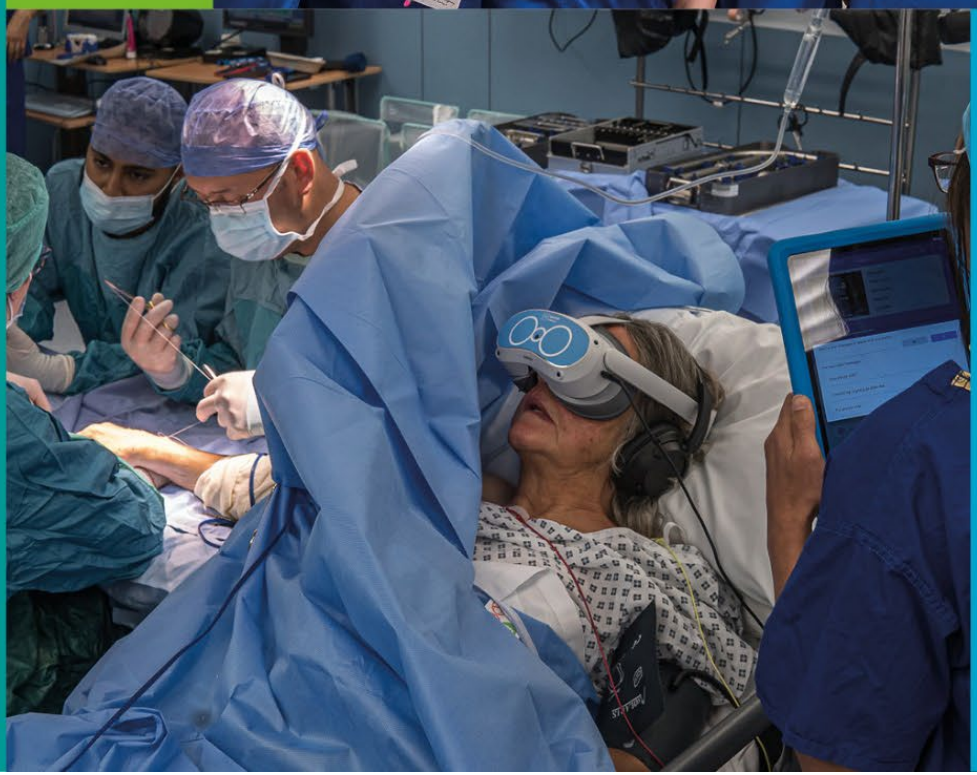
NHS
The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Quality Account 2024/25



Ambitious
Caring
Together

Part One: Statement on Quality from the Chief Executive

The Rotherham NHS Foundation Trust's Quality Account provides a summary of the Trust's quality performance and improvement journey during 2024-25. This includes both a retrospective look at the previous year's data and a forward-looking plan for improvement. 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.

Whilst the report covers a broad range of quality metrics, there is a focus on three quality priorities selected by the Trust each year. During 2024/25, these priorities were diabetes management, acute pain management and frailty. The first two of these priorities met all of their aims and objectives. Although we did not fully meet the ambitious target for the frailty priority, significant progress was made in this area and we will continue to build on these improvements in the coming year.

We have selected our three quality priorities for 2025-26, based on triangulation of information from a broad range of sources, including independent patient surveys. These three priorities are a continuation into the work on diabetes management, antimicrobial stewardship and reducing delays in cancer diagnosis and treatment. We believe these choices reflect areas where a positive impact can be achieved for the patients in our care and their families. Details of the ambitions for these priorities as well as the key achievements against last year's priorities, are included within the report.

In line with the wider NHS, we continue to recover from the impact of the pandemic and industrial action, particularly within elective care for planned procedures. Our performance has improved during the year, particularly with achievement of the national ambition to eliminate all patients waiting over 65 weeks by the end of March, but we acknowledge that patients are still waiting too long for some procedures. We will continue to build upon these improvements in 2025/26 to ensure we deliver significant reductions in waiting times for our patients. We will also be building upon the achievements already seen this year in treating patients within 4 hours within our Urgent and Emergency Care Centre (UECC) and look forward to the opening of our improved UECC facility with a co-located medical Same Day Emergency Care (SDEC) to help us achieve this ambition.

The report highlights a significant number of quality achievements this year and I would like to take the opportunity to highlight some of these that have contributed towards our improvement journey.

- We have not received any inspections from the Care Quality Commission (CQC) this year meaning that our current CQC rating reflects a historic position from 2021. Despite this, we have completed the first year of our Exemplar Accreditation programme to gain assurance around quality of care within adult inpatient areas, maternity and paediatrics and teams are using the findings to drive further improvements. We will expand this in the coming year to incorporate an even greater range of clinical areas.
- The Trust delivered improved scores for the Maternity, Inpatient and UECC national CQC patient experience surveys this year which is great news for our patients although we recognise that there is still significant scope to improve these even further. Initiatives linked to waiting times, discharge co-ordination, communication

and end of life care will continue during the coming year to help improve the experiences of our users.

- Our new PALS (Patient Advice and Liaison Service) was formally opened in November 2024. This purpose built facility enables members of the public to easily seek advice and support and is already resulting in a reduction in the number of concerns being reported by our service users. We also built a new wheelchair store near the main entrance, complimented by meet and greet volunteers, to improve accessibility within the hospital main site.
- Diagnostic performance remained strong, with the Trust consistently delivering the constitutional DM01 standard throughout 2024/25, ending the year at 0.59% exceeding the national standard of less than 5% waiting over 6 weeks. The Trust remains one of the top-performing organisations nationally, consistently benchmarking in the top decile.
- We remain committed to delivering healthcare in the best environment for our patients, which is often their own home. Our Virtual Ward continues to develop to support this alongside our wider community offering. There are further exciting developments such as mobile x-ray facilities planned for the coming year to improve this service even further.
- We launched our new Carer/Care Partners Promise during the year. This was co-created with Carers from various forums across Rotherham and includes a publically declared promise, with lanyards and badges for carers to wear if they choose. This work was further promoted during Carers Rights Day in November where an event in the main entrance saw many community carers join us to promote the rights of Carers.
- We recognise the positive impact a stable workforce has on delivering high quality care and have continued to run successful recruitment and retention campaigns, across many disciplines to support this. We have presented at a number of regional and national nursing events to promote some of the innovative approaches we have taken to achieve this and were recognised as a finalist for the ‘Nurse Employer of the Year’ award at the Nursing Times awards.
- TRFT continues to poll above the national average in the national staff survey with 2024 delivering the second best result that the Trust has ever posted. We have identified key themes from this year’s results to help us focus on achieving even greater success in the coming year.
- Partnership working with Barnsley Hospital NHS Foundation Trust has continued to strengthen over the last year leading to benefits for patients from shared expertise and resources. Of note, we have appointed a joint Director of Midwifery which will bring consistent improvements to both organisations. Collaboration within gastroenterology and haematology services continues to be positive and we look forward to developing other close working relationships during the coming year.

Alongside these accomplishments, there are still areas where we need to improve in the coming year and we will maintain our focus in these areas.

- We will reduce the number of patients waiting more than 52 weeks for their treatment, in line with national expectations.
- We recognise that too many of our patients accessing our Urgent and Emergency Care Centre continue to wait too long before they are admitted or discharged. This will remain a key priority for improvement in the coming year.
- Although the Trust improved in all national patient surveys, we recognise that we can do more. We have developed detailed improvement plans based on what our service users are telling us and will use these to make further improvements. 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 2024-25. As we move into 2025/2026, we face many national developments and we will be agile in responding positively to these. We will maintain our previous focus on being ambitious to deliver safe, high quality care with positive outcomes for patients, supported by a newly developed Quality Strategy. 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 2025/26 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.

