-parties, new clothes store, hospital hairdresser and self-administration of medicines policy.

Working in partnership with South Yorkshire Transport – bespoke bus stop stations were developed for Wards A4 and A2 to encourage patients to walk from their beds and keep active.

Board Rounds/Ward Rounds – Working with the improvement academy – Achieving Reliable Care was launched on ward A5.

Discharge to Assess commenced and the virtual ward expanded. The in-reach service works really well with earlier discharges/admission avoidance being achieved.

Length of stay has reduced through this work with more patients also going through the Community Ready Unit.

Pain management – what have we achieved

The acute pain team have worked to refresh the audit on Tendable to have a greater understanding of learning oportunities in pain management across the Trust. Although there is a pain assessment tool for people who may not be able to verbalise their pain score – more work is required to consider how this is embedded in all areas.

Nutrition and Hydration – what have we achieved?

A Trust Wide Task and Finish Group has formed to look at the increased use of parental feeding across the Trust (Total Parental Nutrition) where enteral feeding may have been more appropriate. The benefits of early nutrition (and in some cases – pre-nutrition prior to planned admission) are well established but work continues to develop a naso-gastric feeding training plan and an updated policy. The work of the dietetics, pharmacy and speech and language therapists in this field is expanding annually.

Pictorial menus were developed and delivered to wards with electronic versions of the menus now on the Trust website. Four inpatient tea-parties were held this year with the King's Coronation seeing celebrations across the whole Trust.

Tea for Two was introduced to encourage any member of Trust staff to have a drink with a patient to demonstrate the values of social dining. This initiative has been supported by executive colleagues for the benefit of patients.

Involving people in decisions around care – what have we achieved?

To ensure patients were receiving excellent information and in formats that are accessible to them, the Trust has successfully invested in the EIDO library. This is an electronic library of information available to patients who may need that information in order to make an informed decision about their care. EIDO also has information that can be converted into e-consent.

Patient Advice and Liaison Service (PALS)

A business case to develop a new PALS was approved this year and building work is now complete. Once staff are in post and the appropriate training provided, the service will help support front line resolution for patients and families in real time.

Healthcare Associated Infections

The Chief Nurse is the Director of Infection Prevention and Control (DIPC), the Deputy Chief Nurse is Assistant DIPC and works closely with the Lead Nurse for the IPC team.

Clostridioides difficile infection (CDI)

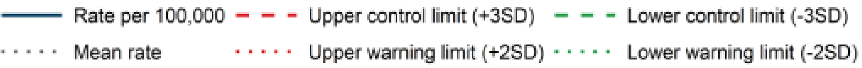
45 incidents of CDI were reported in 2023/4 against a trajectory of 18 cases. Trends in Healthcare Associated CDI in the Trust are reported to the national data capture system. The rates are then calculated from data as stated in April 2024 on the UK Health Security Agency HCAI database using KHO3 occupied overnight beds per 100,000 as denominator for this parameter.

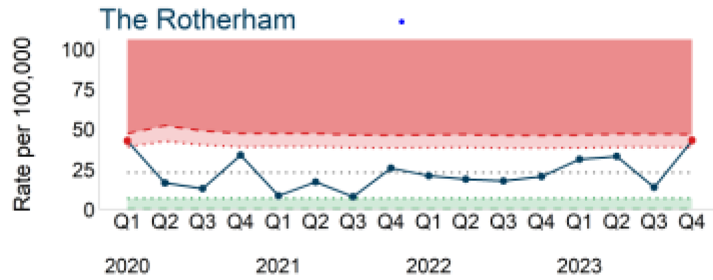
Data is shared via funnel plots and statistical process charts to identify existing variation in rates between Acute Trusts and Integrated Care Boards.

Number of reported cases of C.diff													
Target = Target <24 in 2023/24	**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
2023/24	**45**	4	5	4	2	1	2	5	7	4	0	4	7

(Source: Trust Winpath System)

Figure 4: Trends in healthcare associated CDI incidence by NHS Acute Trust in Yorkshire and Humber: Quarterly rates of healthcare associated *Clostridioides difficile* infections per 100,000 bed days from January 2020 to December 2023





The new Trust Harm Free Care Panel started in 2023 to have a facilitated learning discussion from the Post Infection Review (PIR) of all cases of Clostridioides Difficile (C.difficile) and MSSA bacteraemia. Learning is sent out via email to all senior clinicians (medical and nursing) for wider sharing.

Clostridioides Difficile (C.difficile) is cross referenced using time/space and Ribotype including where relevant enhanced DNA fingerprinting of the Ribotype, which resulted in one case of cross infection on ward A3. The whole ward was decanted for a thorough deep clean and use of Bioquell (hydrogen peroxide vapour) decontamination.

Other themes from the Post Infection Review process include:

- Antibiotic prescribing, including sepsis review and screening
- Adherence to the Trust antimicrobial policy
- Prompt isolation of patients
- Hand hygiene
- Environmental cleaning

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

There was one case of MRSA bacteraemia this financial year against a trajectory of 'zero preventable cases.' Post Infection Review was held to establish opportunities for learning and established the probable cause was a contaminated sample.

Number of reported cases of MRSA bacteraemia													
Target = 0	**YTD**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2022/23	**0**	0	0	0	0	0	0	0	0	0	0	0	0
2023/24	**0**	0	0	0	0	0	0	0	0	0	0	0	0

(Source: Trust Winpath System)

MSSA bacteraemia

There have been 15 cases of MSSA bacteraemia this year which does not have a trajectory. Learning from MSSA bacteraemia this year has focused on the care of venous cannula, hand hygiene and encouragement of clinical colleagues to reduce the use of plastic gloves.

Gram-negative bacteraemia

	Trajectory	Cases
E. coli bacteraemia	47	49
Pseudomonas aeruginosa bacteraemia	5	9
Klebsiella species bacteraemia	11	16

Key strategies for prevention and control focus on contact precautions, the management of invasive devices and maintaining a clean, dry environment to prevent the build-up of environmental reservoirs and cross-infection.

The importance of hydration in reduction of Gram-negative bacteraemia has also been integrated into Quality Improvement work throughout the year.

Influenza and Covid-19

During winter months, there are higher than average numbers of patients presenting with influenza, Covid-19. This puts additional pressure on the whole system and hospital premises with limited numbers of isolation facilities. Where appropriate patients are co-horted together with the clinical teams adhering to infection, prevention and control, practices.

Carbapenemase Producing Enterobacterales (CPE)

CPE is an antimicrobial resistant finding for some bowel organisms. The UK Health Security Agency (UKHSA) Field Epidemiology Team visited the hospital on 16 June 2023 to provide a 'fresh pair of eyes' on how cases of CPE are managed and risks of cross infection reduced.