Dr Richard Jenkins
Chief Executive
May 2025

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

2.1 Priorities for improvement during 2025/26

Our vision is to be an outstanding Trust, delivering excellent care at home, in our community and in hospital. To achieve this, every team and colleague is expected to be involved in Quality Improvement (Qi). Qi will be part of everyday business. The Quality Improvement programme at the Trust has continued to expand over 2024/25, with 154 Quality Improvement Practitioners now successfully completing training. The new AMaT (clinical audit assurance) system is utilised to register and track progress of all quality improvement initiatives. 97 projects were registered through the system over the past year.

The Trust has led on a collaborative production of the new Improving Learning South Yorkshire (ILSY) course for Quality Improvement. This includes partners from Rotherham Doncaster and South Humber NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. More recently the ICB has committed to being a partner in this work, providing a standardised approach to Quality Improvement methodology and training across South Yorkshire.

The team has expanded significantly and we have appointed a Quality Improvement Facilitator and Practitioner to support the Head of Quality Improvement. The expansion of the Qi team will provide resource to be able to review the impact of quality improvement throughout the Trust. 2025/26 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

A systematic approach is taken to address and manage patient safety incidents effectively. The key components of incident responses include, 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 2025/26, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process, including communication with colleagues and Non-Executive Directors, 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 Care Groups, each ultimately accountable to the Board of Directors for its contribution to the performance of the Trust as a whole. Each Care Group is led by a Care Group 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 2025/26 are:

- Diabetes Management
- Antimicrobial Stewardship
- Delayed Cancer Diagnosis and Treatment

Diabetes Management

To create a 20% reduction in the number of avoidable/unwarranted harm for adult patients admitted with diabetes to the acute hospital, reduce the length of stay for patients with type 1 diabetes and reduce the number of admissions to hospital by improving patient pathways.

Diabetes Pathway Redesign

- Improve policies and guidelines
- Review and update pathways within the community and acute areas
- Create better access to Diabetic Nurse Specialists including referral mechanisms
- Revision of current Key Performance Indicators for the Diabetic Nurse Specialists

Digital Transformation

- Early identification of patients admitted to the Trust
- Glucose and Ketone meter readings within Meditech
- Order sets to be available to improve and standardise prescribing for Diabetic Ketoacidosis (DKA)
- Digital BM monitoring
- Digital DKA protocols

Electronic Prescribing

- Admission processes in UECC
- Guidance in UECC
- Standardisation of pre-made prescriptions for Diabetic patients
- Discharge processes
- Standardised place/system for the prescribing for patients with e.g. DKA patients Sliding scale flagged also as an issue within this area.

Antimicrobial Stewardship

Reduce the risk of antimicrobial resistance while safeguarding the quality of care for patients with infection.

Objective breakdown:

- Increase the numbers of patients assessed for clear evidence of infection – to establish whether the patient is likely to benefit from antimicrobials
- Increase the number of patients who have had appropriate specimens for culture prior to commencing antibiotic therapy (including blood cultures prior to starting IV antibiotics)
- Increase appropriate prescribing using local guidelines for prompt effective antimicrobial treatment after diagnosis in patients with life-threatening infections such as severe sepsis.
- Reduce indiscriminate use of broad-spectrum antimicrobials – to preserve the effectiveness of these agents, reduce collateral damage to the patient's microbiota and reduce the risk of opportunistic infection (such as C. difficile).
- Increase evidence of review of antimicrobials after 48 – 72 hours

Objective output/metrics:

- Documentation evidence of infection, working diagnosis and disease severity
- Documentation of appropriate sampling
- Documentation of appropriate prescribing (and where broad-spectrum antimicrobials have been used)
- Documentation of 5 antimicrobial review outcomes: 'CARES ' to cease, amend, refer, extend or switch

Reducing Delays in Cancer Diagnosis and Treatment

To provide timely access to cancer services and high quality cancer care for the people of Rotherham

- To work towards improving the experience for all that are affected by cancer, and their families and carers.
- To reduce the risk of patient harm and embed a continual learning culture.
- To produce a Trust level cancer strategy to support the South Yorkshire and Bassetlaw Cancer Alliance direction of travel.

- To optimise cancer performance and service productivity to the benefit of patients utilising cancer services.
- To develop and progress robust improvement plans which support delivery of the cancer wait standards.

2.2: Statement of Assurance from the Board of Directors

During 2024/25 the Trust provided and/or subcontracted 64 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 2024/25 represented 65.21% of the total income generated from the provision of health services by The Rotherham NHS Foundation Trust for 2024/25.

Clinical Audit

Information on Participation in Clinical Audits during 2024/25:

During 2024/25, 58 national clinical audits and 9 national confidential enquiries covered NHS services that The Rotherham NHS Foundation Trust provides.

During that period the Trust participated in 95% of national clinical audits and 100% 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 2024/25, 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	BAUS Penile Fracture Audit	No	Yes	Yes	Yes	(No eligible cases)
	2	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	No	Yes	No	NA	NA
	3	BAUS – Environmental Lessons Learned and Applied to the bladder cancer pathway audit (ELLA)	No	Yes	Yes	Yes	100% (11/11)
2	4	Breast and Cosmetic Implant Registry	No	Yes	Yes	Yes	35**
3	5	British Hernia Society Registry	No	Yes	Yes	No	N/A***

4	6	Case Mix Programme (CMP)	No	Yes	Yes	Yes	100% (605/605)*
5	7	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme					
		Emergency surgery in children and young people	Yes	Yes	Yes	Yes	79% (11/14) 3, surgical cases extended to 30/04/2025
6	8	Cleft Registry and Audit Network (CRANE)	No	Yes	No	NA	NA
7	Emergency Medicine QIPs						
	9	Adolescent Mental Health	No	Yes	Yes	Yes	Deferred nationally to start 25/26
	10	Care of Older People	No	Yes	Yes	Yes	100% (362/362)
	11	Time Critical Medications	No	Yes	Yes	Yes	100% (200/200)
8	12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People1	Yes	Yes	Yes	Yes	100% (17/17)
9	Falls and Fragility Fracture Audit Programme (FFFAP)						
	13	Fracture Liaison Service Database (FLS-DB)	Yes	Yes	Yes	Yes	91.8% (1144/1350)
	14	National Audit of Inpatient Falls (NAIF)	Yes	Yes	Yes	Yes	100% (14/14)
	15	National Hip Fracture Database (NHFD)	Yes	Yes	Yes	Yes	100% (291/291)
10	16	Learning disability and autism Programme - Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	No	Yes	Yes	Yes	100% (20/20
11	MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme						
	17	Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	Yes	Yes	Yes	100% (1/1)
		Maternal mortality confidential enquiries	Yes	Yes	Yes	Yes	100% (1/1)
		Maternal mortality surveillance	Yes	Yes	Yes	Yes	100% (1/1)
		Perinatal mortality and serious morbidity confidential enquiry	Yes	Yes	Yes	Yes	100% (13/13)
		Perinatal Mortality Surveillance	Yes	Yes	Yes	Yes	100% (13/13)

12	NCEPOD Medical and Surgical Clinical Outcome Review Programme						
	18	Acute Limb Ischaemia	Yes	Yes	Yes	Yes	100% (1/1)
		Rehabilitation following critical illness	Yes	Yes	Yes	Yes	100% (5/5)
13	NCISH Mental Health Clinical Outcome Review Programme						
	19	Real-time surveillance of patient suicide	Yes	Yes	No	NA	NA
		Suicide (and homicide) by people under mental health care	Yes	Yes	No	NA	NA
		Suicide by people in contact with substance misuse services	Yes	Yes	No	NA	NA
14	National Adult Diabetes Audit (NDA)						
	20	National Core Diabetes Audit	Yes	Yes	Yes	Yes	100% (501/501)*
	21	National Diabetes Prevention Programme (DPP) Audit	Yes	Yes	No	NA	NA
	22	National Diabetes Foot care Audit (NDFA)	Yes	Yes	Yes	Yes	100% (45/45)*
	23	National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Yes	Yes	100% (14/14)*
	24	National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Yes	Yes	100% (30/30)
	25	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Yes	Yes	100% (8/8)*
	26	Gestational Diabetes Audit	Yes	Yes	Yes	Yes	Data extracted from Maternity Minimum Dataset (MMDS)
15	27	National Audit of Cardiac Rehabilitation	No	Yes	Yes	Yes	100% (461/461)*
16	28	National Audit of Cardiovascular Disease	Yes	Yes	No	N/A	N/A
17	29	National Audit of Care at the End of Life (NACEL)	Yes	Yes	Yes	Yes	100% (250/250)
18	30	National Audit of Dementia - Care in general hospitals	Yes	Yes	Yes	Yes	100% (78/78)
19	31	National Bariatric Surgery Registry (NBSR)	No	Yes	No	N/A	N/A
National Cancer Audit Collaborating Centre (NATCAN)							

20	32	National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer (NAoME)	Yes	Yes	Yes	Yes	100% 22/22*
21	33	National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer (NAoPri)	Yes	Yes	Yes	Yes	100% (249/249)
22	34	National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)	Yes	Yes	Yes	Yes	100% (169/169)
23	35	National Kidney Cancer Audit (NKCA)	Yes	Yes	Yes	Yes	100% (44/44)
24	36	National Lung Cancer Audit (NLCA)	Yes	Yes	Yes	Yes	100% (205/205)
25	37	National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	Yes	Yes	Yes	100% (63/63)
26	38	National Oesophago-Gastric Cancer Audit (NOGCA	Yes	Yes	Yes	Yes	100% (51/51)
27	39	National Ovarian Cancer Audit (NOCA)	Yes	Yes	Yes	Yes	100% (30/30)
28	40	National Pancreatic Cancer Audit (NPaCA)	Yes	Yes	Yes	Yes	100% (30/30)
29	41	National Prostate Cancer Audit (NPCA)	Yes	Yes	Yes	Yes	100% (326/326)
30	42	National Cardiac Arrest Audit (NCAA)	No	Yes	Yes	Yes	100% (39/39)
31	National Cardiac Audit Programme (NCAP)						
	43	National Adult Cardiac Surgery Audit (ACS)	No	Yes	No	N/A	N/A
	44	National Congenital Heart Disease Audit (NCHDA)	No	Yes	No	N/A	N/A
	45	National Heart Failure Audit (NHFA)	No	Yes	Yes	Yes	6% (30/436)**
	46	National Audit of Cardiac Rhythm Management (CRM)	No	Yes	Yes	Yes	100% (351/351)
	47	Myocardial Ischaemia National Audit Project (MINAP)	No	Yes	Yes	Yes	100% (316/316)
	48	National Audit of Percutaneous Coronary	No	Yes	No	N/A	N/A

		Interventions (NAPCI)					
	49	The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	No	Yes	No	N/A	N/A
	50	Left Atrial Appendage Occlusion (LAAO) Registry	No	Yes	No	N/A	N/A
	51	Patent Foramen Ovale Closure (PFOC) Registry	No	Yes	No	N/A	N/A
	52	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	No	Yes	No	N/A	N/A
32	53	National Child Mortality Database (NCMD) Programme	Yes	Yes	Yes	Yes	20% (4/20) **
33	54	National Clinical Audit of Psychosis (NCAP)	Yes	Yes	No	N/A	N/A
34	National Comparative Audit of Blood Transfusion						
	55	Audit of Blood Transfusion against NICE Quality Standard QS138	No	Yes	Yes	Yes	100% (28/28)
	56	2023 Bedside Transfusion Audit	No	Yes	Yes	Yes	100% (10/10)
35	57	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Yes	Yes	70% (69/98)**
36	58	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Yes	Yes	100% (122/122) (year 10)
	59	National No Laparotomy Audit (NoLap)	Yes	Yes	Yes	Yes	2**
37	60	National Joint Registry (NJR)	No	Yes	Yes	Yes	97 - 98%
38	61	National Major Trauma Registry (NMTR) (previously TARN)	No	Yes	Yes	Yes	68% (336/489)**
39	62	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Yes	Yes	Data extracted by RCOG from NHSE **
40	63	National Neonatal Audit Programme (NNAP)	Yes	Yes	Yes	Yes	100% (273/273)
41	64	National Obesity Audit (NOA)	Yes	Yes	No	N/A	N/A
42	65	National Ophthalmology Database Audit (NOD) - Age Related Macular Degeneration Audit	No	Yes	Yes	No	N/A***
	66	National Ophthalmology Database Audit	No	Yes	Yes	No	N/A***

		(NOD) - National Cataract Audit					
43	67	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Yes	Yes	100% (131/131)
44	68	Perinatal Mortality Review Tool (PMRT	Yes	Yes	Yes	Yes	100% (13/13)
45	69	National Audit of Pulmonary Hypertension	No	Yes	No	N/A	N/A
46	National Respiratory Audit Programme (NRAP)						
	70	COPD Secondary Care	Yes	Yes	Yes	Yes	67% (123/182)**
	71	Pulmonary Rehabilitation	Yes	Yes	Yes	Yes	100% (347/347)*
	72	Adult Asthma Secondary Care	Yes	Yes	Yes	Yes	43% (83/193)**
	73	Children and Young People's Asthma Secondary Care	Yes	Yes	Yes	Yes	100% (83/83)
47	74	National Vascular Registry (NVR)	No	Yes	No	NA	NA
48	75	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	No	Yes	No	NA	NA
49	76	Paediatric Intensive Care Audit Network (PICANet)	Yes	Yes	No	NA	NA
50	77	Perioperative Quality Improvement Programme (PQIP)	No	Yes	Yes	Yes	65% (158/245)
51	Prescribing Observatory for Mental Health						
	78	Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	No	Yes	No	N/A	NA
	79	Monitoring of patients prescribed lithium	No	Yes	No	N/A	NA
	80	The use of opioids in mental health services	No	Yes	No	N/A	NA
53	86	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Yes	Yes	B 85.8%**
54	87	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	No	Yes	Yes	Yes	44/44 100%
55	88	Society for Acute Medicine Benchmarking Audit (SAMBA)	No	Yes	Yes	Yes	100% (73/73)
56	89	UK Cystic Fibrosis Registry	No	Yes	No	NA	NA

57	90	UK Renal Registry Chronic Kidney Disease Audit	No	Yes	No	NA	NA
58	91	UK Renal Registry National Acute Kidney Injury Audit	No	Yes	Yes	Yes	100% (10739/ 10739)

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 continue to be reviewed and validated during April, May or June 2025 and therefore final figures may change.