Improvements the Trust has put in place were recognised by UKHSA, including an improved system for recognising and flagging CPE patients on admission, deep cleaning, improvements in commode cleaning and audits and increased Infection Prevention and Control (IPC) training.

Areas for consideration included a long term plan for the ageing ward environments, including hand wash basins, ward environments and a review of the IPC team. A full action plan from this visit has been developed and is being monitored through the IPC Committee.

National Point Prevalence Survey

In 2023, the Trust took part in the National Point Prevalence Survey (PPS) on Healthcare-associated infections (HCAIs), Antimicrobial Use (AMU) and Antimicrobial Stewardship (AMS) 2023 in England. Recommendations for consideration include:

- Identify high risk areas
- Identify priorities for local surveillance
- Identify where IPC policies may need to be modified
- Identify where staff may need education/training
- Undertake benchmarking with peer group hospitals in England to understand quality of care locally and identify opportunities for improvement
- Provide information on appropriateness of AMU
- Establish a post-COVID-19 baseline

Quality Improvement (Qi)

Through the Florence Nightingale Foundation and the Regional workforce team, places were sought for Health Care Support Workers to receive free leadership training in IPC. Over two separate cohorts, a total of 26 people have completed this course and were invited to the Board of Directors each time, to celebrate this achievement.

To maximise the additional leadership training for Health Care Support Workers in IPC, the Golden Commode Award was launched. This is awarded to any clinical area achieving three consecutive months of 100% compliance with their commode audit. Acute Surgical Unit achieved seven months of 100% compliance and Ward A3 achieved six months of compliance in 2023/4 (this will roll on into 2024/5).

Overall seven clinical areas were awarded the Golden Commode Award during 2023/4

Health Education and Promotion

The team used IPC week and Hand Hygiene day to further promote good Infection, Prevention and Control practices, including the Gloves Off campaign.

The team led on Trust wide roadshows, taking IPC awareness to clinical areas. Hand Hygiene training was also provided at this time to ensure as many staff were in date as possible. A hydration prize was given to Fitzwilliam for the most informative ICP display board during this week.

<u>Hydration</u>

The Trust have been active members of the regional hydration network throughout the year, including presenting work on the traffic light water jug lids, inpatient tea parties. Additional new work included the removal of plastic spouted beakers and the purchasing of new cups for patients as well as the launch of #ButFirstADrink.

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**	**2024-24**
Falls	741	799	796	892	921	1048	1044	1032
Bed Days	144,505	145,153	132,557	158,207	118,098	151, 353	152,201	156,783
Falls Rate per 1000 Bed Days	5.12	5.50	6.00	5.63	7.79	6.92	6.85	6.58

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 Trust's 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.

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. There is a monthly audit of all Duty of Candour completed and this is reported quarterly to the Patient Safety Committee and Quality Committee. There has been significant improvement in not only the compliance, but with the introduction of a standardised template which enables consistency of information given to patients and their families.

Safeguarding Vulnerable Service Users

Safeguarding is everyone's business, and remains one of the Trust's key priorities. With executive leadership provided by the Chief Nurse, supported by the Deputy Chief Nurse and Head of Safeguarding, there is visible and active leadership all levels who drive a continuous improvement approach to safeguarding. TRFT has remained compliant throughout the year in discharging all contractual and legal safeguarding duties to keep patients, staff, and those who touch our services safe, and help them to live free from abuse and neglect.

Recognising that adults and children do not live in isolation, the co-located safeguarding and vulnerabilities team provide specialist advice and support across the spectrum of adult and children's safeguarding. In addition to safeguarding, the team work across the public protection agenda including Domestic Abuse, Exploitation and Prevent. The team are consistent members at the Multi Agency Risk Assessment Conference to develop safety plans for those at high risk of harm from domestic abuse, attend Multi Agency Public Protection Arrangements meetings, and although there is little Prevent activity to report from the Trust, we continue to raise awareness of the risks of grooming for radicalisation, and share information when any concerns are raised. The Team is represented at the Multi Agency Child Exploitation Meeting by the Lead Nurse for Child Exploitation.

The team includes a Learning Disabilities and Autism Matron, and two additional Nursing Associates who support those with a learning disability and autistic people to access health care. The Team have seen a 30% increase this year in the number of patients the team are supported, with bespoke pathways established in surgery, support with all in-patients, children, and community patients. The team work closely with the medical and nursing leadership team to make reasonable adjustments to improve access to care and treatment, and through support from Rotherham Hospitals Charities, are able to provide resources to help individuals throughout their care and treatment, by providing, for example, ear defenders, sensory lights, or fiddle toys.

Although the Government has paused the work on the Liberty Protection Safeguards, at TRFT we have continued with planned work to strengthen the workforce confidence with Mental Capacity Act Assessments, and delivered targeted interventions across the Trust. Developed in Partnership with the Mental Health Steering Group, an all age Mental Health Strategy was launched in TRFT this year, which seeks to ensure that clinical staff take a 'whole person' person perspective, and that all patients presenting with mental health concerns have their physical and mental health care needs addressed.

The safeguarding annual work plan, and activity relating to safeguarding and vulnerability is monitored through robust safeguarding governance arrangements, with Safeguarding Group and Mental Health Steering Group both chaired by the Deputy Chief Nurse feeding upward into the Safeguarding Committee which is chaired by the Chief Nurse.

There have been a number of small changes within the Team, aimed at moving away from focusing on adults or children, to the holistic Think Family approach, focusing on workforce development and succession planning, as well as increasing capability and capacity of the workforce across the safeguarding and vulnerability agenda. The Children's and Adult's safeguarding team are working as one team, with further team development planned over this next year.

Safeguarding Mandatory and Statutory Training compliance has remained a priority across the organisation, with compliance across the organisation 90%, and targeted interventions in place to support pockets of staff who are out of compliance. The Think Family training day continues to evaluate well, with staff attending gaining a lot from the day. The Oliver McGowan tier 1 training has been launched and is available to staff on ESR, with 47% of staff completing this to date, and plans for tier 2 are being coordinated by the ICB, and this will be launched during April 2024/25. There is good compliance across the Trust with Mental Health (95.7%), Dementia (99%), and Prevent (93%) training, which forms part of the national CONTEST anti-terrorism strategy.

The safeguarding team are consistent and reliable partners across the Safer Rotherham Partnership, Rotherham Safeguarding Children's Partnership, and Rotherham Safeguarding Adult Board. TRFT is represented appropriately in all forums, including chairing of meetings. TRFT has contributed to and participated in the SAB peer review, which has resulted in a new governance structure being developed. Safeguarding Partners attend Safeguarding Committee at TRFT which enables partners the opportunity to provide comment, support or constructive feedback on areas of safeguarding practice. This forum has been highlighted by partners in increasing the flow of information both ways and enables transparency with safeguarding practice.