****Supporting Statements – lower than expected case ascertainment**

NCAPOP – National Respiratory Audit Programme (NRAP) - Adult Asthma – An Asthma Discharge Care Bundle has now been implemented in the electronic record system. Improvement work continues with the Business Intelligence Team to ascertain further data fields to reduce data burden and increase case ascertainment.

NCAPOP – National Respiratory Audit Programme (NRAP) - COPD – A COPD Discharge Care Bundle has now been implemented in the electronic record system. Improvement work continues with the Business Intelligence Team to ascertain further data fields to reduce data burden and increase case ascertainment.

NCAPOP – Sentinel Stroke National Audit Programme (SSNAP) – lower case ascertainment due to partner organisation not having opened cases on the pathway for TRFT to enter the data. Re-patriated patients who commenced the stroke pathway at another NHS Trust and transferred across to TRFT

NCAPOP - National Child Mortality Database (NCMD) Programme – twenty notifications received 1 April 2024 – 31 March 2025. Four completed reviews submitted. There is no deadline for submission of reviews. Each review carries an individual timeline and is dependent upon coroner court dates etc.

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 an increased case ascertainment for 2023/24 data submitted in April 24 and reported within the 2024/25 Quality Account. Case ascertainment is expected to be at 100% for the 2024/25 data submitted April 25 and to be reported within the 2025/26 Quality Account

NCAPOP – National Emergency Laparotomy Audit (NoLap) – case identification is prospective and various methods of identifying cases has been explored during 2024/25. This represents the same challenge across other organisations. Local process now agreed and case ascertainment expected to increase for 2025/26 reported data.

NCAPOP - National Maternity and Perinatal Audit (NMPA) - data unavailable as the RCOG states that there had been delays in receiving the data from NHS England for the last 2 years. They have now received the data but still to publish outcomes.

Quality Accounts – National Cardiac Audit Programme (NCAP) - National Heart Failure Audit (NHFA) - Workforce challenges continue to impact on case ascertainment for the NHFA. Improvement work continues with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment.

Quality Accounts - National Major Trauma Registry (NMTR) – resource continues to be a challenge to collect all cases within deadlines. Work continues with Business Intelligence to automate extraction of metrics from the EPR where possible to further reduce data burden.

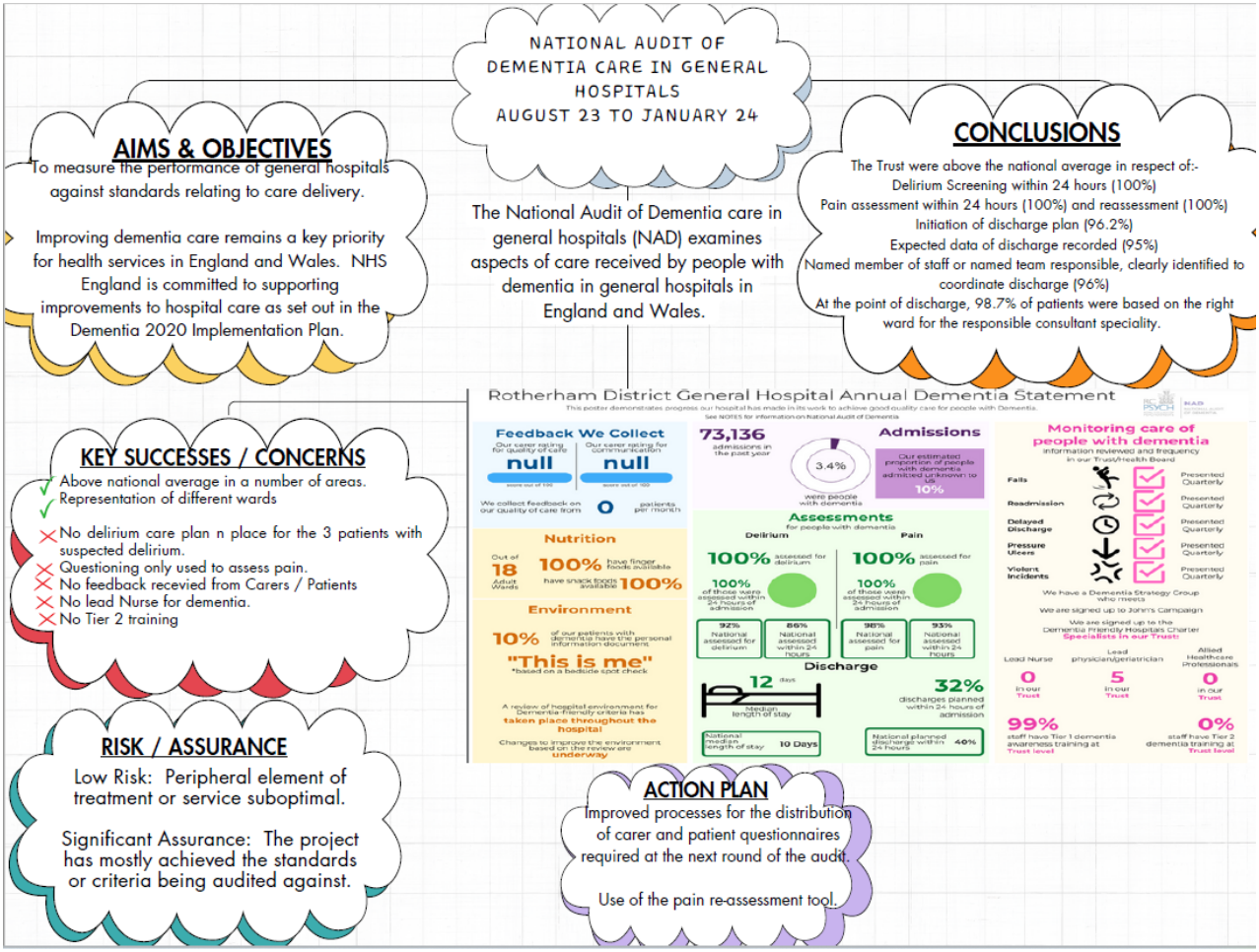
Quality Accounts - **Breast and Cosmetic Implant Registry (BCIR)** – Approximately 35 breast implants were deployed in various settings including immediate and delayed breast reconstructions for breast cancers; risk reducing surgeries associated with reconstruction; exchange of implants; correction of defects. There is a small backlog of entries onto the registry which is being updated at regular intervals.

*****Supporting Statements – non participation**

Quality Accounts - National Ophthalmology Database Audit (NOD) - National Cataract Audit & **Age Related Macular Degeneration 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 in 2023/24. The Registry did not open for wider participation until the 2024/25 financial year. Concern was raised nationally with information governance requirements in place for the Registry. Whilst this is being addressed by NHSE the Trust have not started to participate. The Trust will participate in 2025/26 providing outstanding concerns are addressed.

The reports of 38 National Clinical Audits, published in the calendar year of 2024, were reviewed by the provider in the financial year 2024/25. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which are detailed below:



THE NATIONAL PULMONARY REHABILITATION AUDIT 22/23

OVERVIEW

The National Respiratory Audit Programme (NRAP) for England and Wales aims to improve the quality of care, services and clinical outcomes for people with respiratory disease (including Asthma and COPD).

The audit is an analysis of data derived from the pulmonary rehabilitation clinical audit component of the National Asthma and COPD Audit Programme. This continuous audit captures the process of treatment in patients who are treated by pulmonary rehabilitation services in England, Scotland and Wales for COPD.

RESULTS

	TRFT	England
KPI1: Start date for PR offered within 90 days of receipt of referral for all people referred with stable COPD	46%	48%
KPI2: People undertaking practice exercise test (ISWT or 6MWT)	0%	58%
KPI3: People enrolled for PR who go on to have a discharge assessment.	76%	69%
KPI4: A written individualised discharge exercise plan is provided as part of the discharge assessment.	76%	69%
KPI5: One walking test minimal clinical important difference (MCID) achieved.	83%	87%
KPI6: At least one health status questionnaire MCID achieved.	73%	71%

IDENTIFIED AREAS OF GOOD PRACTICE

- Majority of patients receive imaging in less than 4 hours.
- There is radiographer reporting on heart strain, in 75% of cases.
- Echo's are arranged appropriately as outpatient.
- Probable cause of PE well documented.
- Good documentation of follow-up arrangements.

AREAS FOR IMPROVEMENT

- Wells score not routinely documented.
- Pesi score not calculated, documented and acted upon.
- Trops not taken in 40% of cases.
- Poor documentation of whether patient leaflet provided.

RISK / ASSURANCE LEVELS

Limited Assurance: The project mostly did not achieve the standards or criteria being audited against.

No Risk: Standards met and findings demonstrate no risk to patient safety.

CHANGES IMPLEMENTED

Practice walk test to be commenced at initial assessment for pulmonary rehab - *Support workers are now working alongside the physio clinic to support with the second walk test, which is going well. Additional rooms have been allocated to each clinic on bookwise for this.*

Individual written discharge exercise plan should be given to the patient - *A tick box has been added to SystmOne to confirm when an individual written discharge exercise plan has been given to the patient.*

Validation of PR data - *Data submitted to the audit to be validated on a monthly basis by the Team and any changes made. *Pending completion**

NATIONAL PAEDIATRIC DIABETES AUDIT 22/23

NPDA

The National Paediatric Diabetes Audit was established to support improvements in diabetes care and outcomes required to bring these in line with those achieved in comparable western European counties, and to measure progress towards the achievement of NICE Guidance.

Audit Aims

- To monitor the incidence and prevalence of diabetes amongst children and young people receiving care from a PDU in England and Wales.
- To establish whether recommended health checks are being received by children and young people with diabetes.
- To enable benchmarking of performance agains tstandards of care specified by NICE.
- To determine the prevalence and incidence of diabetes-related complications amongst children and young people with diabetes.

Summary of Results

- Overall comparable results to national and regional services.
- Positive outlier for Hbalc results.
- Certain care process submissions lower than the national average.
- Lower Ketone testing by patients.
- Lower usage of technology (CGMS and Hybrid Closed Loop)

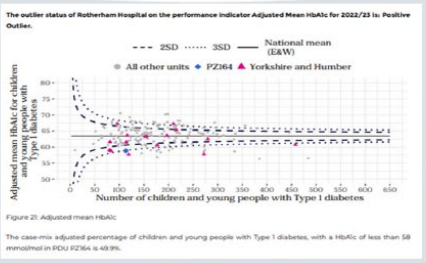


Figure 21: Adjusted mean HbA1c

The case-mix adjusted percentage of children and young people with Type 1 diabetes, with a HbA1c of less than 58 mmol/mol in PDU PZ164 is 49.9%.

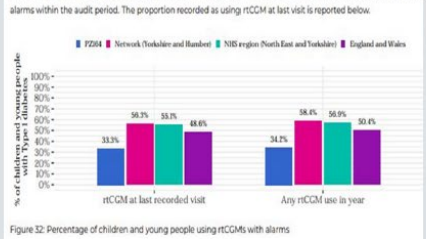


Figure 32: Percentage of children and young people using rtCGMs with alarms

Recommendations / Actions

Improve submissions of certain key care processes - Have a robust plan of regular checks that diabetes children are having in their annual review checks.

Improve screening process at the time of diabetes diagnosis - Ensure all newly diagnosed have their autoimmune conditions checked within 90 days of diagnosis.

Maintain and improve outcomes / results (especially mean and median Hbalc) - Although already positive outlier, need to upkeep the robust plan to meet national and regional targets.

Regular uploading of data to National Audit Platform - CE team to liaise with business intelligence to revise SystmOne reports for complete data capture.

Improve uptake of technologies - QI project undertaken and results have improved.

Improve transitional care - Transitional Nurse business case now approved, pending recruitment. Next step will be discussions with Adult Diabetes Team to increase transitional care clinics and a plan to work together with DSN.

Recruit Psychologist for MDT Team - Agreement with ICB that Barnsley and Rotherham will have a joint Psychologist post advertised. Monthly meetings to have an SLA agreed.

Review of Local Clinical Audits

The outcomes of 203 Local Clinical Audits were reviewed by the provider in 2024/25. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which can be seen in Appendix 1.

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2024/25 that were recruited to participate in research approved by a Research Ethics Committee was 3237 [data taken from the National Institute for Health Research (NIHR) Open Data Platform 28 April 2025].

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

The table below shows the total number of studies that have been supported by the Trust (i.e. actively recruiting or in follow up) during 2024/25.

Study Type	Number of studies
NIHR Portfolio Commercially sponsored	1
NIHR Portfolio Non-commercial	61
NIHR Portfolio Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	4
Non-portfolio The Rotherham NHSFT Sponsored	4
Other Non-portfolio (supporting academic qualifications)	0
Studies undertaken at TRFT which required no Capacity & Capability review	2

CQUINs (Commissioning for Quality and Innovation)

As directed in the 2024/25 National Planning Guidance there were no national or local CQUIN schemes in this year.

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 2024/25. The current CQC ratings are from 2021 or earlier and 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

Given the historical nature of these inspections, it should be noted that the Trust no longer operates inpatient community beds.

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. Due to there being no formal inspections since 2021, there are no current actions outstanding for any of our services.

The CQC have moved to the new Single-Assessment framework. The Trust has implemented an Exemplar Accreditation programme which is reflective of the core standards and all inpatient areas are continually assessed utilising this.

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 has worked continuously with the CQC to ensure that the standards of care we have provided are clearly demonstrated and they have full oversight. Through this partnership working we have been able to provide a high level of assurance in relation to our services for patients.

Ionising Radiation Regulations

The Trust is required to report any breaches of the Ionising Radiation Regulations (IRR) to the Care Quality Commission (CQC). Below is a summary of the radiation incidents reported to the CQC from 1 April 2024 to 1 April 2025.

CQC Reporting Requirements:

The CQC requires employers to report exposures to ionising radiation that are clinically significant, accidental, or unintended. The relevant CQC statement is as follows:

"When there is an accidental or unintended exposure to ionising radiation, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) employer knows or believes 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))."

Incidents Reported to the Radiation Protection Advisor (RPA):

During the period from 1 April 2024 to 1 April 2025, the Trust has reported a total of 27 radiation incidents to our local RPA for a dose report and recommendations. This includes incidents from the Community Dental Services.

One of these incidents met the requirement for reporting to the CQC.

Reportable Incident 1 – CT Scan Exposure:

Date of Incident: March 2025

Incident Description:

A CT scan of the chest, abdomen, and pelvis was performed on a female in-patient. All standard checks were completed, and the patient was asked about the possibility of pregnancy. The patient responded negatively and signed a waiver form to this effect, as it was an urgent scan. The radiographer contacted the ward and received verbal confirmation from the nurse that the patient had a negative pregnancy test result. Additionally, the referring clinician noted on the referral that the patient was not pregnant. However, the following day, an ultrasound revealed that the patient was approximately 7 weeks pregnant.

This incident was discussed at the Trust's Incident Panel, and a duty of candour was issued to the patient.