TRFT are committed to protecting vulnerable patients by providing high quality healthcare services that are accessible and are delivered in a way that respects the different needs of individuals, and protecting children and adults from abuse and harm. We continue to learn from and embed best practice across the vulnerability agenda.

Dementia Care

Education on Dementia has been delivered to 387 Trust staff by one of our Divisional Directors and Consultant in Care of Older People. This is part of the Trust Person Centred Care day which is led by our Person Centred Care Practitioner.

From this work a series of improvement initiatives, such as Eyes, Ears Teeth boxes (to look after glasses, hearing aids and dentures) have been bought from the Trust charity and the Trust has adopted the initiative Call Me. This is work to ensure all patients are referred to by the name they wish to be called which is important for patients living with dementia.

The Trust continues to support and promote John's Campaign, which 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 2023, to celebrate National Healthcare Support worker day, the virtual Dementia Tour was organised through Train2Care for the second time. 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. Another 60 colleagues took part in this learning experience in November 2023.

A tier one dementia awareness video has also been developed and will be available to support awareness for people who do not need to attend the Person Centred Care day.

Dementia & Delirium Screening

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). Between April 2023 and March 2024, 8582 patients over the age of 65 with an inpatient stay longer than 72 hours were eligible for screening. Of those patients, 8139 were screened for both Dementia and Delirium (94.83%).

Learning Disability and Autism Team

The Rotherham NHS Foundation Trust is committed to improving the experience for both children and adults who have a learning disabilities and Autistic people. 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 both children and adults who are attending 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:

We implemented 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 on their medical records. These flags populate a ‘live’ patient board, to enable our team to know which inpatient ward the patient who have a learning disability, or a patient with Autism is. The Learning disability and Autism team can then visit in order to enhance their care pathway in Trust.

At TRFT we champion the use of the Hospital passport, which is a person-centred assessment tool for people with Learning Disabilities. It can assist 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. For our patients with Autism, we also champion the use of the Autism passport, or a format which that person is comfortable in using. Both assessments are holistic guides to the previous care baseline of the individual and saves the patient from unnecessarily repeating information about themselves and their care needs which for many people can cause an increase in their anxiety.

The team have collaboratively produced staff resource files for people with a learning disability and autism. To enable our generally trained colleagues to have some help and information at their fingertips, in the absence of the team. The files are an excellent resource in prompting staff to read the Hospitals passports we have in place, communication aids, information about what a learning disability is and information around what Autism is – describing some of the areas that people may find difficult about coming into hospital. There are health and care related pictures within the file, to perhaps initiate better communication through pictures.

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. This may be for some patients, not attending pre op and only attending on the day of surgery/treatment. All the aspects of the admission process are covered in an MDT approach and planned for prior to the patient coming to the Trust. Without such a pathway, many patients would simply not be able to tolerate coming to hospital, or having what are classed for some people as simple investigations/treatments within primary care.

The team has a specialist medic attached to the team who provides medical overview and expertise. They are currently undertaking a specialist qualifications in Learning Disability and Autism to enhance their knowledge within this specialist area of practice.

Our team currently provides bespoke training regarding learning disabilities and Autism in conjunction with the local advocacy organisation. This can take the format of formal training on the Midwifery MAST training programme for example, or attending the safety huddles on our AMU ward. We champion where possible, our training to be delivered by experts with experience. The team have provided training to the medical teams, social care colleagues within Rotherham Metropolitan Borough Council and the Trust’s wards and departments.

We have created sensory boxes, which include light therapy to help to reduce perhaps anxious feelings of being in hospital. Distraction toys which can help with distraction and focus, noise cancelling headphones and weighted blankets. The equipment we have has come from the feedback which we have received from our patient group. We have a bi-monthly patient experience meeting, which is attended by people with learning disability and people with autism, service providers, Healthwatch and other organisations across Rotherham. Within our meeting, we discuss

direct patient experience and look to learn and develop directly from those experiences. Our sensory boxes and equipment can be found on all wards and departments or by contacting our team for assistance.

Within both our adult and paediatric UECC departments, we have portable sensory/bubble tube equipment to further help and reduce anxieties around being in such a busy environment.

As a team, we continue to build links with established organisations to support learning, such as Speak Up, CHANGE organisation and NHSE. From a training perspective we facilitate 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 and other staff members who have a special interest within the Trust.

We work closely and support our Volunteer Coordinator to mentor and support volunteers in the Trust who have a Learning Disability/Autism. Likewise, we provide support to staff members who have a learning disability or who are autistic.

The team work closely with our Trust and community facilities to help reduce unnecessary admissions to hospital. We provide a nurse prescribing element to this and currently our Matron is undertaking a MSC in Advancing practice for people with a learning disability and Autism. These services include joint working with our Virtual Ward teams, Community Matrons, Fast Response and District Nurses.

We work with the process of 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, who are transitioning back over to Rotherham Adult services. This process involves complex MDT working across our partner organisations.

The team ensure work to and Implement relevant Learning Disability and Autism strategies within the Trust and working in conjunction with partnership organisations across Rotherham PLACE. This includes the Accessible Information Standard and the Annual Learning disability and Autism Standards for Acute Trusts.

We champion and support the learning coming from the Learning Disability Mortality Review programme (LeDeR) process. This is now centralised within Sheffield for our ICS.

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. We champion the use of the Mental Capacity Act, assisting with best interest processes and the use of Deprivation of Liberty Standards where appropriate.

We work to help 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 when treated for the same condition. This may be around on average 5-7 days longer. The discharge of patients with a learning disability remain complex in nature, due to the potential complex and specialist level of support the person may require and the continued challenge in service provision in the community.

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.

As a team we are always looking to plan for improved and better care for our patient group. Some of our future initiatives may include exploration of the learning disability and autism team workforce, incorporating different roles and working patterns. This could include out of hours working patterns, or weekend working. These potential changes also come from direct patient experience and suggested learning from complaints and serious incidents.

We continue to champion the role of the Learning Disability Champion and Autism Champions on all wards and departments. This role is one of empowerment and advocacy. With staff members encouraging their peers to improve the patient experience for people with a learning disability and people with autism who are in attendance on their wards and departments.

From a training perspective as a Trust we have now started the implementation of the mandatory Oliver McGowan Learning Disabilities and Autism awareness training. This is supported Trust wide and from a Trust executive level.

Continued use of the Traffic light magnet scheme – which champions and highlights the need to read the Hospital passport for patients with a learning disability. They are small Traffic light coloured magnets which attach on the back on the patient board above the patient bed. This initiative came from the learning following a complaint within the Trust.