Incident Investigation and Escalation:

All incidents are thoroughly investigated and escalated as necessary. This particular incident has been reviewed at the following meetings:

- Care Group 4
- Medical Imaging, Physics and Illustration Quality Governance Committee
- Radiation Protection Committee (quarterly meetings)
- Health and Safety Committee

Additionally, all radiation incidents are recorded in the internal Datix system, with a dose report and recommended actions provided by the Radiation Protection Advisor (RPA). Each incident undergoes investigation to determine any learning outcomes, which are then shared across the Trust.

Special Reviews and Investigations

The Trust has not participated in any Specialist Reviews during 2024/25.

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 99.9% (99.9% for 2024/25) for admitted patient care
- 100.0% (100.00% for 2024/25) for outpatient care
- 99.8% (99.8% for 2024/25) 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 2024/25) for admitted patient care
- 100% (100% for 2024/25) for outpatient care
- 100% (100% for 2024/25) for accident and emergency care

For both data set (years) the data is reported for the period April – March.

Information Governance Toolkit/Cyber Assurance Framework (DSPT/CAF) attainment levels

The DSPT/CAF demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards and incorporates elements of the Cyber Assurance Framework, 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/CAF by 30 June each year.

The Trust's Data Security and Protection Toolkit Audit Report overall score for 2023/24 was 'Standards Met' with Substantial Assurance.

The Trust will submit again by 30 June 2025 and is aiming for full compliance with this year's requirements. Assurance will also be sought from the auditors prior to the end of May 2025.

Payment by Results (no longer in use)

The Trust was not subject to the Payment by Results clinical coding audit during 2024/25 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 finally NHSE. 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 a Band 7 Clinical 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 November 2024, during the 2024/25 reporting period as required by NHS England. The Trust again achieved an Information Governance rating of level three (Advisory), for the seventh year running, which is the highest possible rating that can be achieved. An aggregate percentage score of 98.49%% 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 to improve the quality of the data submitted from systems thus ensuring that additional data quality activities can be performed prior to submission.

As a team the Data Quality Indicators are reviewed monthly both from a 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. During this financial year the Trust ECDS data has had SDEC (Same Day Emergency Care) data included in their submissions, since August 2024 – this has seen a drop in the data completeness reported due to staff having to capture new data items, that not all staff are familiar with capturing – a work programme is in place to improve the data capture in these new areas. The Data Quality Team also works closely with the Reporting Teams to ensure that they

are aware of any errors that may be present from a submission perspective to ensure these are rectified at source, thus ensuring the Trust maintains its high standards with regards to the integrity of our data.

Clinical Coding

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

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	99.00%	98.48%	97.89%	98.58%

(Source: The Rotherham NHS FT Information Governance Audit Report 2024/2025)

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 2023/24 the Trust worked with the following actions to improve clinical coding and data quality and these continued throughout 2024/25:

- 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 2025/26 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 2024-25	Qtr 2 2024-25	Qtr 3 2024-25	Qtr 4 2024-25	YTD 2024-25	Progress
IMPROVING DATA QUALITY	IDQ-1 DQMI ECDS	2021-22 **	69.2	Increase	85.10	82.80	82.50	82.00	82.00	
	IDQ-2 DQMI APC	2020-21 **	98.9	Increase	95.40	99.40	99.50	99.50	99.50	
	IDQ-3 DQMI CSDS	2020-21 **	93.0	Increase	94.10	94.20	94.10	94.20	94.20	
	IDQ-4 DQMI MSDS	2020-21 **	99.6	Increase	99.90	99.9	99.90	99.80	99.80	
	IDQ-5 DQMI OP	2020-21 **	99.2	Increase	98.60	98.60	98.50	98.70	98.70	

	IDQ-6 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015-16	99.8%	Increase	99.9%	99.9%	99.9%	99.9%	99.9%	
	IDQ-7 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015-16	100%	Maintain	100%	100%	100%	100%	100%	
	IDQ-8 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015-16	99.9%	Increase	100%	100%	100%	100%	100%	
	IDQ-9 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015-16	99.9%	Maintain	100%	100%	100%	100%	100%	
	IDQ-10 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015-16	86.6%	Increase	99.7%	99.8%	99.8%	99.8%	99.8%	
	IDQ-11 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015-16	99.1%	Increase	100%	100%	100%	100%	100%	

Learning from Deaths

The Rotherham NHS Foundation Trust's Learning from Deaths process 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 reviews are 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 or locally selected 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 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 higher than expected deaths in the Trust or 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

Since 9 September 2024, it been a statutory requirement for the Medical Examiner Service (MES) to provide scrutiny of deaths that do not require a Coroner's investigation. This provides an independent review of the care given to the deceased and helps to identify any situations in which there is potential learning for care organisations.

Scrutiny Aims:

Accurate Cause of Death

Medical examiners review medical records and may speak with healthcare professionals involved in the deceased's care to ensure the cause of death is accurately recorded on the Medical Certificate of Cause of Death (MCCD).

Patient Safety

They help identify potential concerns about the deceased's care and may refer cases to the Coroner for further investigation if necessary.

Bereavement Support

Medical Examiners provide a non-clinical voice for bereaved families to ask questions and address concerns about the death and the care provided.

System Improvement

By identifying issues with care, Medical Examiner scrutiny helps improve the quality of care provided to patients and support for their families. For TRFT deaths this includes highlighting deaths which should be considered for a Structured Judgment Review, or for investigation.

Success we are having

- There is minimal delay in registering deaths with the new process
- Families are appreciative of the additional step of being contacted by The Medical Examiner (ME) office
- Despite the challenges created by the additional requirement for scrutinising Rotherham community deaths (1003 in 2024/25), the service had maintained high scrutiny completion rates for TRFT deaths.

Feedback from families has been positive. They have been extremely grateful that the Medical Examiner and the Medical Examiner Office (MEO) have been available to discuss their cases. The availability of the ME to answer medical queries in a timely manner reduces anxiety and may reduce hospital complaints.

The service has a dedicated mobile phone number available through switchboard for any urgent out of hours questions by the medical teams. This has avoided many unnecessary coronial referrals due to discussing the most appropriate cause of death.

The Coroner and her team have been complimentary about the appropriateness of the referrals received, and the number of unnecessary referrals has been reduced. The medical advice given to the coroner's officers, in some cases has avoided an inquest, The ME contribution has been sighted as being very welcome.

Achievements

- Full implementation of the statutory system in place
- Weekend on calls started
- The quality of MCCD's has improved with the help of the discussions held with ME’s & MEO’s

Operational Issues

- Been much busier than intended having to carry out extra sessions for ME’s

- Difficult to cover the service with ME's and MEO's whilst on annual leave
- Not fully established staffing – from the ME and MEO aspect.

Medical Examiner Scrutiny Figures for 2024/25:

Month of Death	No of Adult TRFT UECC & Inpatient Deaths	Medical Examiner Scrutinies Completed	Medical Examiner Scrutinies % Completed	Medical Examiner Scrutinies % Completed < 5 Days
2024/25	1053	1025	97%	86%
Q1	248	247	100%	83%
Q2	212	212	100%	90%
Q3	270	270	100%	86%
Q4	323	296	92%	85%

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, ensuring that feedback from SJRs relates to recent care delivered by the Care Groups. The target for compliance is 75%

100% of SJR for deaths in 2024/25 have been completed. 69% were completed within 60 days. This represents an improvement on the 2023/24 timeliness figure of 57%. This is a result of the continued progress in the SJR process. Improvement was seen during the year; and for the last two quarters, the 75% target was surpassed.

SJR Figures for 2024/25:

Discharge Date	Adult Inpatient & UECC Deaths	SJR Requested	Completed	Outstanding	% Completed	Overall Care Score < 3	Preventa-bility Score < 4
2024/25	1038	217	217	0	100%	27	0
Q1	243	60	60	0	100%	6	0
Q2	210	45	45	0	100%	4	0
Q3	267	47	47	0	100%	8	0
Q4	318	65	65	0	100%	9	0

Discharge Date	% Completed < 60 Days
2024/25	69%
Q1	45%
Q2	64%
Q3	83%
Q4	83%

Preventability score	6 – Definitely not	5 – Slight evidence	4 – Possibly: less than 50-50	3 – Possible: 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 logged as incidents and reviewed following the Trust's governance processes. In addition these SJRs 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 or negative. 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, held 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 may 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

Discharge Date	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
2024/25	30	30	0	5	0
Q1	8	8	0	1	0
Q2	7	7	0	0	0
Q3	8	8	0	3	0
Q4	7	7	0	1	0

All SJRs have been completed and distributed for deaths in 2024/25.

2.3: Reporting against core indicators

SHMI

The Summary Hospital Level Mortality Indicator (SHMI) is a mortality indicator produced by NHS Digital on a monthly basis, with each publication reporting on a 12 month period.

The SHMI compares the actual number of patients who die following hospitalisation at a Trust with the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Characteristics includes the patient demographics, primary diagnosis and comorbidities.

The SHMI includes deaths which occurred in hospital or within 30 days of discharge.

The score is a ratio between the number of patients expected to die and the actual number of deaths. Upper and lower control limits are calculated. SHMI values which fall outside of the control limit range are considered to be higher or lower than expected. Scores are produced for the Trust as a whole and for 10 Diagnosis Groups.

The difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths for the Trust. The SHMI is not a direct measure of quality of care. Higher than expected values should be viewed as requiring further investigation by the Trust.

SHMI Quarterly Figures

12 Month Period End Month	Sep-23	Dec-23	Mar-24	Jun-24	Sep-24
SHMI	102.4	102.5	103.9	104.0	104.8
Banding	As Expected	As Expected	As Expected	As Expected	As Expected
% of Deaths with Palliative Care Coding - TRFT	49	52	50	48	47
% of Deaths with Palliative Care Coding - England	42	42	43	44	44

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 NHS Digital 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 2022 - 31st March 2023	1	-0.074	0.760	0.834	1	0	0
	1st April 2023 - 31st March 2024	19	0.180	0.800	0.62	18	0	1
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2022 - 31st March 2023	5	0.153	0.542	0.389	4	0	1
	1st April 2023 - 31st March 2024	11	0.500	0.870	0.370	10	1	0
	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 1st April 2022 - 31st March 2023. 1st April 2023 - 31st March 2024 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

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 23 - Mar 24	95.76%	national data not available		
		Apr 24 - Mar 25	95.65%	national data not available		
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over (total cases)	Apr 22 - Mar 23	32.5	43.5	133.64	0
		Apr 23 - Mar 24	55.9	46.6	131.2	0
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison)	Apr 21 - March 22	51.88	national data no longer available		
		Apr 22 - Dec 22	68.8	national data no longer available		
	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	Apr 21 - March 22	0.44%	national data no longer available		
		Apr 22 - Dec 22	0.21%	national data no longer available		

***VTE No further national data to report as collections were suspended March 2020 due to Covid-19**
*** C Diff next publication due September 2025 for April 2024 to March 2025**
*** Patient safety – collection system has now changed and data is not comparable. National data no longer available for reporting by the Trust**

% of Admitted patients assessed for VTE													
Target = 95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%
2024/25	**95.65%**	95.88%	96.26%	95.03%	96.27%	93.94%	94.82%	95.44%	95.00%	96.28%	96.30%	96.28%	96.30%

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	When a Trust's SHMI value is in the *As Expected* band, it means that any variation from the number of expected	The Trust continues to closely monitor and report on data released in the SHMI publication each month.

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:
Trust for the reporting period.	deaths is not statistically significant. NHS England tell us that the SHMI is not a performance metric or indicator of quality care. It is designed to act as a prompt for the Trust to consider investigating areas of potential areas of concern.	This includes the Trust's overall SHMI banding, and that of the 10 diagnostic groups. This also includes contextual indicators, which affect the SHMI, such as the depth of comorbidity capture. Any alerts are reported to the Trust Mortality Group, and decisions made with regards to any investigation required. These are completed and reported in the Trust's quarterly Learning from Deaths Report and its Integrated Performance Report.
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, Care Groups, Clinical Support Units 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 Care Group 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 2023. Full results are available later in this report.	The CQC published the 2023 patient survey results in September 2024. Picker were invited to deliver a facilitated feedback session with all Care Groups participating. From this, a Trust wide Quality improvement plan was developed with Care Groups which included development of a new Patient Advice and Liaison Service, improving End of Life Care, developing a Carer's Promise, improving facilities and sharing improvements through the communications team.
21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the	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 has

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:
Trust as a provider of care to their family or friends.		maintained since last year. This will be a key priority for the upcoming Quality Strategy.
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 Care Group governance meetings. Care Groups have robust mechanisms in place to ensure that the feedback via the FFT dashboard is reviewed and acted upon where required. All data is available through the FFT dashboard Power BI. Activity and learning also feature within Care Group's 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.	Submission of data nationally re-commenced in April 2024.	The Trust will continue to monitor VTE rates, and report through local performance meetings and Care Group 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.	The NHS has now moved to the Learning From Patient Safety Events (LFPSE) framework. There is currently no ability to extract data from that system, however we continue to utilise the local management system of datix to track our safety activity and profile. The total number of reported patient safety incidents in the period April 2024 to March 2025 was 9504. The percentage of severe harm or death was 0.23%.	The Trust will continue to investigate all patient safety incidents with learning shared through the Care Group clinical governance structures, shared learning events and patient safety bulletins. The Trust's Patient Safety Incident Response Plan (PSIRP) sets out how The Rotherham NHS Foundation Trust (TRFT) will respond to patient safety incidents reported by staff and patients, their families and carers as part of the work to continually improve the quality and safety of the care we provide.

(Source: Trust Information System)

His Majesty's Coroner's Inquests 2024/25

During the relevant period the Trust received 99 referrals from His Majesty's Coroner, compared with 72 referrals from the previous year, which represents another significant increase for the second financial year in a row. These included both confirmed inquests and preliminary investigations.

His Majesty's Coroner heard 84 inquests during the last financial year, which is nearly double that of financial year 2023/24 (46). The Trust were required to attend 26 of those inquests, 24 as an Interested Party. The Trust's interests were represented by both external solicitors and the Trust Healthcare Solicitor. Trust clinicians were required to give evidence as witnesses of fact at 7 inquests.

The majority of the attended inquests were listed for 1-2 days. A total of 53 inquests were documentary (i.e. evidence was read under Rule 23).

The Trust is expected to attend approximately 33 inquests in 2025/26 which are referrals received during 2025/26.

His Majesty's Coroner did not issue any Prevention of Future Reports to the Trust in 2024/25.

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 2024/25

A summary of the Trust's three quality priorities for 2024/25 is provided below.