Staff Experience and Engagement

The Trust had its highest ever response to the national staff survey with 67% of colleagues completing it, providing valuable feedback to the organisation as to how it can improve and make it a better place to work. All clinical divisions had increased engagement with their teams with lots of innovative ideas, incentives, and a small element of competition to achieve the high response rates. This was visibly led by the Executive team and supported with targeted communications. In response to operational pressures 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.

In response to last year’s survey there was 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.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2023/24 survey among trust staff was 67% (2022/23: 61%).

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community) are presented below.

Indicators ('People Promise' elements and themes)	**2023/24**		**2022/23**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:				
We are compassionate and inclusive	7.53	7.24	7.4	7.2
We are recognised and rewarded	6.28	5.94	6.0	5.7
We each have a voice that counts	7.01	6.70	6.8	6.6
We are safe and healthy	6.27	6.06	6.1	5.9
We are always learning	5.94	5.61	5.6	5.4
We work flexibly	6.57	6.20	6.2	6.0
We are a team	7.07	6.75	6.9	6.6
Staff engagement	6.98	6.91	6.7	6.8
Morale	6.20	5.91	5.9	5.7

The Trust has improved its score against all the staff survey domains and benchmarks above the national average for all domains when compared to the peer group.

	2018	2019	2020	2021	2022	2023
Best	71.6%	76.0%	79.8%	79.4%	60.9%	69.5%
TRFT	38.5%	48.0%	52.2%	59.7%	61.0%	67.0%
Median	43.6%	46.9%	45.4%	51.1%	44.5%	45.8%
Worst	24.6%	27.2%	28.1%	36.5%	26.2%	21.4%

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and subscores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**

Rotherham

We ...

Score (0-10)

	are comp'sionate & inclusive	are recognised and rewarded	each have a voice that counts	are safe and healthy	are always learning	work flexibly	are a team	Engagement	Morale
Your org	7.53	6.28	7.01	6.27	5.94	6.57	7.07	6.98	6.20
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	3239	3240	3190	3178	3029	3207	3229	3241	3241

The Rotherham NHS Foundation Trust Benchmark report 1

The 2023/24 national staff survey results are very positive and demonstrate the progress that TRFT continues to make, particularly in relation to the three advocacy questions (25a, 25c, 25d) where the Trust now ranks in the top 3 most improved organisations across England.

NHS Response Rate

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

The Trust had excellent engagement with the 2023 national staff survey, with 67% of colleagues responding to the questionnaire and providing their valuable feedback; this is the highest return rate the Trust has ever achieved and well above the national average.

Advocacy / Year	2022	Rank	Quartile	2023	Rank	Quartile	Change +/-
Q25a							
Care of patient/service users is my organisation's top priority	69%	93th	bottom quartile	74%	68th	3rd quartile	Ranking up 25 places 5% increase = **3rd biggest increase in England**
Q25c							
I would recommend my organisation as a place to work	54%	77th	3rd quartile	63%	43rd	2nd quartile	Ranking up 34 places 9% increase = **2nd biggest increase in England**
Q25d							
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	50%	98th	bottom quartile	58%	90th	3rd quartile	Ranking up 8 places 8% increase = **biggest increase in England**
Engagement (Advocacy, Motivation and Involvement)	6.73	71st	3rd quartile	6.98	37th	2nd quartile	Ranking up 34 places

Future priorities and targets

Top 5 scores vs Organisation Average	Org	Picker Avg
q23a. Received appraisal in the past 12 months	93%	83%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	65%	56%
q19d. Feedback given on changes made following errors/near misses/incidents	69%	60%
q6c. Achieve a good balance between work and home life	63%	56%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	73%	66%

Most improved scores	Org 2023	Org 2022
q25c. Would recommend organisation as place to work	63%	54%
q3i. Enough staff at organisation to do my job properly	34%	25%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	50%
q4c. Satisfied with level of pay	35%	27%
q6b. Organisation is committed to helping balance work and home life	55%	47%

Key Areas for Improvement and Future Priorities

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	63%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	84%	87%
q12c. Never/rarely frustrated by work	20%	22%
24b. There are opportunities for me to develop my career in this organisation	54%	55%
q23b. Appraisal helped me improve how I do my job	25%	26%

Most declined scores	Org 2023	Org 2022
q2c. Time often/always passes quickly when I am working	72%	74%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	76%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	80%	81%
q13d. Last experience of physical violence reported	70%	71%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	94%

Top 5 Priorities for 2024/25

Taking on board feedback from the 2023 staff survey and the free text comments from colleagues a number of areas have been identified for action during the new financial year. These priorities have been agreed by the Executive team with a lead Executive Director being assigned against each priority area. These will be developed into a branded "We Said, We Did" action plan during April/early May and shared across the Trust in May following the launch of the new People and Culture Strategy.

No.	Area	Lead Director
1	Appraisal	Director of People
2	Car Parking	Director of Estates & Facilities
3	Reasonable adjustments	Director of Finance
4	Sexual safety	Chief Nurse
5	Violence and Aggression	Managing Director

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 & Culture Committee, the Executive Team and ultimately the Board of Directors.

Locally each Care Group will develop "We Said, We Did" 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 care group performance meeting and dashboards, providing assurance to the Executive Team and Board of Directors.

The wider workforce and people 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 & Culture Committee.

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 eight 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; one of these have also attended the National Guardians Office training session. The current FTSU lead was appointed in January 2024, and the time dedicated to the role increased to 0.6 Whole Time Equivalent.

Since the appointment of a National Guardian there has been increased direction from the National Office regarding the role of FTSUG. The regional network now meets virtually every two months and the annual national event, can now be attended In person or 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 2023/24, the FTSUGs have received 7 concerns. The majority of the concerns have related to attitudes and behaviour, 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 2023, the Trust's annual Proud Awards returned to celebrate our dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

More than 700 nominations were received for the 2023 Proud Awards. The event was held at Magna and hosted by Liesl from Hallam FM's Big John at Breakfast with around 400 colleagues in attendance, alongside partner organisation representatives and sponsors.

The award categories were announced by members of the Executive Team, Non-Executive Directors and representatives from the Council of Governors.

The 2023 winners were:

Chairman's Award
Lynsey Maton, Head of Nursing (UECC)

Chief Executive's Award
Amy Mills, eRoster

NHS75 Award for outstanding contribution to the NHS
Dr Bijoy Mondal

Public Recognition Award
Stroke Therapy Team

Non-Clinical Team of the Year
Sterile Services

Inspiring Leader
Tom Nield, Head of Nursing (Surgery)

Diversity and Inclusion Award
Day Surgery Bespoke Elective Pathway

Learner of the Year
Benjamin Proctor

Quality Improvement Award
Care Homes Team Occupational Therapists

Unsung Hero
Julie Foster

Clinical Team of the Year
Ward A1

Governors' Award for Living the Values
Hannah Hall

Outstanding Volunteer Award
Diane Schofield

Excellence Award - Team of the Year
Emergency Preparedness, Resilience and Response

Excellence Award - Individual of the Year
Munazza Shah

Excellence Award - Public Excellence
Maternity

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

Junior doctor rotas are unfortunately often subject to gaps, which can occur for various reasons. Long-term placement gaps occur if the training scheme does not fill all available posts. Less than full time working also has a substantial impact on these training posts, and we are noticing a rapid increase in numbers of doctors wishing to work on a less than full time basis across the region. The current vacancy rate for training grades is 7.01%, the equivalent of 11.6 posts out of an establishment of 165.4 across all training grades and specialties. Taking into consideration ad hoc vacancies due to sickness/other absence, it is appreciated that rota management can become challenging. Despite any vacant posts there are a number of shifts, designated Red Flag Shifts, which must be filled e.g. Medical Registrar On-Call. Minimum staffing levels are set for ward areas in order to ensure that sufficient junior doctors are available to maintain the safety of patients and staff. Any vacancies which cause staffing levels to fall below minimum will require cover.

The Trust utilises a centralised rota co-ordination function, which currently supports rotas across Medicine, General Surgery, Urology and the UECC. This model provides business resilience in terms of rota co-ordination across the divisions. Management of rota gaps is required on a daily basis, with Rota Co-ordinators taking a proactive approach in order to ensure gaps are filled in a timely manner. If a gap cannot be filled by a substantive member of staff, there is a process in place in order to fill this, starting with cover via the Trust's Internal Bank. In June 2022, 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, the next step is to seek agency cover, and the Trust utilises a Master Vendor in order to source agency locums.

Alternative staffing groups, such as Advanced Nurse Practitioners/Advanced Clinical Practitioners can fill appropriate junior vacancies, and it is evident that our clinical workforce is now trending towards a more integrated approach. Rota design plays an important role in ensuring optimum cover is provided. Any modification to rotas involves the junior doctors, from design to signoff in respect of any 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 management representatives and representatives from the Rota Co-ordination Team.

External Agency Visits, Inspections or Accreditations

During 2023/24 there have been 14 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

Urgent and Emergency Care

2023/24 marked the return to the national four hour standard for the first time in over four years for the Trust, with our data reported again nationally from May 2023. This is a standard we had not worked to since early 2019, and as such, behaviours and processes had been adapted and embedded to ensure an appropriate clinical and operational response to the pilot standards. This meant a significant programme of work was required throughout 2023/24 to redesign processes and behaviours to align with the return to the core national standard. This included improving our urgent care pathways, developing our workforce model, continued focus on effective discharge processes and enhanced patient experience.

Whilst the Trust did deliver improvements in performance across the year, we did not deliver the national expectation of 76% four hour performance by March 2024, and in particular, there were a number of very challenged weeks throughout the winter period. This meant more patients waited over 4 hours to be admitted or discharged than planned. To ensure the comfort and safety of patients facing delays, we introduced a number of initiatives to support patients including intentional rounding in waiting rooms, refreshment trollies, improved seating and enhanced communication. The improvements compared to the prior year were stark and of note, ambulance delays over an hour fell by 50% over the 12 month period.

Elective Care

The national ambition for patients waiting for elective care was to eliminate all patients waiting over 65 weeks by March 2024. However, with industrial action taking place almost monthly for the majority of the year, this became a more challenging target to deliver nationally than anticipated. Within the Trust, intensive work was carried out in advance of, during and after every period of industrial action to ensure as much elective activity as possible could take place in a safe manner and we could learn to adapt our processes for future periods of action. This took a phenomenal

effort from all colleagues involved, and it is testament to their dedication to our patients that we were able to continue the majority of our activity despite these added challenges.

Despite this, the Trust worked hard to reduce patients waiting over 65 weeks with the Trust reporting 22 patients breaching this at the end of March. The number of patients waiting over 52 weeks for their treatment has stabilised but remains well above where we want it to be for our patients, with five specialties presenting the most significant challenges as we head into next year.

The Trust has set a number of very ambitious targets for elective care delivery in 2024-25 in order to ensure we deliver significant reductions in waiting times for our patients. Despite the ongoing challenges we delivered some significant changes in 2023/24 which will support improvements in 2024/25. These included an internally-designed intelligent solution to theatres scheduling, implementation of patient-initiated follow-up pathways in all major specialties, rollout of automated text messaging for patients awaiting follow-up appointments and our place as one of ten sites selected for the National Digital Weight Management Programme pilot.

Cancer Care

During 2023/24, the previous 10 national cancer standards were reduced to just 3, which has enabled a much more targeted focus on performance. The Faster Diagnosis Standard remains paramount, with a new 62-day combined standard also now a clear priority nationally. These were introduced from October 2023, and as such these three metrics became our primary measure of cancer performance for the second half of the year.

Whilst performance against the Faster Diagnosis Standard has shown improvement towards the end of the year, the Trust did not consistently meet the 75% standard throughout the whole year. This was due to a number of factors, but performance was particularly brought down by lower performance within our Skin and Lower GI pathways. Skin performance is now achieving the standard consistently, and there is intensive work taking place within Lower GI in order to ensure the Trust can deliver a step-change improvement in performance in 2024/25.

The national standard for the new, combined 62-day metric remains at 85%. However, the national ambition for 2023/24 was to deliver 70% performance. The Trust achieved this in all but one month of the year, although performance worsened in the second half of the year due to some of the operational pressures experienced, so this will need additional focus going into 2024/25 as the national expectation increases.

Diagnostic Waiting Times

The Trust continues to benchmark very well against the national constitutional standard for Diagnostic waiting times utilising targeted investment in specific diagnostic outsourcing capacity in order to reduce waiting times for our patients. This enabled delivery of the constitutional standard in the final month of the year, well ahead of national expectations.

Community Performance Indicators

Community services continued to see increased activity across adult and children's services, reflecting the national and local desire to provide care closer to home and away from the acute hospital setting. The full rollout and expansion of our virtual ward capacity has demonstrated how we can use our resources differently in order to provide the care patients need, and the bringing together of some of our community based services into our Care Coordination Centre has enabled more effective community resource allocation and a more direct access to community services for

our partners. Our community teams continue to respond positively to the increased collaboration, and in a number of areas have implemented new and innovative ways of working to solve demand challenges.

As well as these programmes, our Community teams were at the forefront of a number of other significant and innovative developments in 2023-24 including the implementation of a discharge to assess model and growth in the use of our virtual ward. The collaboration across Place on this model has enabled us to discharge patients home at an earlier stage in their pathway leading to a better patient experience.

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

Statement on behalf of the Council of Governors

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

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

The Governors have noted that the leadership of the trust has given special emphasis in 2023/24 to driving quality improvements.

We have built a stronger relationship with the Care Quality Commission (CQC) although an inspection did not take place during the year.

The improvements in quality, patient safety and experience, coupled with robust self-assessment, mean that the Governors are more confident than in the past, of an improved near future CQC rating for the Trust.

Although only four of the quality priorities that have been given focus, are rated as green by the trust, there have been clear and significant improvements across the other priorities. Not all of these have met all of the necessary metrics however and so the Governors will help the trust to monitor progress in the coming year.

The Governors have noted that again, disappointingly, the Trust did fall short of the expected standards for 2-week cancer referrals and 62-day cancer waiting times. However, the Governors know that this is also being prioritised by the leadership of the trust for 2024/25.

The governors also note that there is also a more robust plan to improve and ultimately transform the clinical effectiveness of care within the trust.

One of the key areas to see improvement has been in mortality rates. Rates measured by both the Summary of Hospital Level Mortality Indicator (SHMI) and the Hospital standardised Mortality Rate (HSMR) have improved in 2023/24 and this is commended by the Governors.

The Governors also note that strides have been made where mortality is expected, for example in managing end of life care.

Patient experience has also been a key focus for improvement. In 2023/24 the Governors were disappointed by the rating for UECC and inpatients in this regard. However, the Governors are assured that a great deal of effort has been and will continue to be made to transform patient experience within the Trust.

In line with trust values, an ambitious Quality Improvement Programme has commenced, which will include the Quality Improvement Faculty. This will include a broad range of training for colleagues with a focus on taking a more proactive approach to quality improvement and assurance in all

aspects of the care we give to patients. An increasing number of Quality focused roles have been introduced to embed this programme and make Quality improvement “business as usual”.

The Governors would like to take this opportunity to thank the Trust, colleagues in the Hospital and community, for their unstinting commitment to compassionate, high quality care for the people of Rotherham. We look forward to the continued progress made to become an outstanding trust in the future.

Gavin Rimmer
Lead Governor, The Rotherham NHS Foundation Trust

Statement from NHS South Yorkshire ICB

NHS South Yorkshire Integrated Care Board
Rotherham Place
Floor 1C Riverside House
Main Street
Rotherham
S60 1AE

9 May 2024

Helen Dobson
Chief Nurse
The Rotherham Foundation NHS Trust

Dear Helen

TRFT Annual Quality Account

Having been co-signature to the NHS South Yorkshire Integrated Care Board (ICB) Rotherham Place letter of last year I'm pleased to write the letter this year, welcoming Andrew Russell as the new SYICB Rotherham/Doncaster Place Chief Nurse as co-signature.

2023/24 has shown continual improvement across many aspects of care at The Rotherham NHS Foundation Trust (TRFT) and the ICB would like to commend that progress. Industrial action has made that progress particularly challenging and the ICB will continue to support until the national issue is resolved.

The ICB and TRFT have worked well together this year, and we continue to make improvements in the three domains of Patient Experience, Patient Safety and Clinical Effectiveness, with ongoing engagement at contractual and clinical meetings. The meetings are honest and open and take place in the spirit of our shared goals of excellent and continual improvement across those three domains.

There are some areas that the ICB would like to highlight:

- 112 Quality Improvement Practitioners having completed their training, there have been 93 registered quality projects registered over the year and the use of the AMaT tracking system to register and track those initiatives.
- The Patient Safety Incident Response Framework (PSIRF) which is the new NHS approach of responding to patient safety incidents. I have personally found the new system to be appropriately challenging, robust, and open and honest. Learning from those incidents is very clear with procedures put in place to reduce risk going forwards.

- As Rotherham place, we share two of our priorities, namely Diabetes Management and dealing with patients with frailty more effectively and I have seen plans developed to improve the quality of care for patients with those issues.
- Participation in clinical audits is particularly important to understand how TRFT compares nationally and to help inform national policy and the ICB commends the 93% involvement in those national audits.
- The involvement of the medical examiner in 100% of the required scrutiny of deaths in the trust, with ongoing work to prepare primary care for the requirements in 2024/25.
- The excellent work to provide an improved service to patients who are vulnerable, patients with Dementia and those with Learning Disabilities and Autism
- TRFT staff survey shows an improving picture of staff morale, with TRFT being the 3rd most improved trust in the country in 2023/24. A happier workforce is a more effective workforce, and we should see that reflected in patient care in the future.
- Although the national target of the four hour wait to be seen in the emergency department (ED) remains challenging, the average time waiting for initial assessment has reduced by 9 minutes, equivalent of a quarter, with a similar percentage reduction in terms of time waiting to see a clinician. This means an average person attending ED in Rotherham has waited 81 minutes less before being discharged or admitted than the previous year.

The ICB will continue to support TRFT to improve, working together with all local partners within the systems we have set up previously which are proving to be effective. We will support TRFT in making sure that the patient voice is heard, using complaints and compliments, patient feedback and listening to patient need to enable patient care to be outstanding in TRFT, which is the vision.

Yours sincerely,

Dr Jason Page
Medical Director
NHS SY ICB Rotherham Place

Andrew Russell
Chief Nurse
NHS SY ICB Rotherham/Doncaster Place

Statement from Healthwatch Rotherham

TRFT Quality Account 2023/24 - Healthwatch Rotherham response

Thank you for sharing this report with us. We would like to take this opportunity to thank staff at the Trust who have been working hard through a turbulent year to improve services since the last CQC inspection, which we know the Trust were disappointed by.

We acknowledge it has been a challenging year, given how the strikes have affected the healthcare system, with added pressures on management to establish systems to work through the backlog of elective surgeries and outpatient appointments. The results are encouraging after the Mexborough site opened, and waiting lists are becoming shorter at TRFT, which is still a commendable step forward.

This report shows the Trust's drive to ensure that the quality and safety of the services it provides are at the heart of its continued commitment to a framework for quality improvement that values the voice of people who are experts by experience. With particular attention being given to many projects where improvements are needed, such as pain management within all areas of trust along with Falls and Frailty.

Healthwatch Rotherham is delighted to learn of the appointment of a new Quality Improvement facilitator and a Practitioner who will support the Head of Quality Improvement to drive system improvements throughout 2024-2025. We are keen to continue to improve our links with the Trust to drive patient voice into system improvements at a more senior level and forge stronger links for patient experiences to be heard.

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.

This year saw the hospital become part of a national pilot in an e-meet and greet programme, which helps patients manage their health and wellbeing while waiting. Along with this to inform patients at the start of their elective pathway of the likely waiting time, with improved patient communication along this journey, which is part of a *waiting well service*. This is an element Healthwatch Rotherham has also identified as an area of improvement.

We continue to take part in the Patient Experience Group, where we can see how services are being improved, and we look forward to working more closely with The Rotherham Foundation Trust in the future to ensure that Patient voices continue to be heard, for all communities in Rotherham.

At the TRFT Hospital considerable attention has been given this year to ensure the staff's health and well-being is improved and Healthwatch Rotherham looks forward to hearing about the support staff are being given during this continued challenge in the cost-of-living crisis.

Kym Gleeson
Healthwatch Manager

Health Select Commission Stakeholder Statement

Thank you for sending a copy of your draft Quality Account for consideration by the Health Select Commission. Please accept our apologies for any inconvenience caused, however due to the all-out elections taking place we are unable to provide comments on your draft Quality Account this year.

Please do not hesitate to contact me if required.

Many thanks

Barbel Gale
Governance Manager
Rotherham Metropolitan Borough Council

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 2023/24
- 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 2023 to 31 March 2024
    - papers relating to quality reported to the Board over the period April 2023 to 31 March 2024
    - feedback from governors dated 31 May 2024
    - feedback from NHS South Yorkshire ICB received 9 May 2024
    - feedback from local Healthwatch organisation dated 10 May 2024
    - feedback from Health Select Commission received 8 May 2024
    - the Trust's complaints report (included within the Patient Experience and Inclusion Annual Report) published under regulation 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009, dated April 2024
    - the National Patient Survey published July 2023
    - the National Staff Survey 2023 published 7 March 2024
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated June 2024 (approved at Audit and Risk Committee and Board of Directors on 11 June 2024)
    - 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.

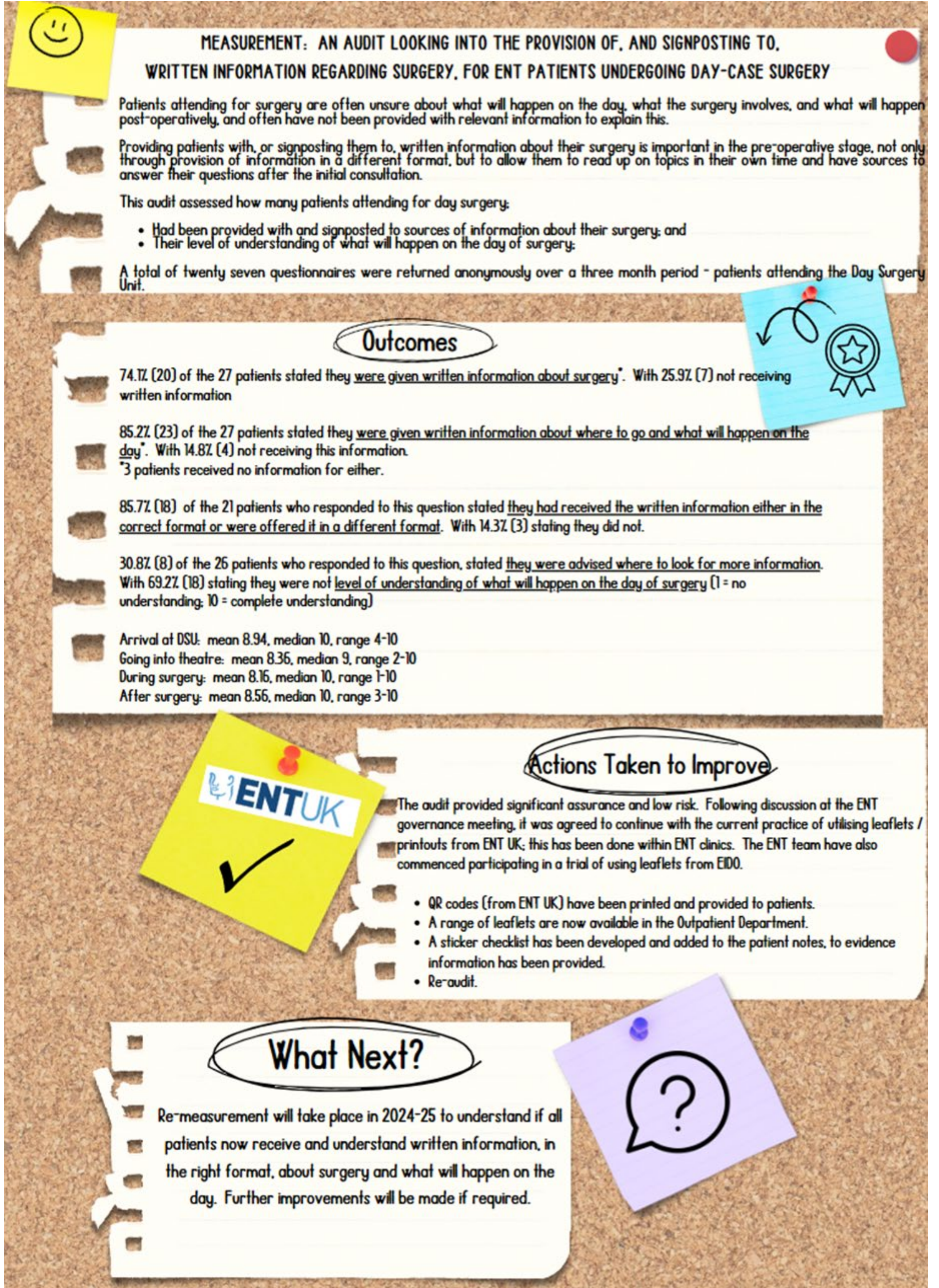
By order of the Board

Dr M Richmond
Chair
June 2024

Dr R Jenkins
Chief Executive
June 2024

Appendix 1: Review of Local Clinical Audits

The outcomes of 123 Local Clinical Audits were reviewed by the provider in 2023-24. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which are detailed below;



Measurement: Palliative Care within the Urgent and Emergency Care Centre (UECC)

Whilst most view the emergency department as a place to seek urgent medical care, it is also a department which sees palliative patients and also start palliative care.

Whilst not considered the ideal place to start palliative care, we need to ensure these patients have the highest possible care during their final moments of life.

01 Outcomes

28 patients within three months who were known to be palliative or palliation was started in ED. Aged 64-97 (average age 81).

All patients were noted to have medical or social dependency e.g. lung cancer to frailty & from a care home.

The audit evidenced significant assurance that good care was provided, and no risks identified.

Actions Taken to Improve 02

There are always improvements that can be achieved. The UECC held its 2nd Annual Palliative Care Study Day which included presentations and discussion on:-

- ReSPECT & Advanced Care Planning
- Breathlessness & Out of Hour Support.
- Organ Donation
- Chaplaincy & their role in Palliative Care.
- Acute Oncology Service (AOS) & Cancer of Unknown Primary (CUP)
- Cultural consideration in Palliative Care.
- Conservations in Palliative Care - Case Based Review

03 What Next?

Continue to share and learn.

Re-measure to evidence delivering effective palliative care in an urgent and emergency care setting.

Measurement: Venous Thromboembolism (VTE) Prophylaxis in Elective Knee Replacement: Improving Compliance with NICE Guidelines

Venous thromboembolic events are a major cause of morbidity and mortality among patients in hospitals.

Surgical patients have been shown to have higher risk, particularly when they suffer prolonged immobilisation, such as in the case of knee joint replacement. The Trust is currently following the established NICE guidelines of aspirin for 14 days as the prophylactic drug of choice.

However, given the fact that the majority of the orthopaedic patients are on LMWH (Tinzaparin) prior to surgeries on admission, there is the potential in delay to switching to aspirin for the 14 days of prophylaxis.

This audit therefore aimed to ensure that the proper drug (aspirin) was prescribed immediately following elective knee surgeries and to provide corrective action if this was shown not to be the case.

Actions Taken to Improve

Clear documentation of VTE prophylaxis option – mandated the requirement to be documented in the operation note.

Revision of VTE assessment form on EPR – to allow prescription of aspirin.

Standardisation of VTE prophylaxis prescribers – VTE prophylaxis is now prescribed by the Orthopaedic Surgeon rather than Anaesthetists. Nursing staff to identify discrepancies – Briefing provided for nursing staff on appropriate VTE prophylaxis.

Timely administration – Ward Manager / Nurse in Charge oversight of surgery, VTE prophylaxis and timely administration.

Outcomes

92% (23) of the 25 patients were prescribed Aspirin, as per the NICE guideline, with the remaining 8% having good reasons (Peptic Ulcer Disease, High BMI) for an alternative (Apixaban)

Partial compliance (87% for same day / post-operative day 1) was noted with regards to starting Aspirin in a timely manner.

44% (11) of the 25 patients were also served Tinzaparin prior to commencing Aspirin / Apixaban.

52% (13) of the 25 patients evidenced post-operative plans specifying the drug to be prescribed (i.e. Aspirin), while the remaining 48% (12) did not specify.

What Next?

Re-measurement will be undertaken in 6 months time.

Taking further improvement action as required.

Appendix 2: Readmissions within 30 days

Emergency Re admissions within 30 days of discharge from Hospital		
Age Bands	**1st April 2022 – 31st March 23**	**1st April 2023 – 31st January 24**
Age 0 - 15 years	11.79%	12.98%
Age 16 years and above	10.48%	9.07%

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 April 2022 the data was amended to exclude all Day Cases from the Denominator, something that was included up to March 2022.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2023/24

Detail of Visits	Date of Visit
Clinical Service Excellence Programme (CSEP) Myeloma UK Accreditation	16 February 2024
UKAS WHO Assessment for Laboratory Medicine (Andrology)	13 April 2023
UKAS Surveillance visit 1 to Laboratory Medicine	10-12 May 2023, 13, 28 June 2023
Police Counter Terrorism Security Advisor visit to Laboratory Medicine	12 May 2023
Health & Safety Executive visit to Laboratory Medicine	23 June 2023, 16 November 2023
Human Tissue Authority visit to Laboratory Medicine	11 October 2023
Dangerous Goods Safety Advisor visit to Laboratory Medicine	30 November 2023
GIRFT Support Day – ENT, Gynaecology and Ophthalmology	17 May 2023
GIRFT Support Day – Urology, Anaesthetics and Perioperative Medicine, Cardiology and Dermatology	19 July 2023
GIRFT ENT Gateway Review	19 December 2023
GIRFT HVLC System Visit – Professor Tim Briggs	10 January 2024
Aseptic Unit inspections against QAAPS (Quality Assurance of Aseptic Preparation Services) standards	28 June 2023
LMNS assurance visit	23 January 2024
Paediatric audiology	29 February 2024

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Acronyms

A&E	Accident & Emergency Department
AMU	Acute Medical Unit
APC	Admitted Patient Care
C-DIFF	Clostridium Difficile
CHKS	Comparative Health Knowledge System
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
DIPC	Director of Infection Prevention and Control
DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
ECDS	Emergency Care Data Set
E.Coli	Escherichia coli
ED	Emergency Department
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GIRFT	Getting it Right First Time
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICS	Integrated Care System
IDQ	Improving Data Quality
IPC	Infection Prevention and Control
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
LeDeR	Learning Disabilities Mortality Review
MaST	Mandatory and Statutory Training
MDT	Multi Disciplinary Team
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSDS	Maternity Services Data Set
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
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OMFS	Oral and Maxillofacial Surgery
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
RCA	Root Cause Analysis
RPA	Radiation Protection Advisor
RTT	Referral to Treatment
SDTI	Suspected Deep Tissue Injury
SHMI	Summary Hospital level Mortality Indicator
SHO	Senior House Officer
SJR	Structured Judgement Review
SOP	Standard Operating Procedure
SQL	Structured Query Language
SUS	Secondary Uses Service
TMG	Trust Mortality Group
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent and Emergency Care Centre
UKAS	United Kingdom Accreditation Service
VTE	Venous Thromboembolism
YTD	Year To Date

Glossary

Term	Definition
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.
AMaT	Audit Management and Tracking (AMaT) was created with NHS clinical audit teams to give more control over audit activity and provide real-time insight and reporting for clinicians, wards, audit departments and healthcare Trusts.
Care Quality Commission	The independent regulator of all health and social care services in England
Clinical Coding	The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.
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 are receiving health care for another condition.

Term	Definition
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
Integrated Care Board	NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the ICP's integrated care strategy
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.
Patient Reported Outcome Measures	Questionnaires measuring the patients' views of their health status
Power BI	Power BI is an interactive data visualization software product developed by Microsoft with a primary focus on business intelligence. It is part of the Microsoft Power Platform.
Quality Account	A report about the quality of services offered by an NHS healthcare provider.
Secondary Uses Service	A collection of health care data required by hospitals and used for planning health care, supporting payments, commissioning policy development and research.
Structured Judgement Review	Usually undertaken by an individual reviewing a patient's death and mainly comprises two specific aspects: explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both

Term	Definition
	specific phases of care and to the overall care received.
Summary Hospital-level 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.