Patient Safety

- Diabetes Management

Patient Experience

- Acute Pain Management

Clinical Effectiveness

- Frailty

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**
Diabetes Management	Year 1 Objectives Achieved
Acute Pain Management	Achieved
Frailty	Partially Achieved

Domain: Patient Safety

Title* – *Diabetes Management

Executive Lead – Medical Director
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

The Trust identified through patient safety incidents, GIRFT reviews and National Audit that there were opportunities for improvement in diabetes care for those patients with Type 1 diabetes being admitted to Hospital.

Data from April 2022 identified a monthly average of 8 incidents per month.

- 101 incidents were reported during 2023/24 relating to diabetes for adult admissions and UECC attendances, resulting in a year end target being set at <81 for 2024/25

There were a number of key drivers that also sit behind the priority which are:

- NICE guidance
- GIRFT
- NCEPOD
- Datix events
- Local health population data
- Critical medication
- NHSE diabetes prevention
- National Clinical Audits

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

To create a 20% reduction in the number of avoidable/unwarranted harm for adult patients with diabetes admitted to the acute hospital by March 2025.

What did we achieve?

There was a reduction in 4 key metrics, these being:

- Reduction in patient harm
- Time to diabetes speciality review improved
- Reduction in length of stay
- Reduction in readmission

The total number of patient harms reduced from 101 in 2023/24, to 21 in 2024/25. That equates to an 80% reduction in patient harms.

The readmission rate reduced from 35% to 5%, and the length of stay reduced from 5.0 days to 4.0 days.

How was progress monitored and reported?

There is a monthly Diabetes oversight group which commissioned three working groups throughout the year. These groups were each led by individuals who have direct responsibility for diabetes care or are key stakeholders/ support teams. The working groups report into the oversight group, which in turn reports to the Patient Safety Committee and Quality Committee.

Progress was monitored through the implementation of a Power Bi dashboard coproduced with the business intelligence team and Senior Responsible Owner for the project.

What further actions need to be undertaken?

Due to the success of the Diabetes work and further improvements that have been identified, this will continue into 2025/26. This will also include ICB partnership working as they extend their work with Diabetes into the next financial year.

Domain: Patient Experience

Title* – *Acute Pain Management

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Recognition and alleviation of pain should be a priority when treating patients in hospital. This process should start at admission and continue through to discharge, ensuring adequate analgesia is offered at all times. There has been significant quality improvement work undertaken in the year by the acute pain team to support improvements for patients in the management of their acute pain.

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

The aim of the Acute Pain Quality Priority was to ensure all people with acute pain have an individualised analgesic plan appropriate to their clinical condition that is effective, safe and flexible with planned review. Measures included:

- Pain being assessed on admission to the ward
- Monthly data collection from Patient hub survey 'do you think hospital staff did everything they could to help control your pain?
- CQC Inpatient Survey

What did we achieve?

- Recruitment of 55 acute pain champions and regular action learning sets
- Standalone pain score on Meditech stood at 92.45% in April 2024 and improved to 97.73% in March 2025
- CQC inpatient survey for pain published September 2023 was 93% and increased by September 2024 to 97%
- Patient hub survey question for acute pain started in September 2024 and had 83.76% of patients feeding back hospital staff did everything they could to help control their pain (9.64% not applicable). This increased to 84.35% by year end (9.84% not applicable)

How was progress monitored and reported?

Quarterly meeting with key stakeholder's to bring together all the metrics and confirm and agree next actions.

What further actions need to be undertaken?

The quality priority will now move into business as usual with twice yearly reporting into the Patient Experience Committee. The 2024 CQC inpatient survey will be published in September 2025.

Domain: Clinical Effectiveness

Title* – *Frailty

Executive Lead – Medical Director
Operational Lead – Deputy Medical Director and Clinical Effectiveness Manager

Current position and why is it important?

The NHS England Frailty Strategy aims to improve the care of frail patients through same day emergency care, virtual ward and an urgent community response.

The aim is for patients to either remain in the community or discharged on the same day to their usual place of residence or to receive ongoing care/support in the community.

The main driver was the NHS England frailty strategy.

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

The Trust identified a need to improve the care of frail patients by increasing the number of patients with a clinical frailty score of 6 and above, who had a comprehensive geriatric assessment and by improving the number of patients discharged to same day to their usual place of residence or to the community with additional support.

What did we achieve?

This year, significant achievements were made in enhancing the Frailty Service, including:

- Completion of a self-assessment to identify areas needing improvement
- Networking with neighbouring Trusts to understand their Frailty Service
- Aligning work streams with South Yorkshire ICB & Rotherham Place priorities for Frailty
- Initiating workforce discussions to model the best approach for Frailty care, such as involving Frailty nurses/Advanced Clinical Practitioners
- Starting the reconfiguration of medicine beds
- Defining what constitutes a complete Comprehensive Geriatric Assessment (CGA) and its elements through agreed MDT collaboration
- Developing a Frailty dashboard to monitor care quality
- Conducting a clinical audit on CGA quality

The percentage of patients having a Comprehensive Geriatric Assessment has improved from only 15% of patients with a clinical frailty score of 6 and above having a CGA to 30% of patients with a Clinical Frailty Score (CFS) of 6 or above, having a complete CGA. The

number of patients discharged the same day has also consistently improved from a low of 188 to a high of 279 over the past year.

How was progress monitored and reported?

The Frailty Group had monthly meeting with colleagues who are involved in the care of frail patients across the Trust and community. A self-assessment and frailty audit were completed. These meetings feed into the Clinical Effectiveness Committee and the Quality Committee.

What further actions need to be undertaken?

Objectives for the coming year include:

- Piloting CGA on a Virtual Ward and expanding it to the Community Matrons service
- Completing medical bed reconfiguration
- Securing approval for Advanced Clinical Practitioners specializing in Frailty
- Establishing a forum for reviewing and monitoring the Frailty Dashboard
- Ensuring CGAs are accessible to all decision-makers

Future focus will be on managing patients with complex health care needs scoring CFS 4 or 5 to prevent progression to higher CFS scores, involving agreed CGA, management plans, and treatment goal reviews to avoid admissions. Despite Frailty not being a Quality Priority for 2025/26, commitment is needed to continue driving progress. Reflecting on objectives, while more CGAs were completed, their effectiveness and quality require further improvement. The newly defined CGA metrics and dashboard provide a foundation for ongoing monitoring and action.

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 also use text messaging within Urgent and Emergency Care.

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

Care Group patient experience reports are 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.

The Trust continue 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 Matron, Operational and Site teams. Unfortunately, there has been 11 mixed gender breaches between April 2024 and March 2025, see breakdown below. This has been due to the unavailability of an appropriate ward bed within the agreed 4 hour time period because of site pressures, where January was a particularly challenging month, which we also saw in January 2024.

April 2024	0
May 2024	0
June 2024	1
July 2024	0
August 2024	0
September 2024	1
October 2024	0
November 2024	0
December 2024	1
January 2025	5
February 2025	2
March 2025	1

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 2024/25 the Trust has reported 1 Never Event in General Surgery which related to a plastic foreign body being identified in a patient's abdominal cavity following a previous procedure, resulting in a return to theatre.

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 2024.

Inspected	TRFT score – 2022 (%)	TRFT score – 2023 (%)	TRFT score – 2024 (%)	National average score	Highest NHS Trust score	Lowest NHS Trust score
Cleanliness	99.32	99.20	95.78	98.31%	100%	83.64%
Food overall	94.73	90.48	87.81	91.3%	100%	65.38%
Organisation (of) food	95.49	100	100	92.17%	100%	42.22%
Ward food	94.51	87.65	83.99	91.38%	100%	74.02%
Privacy, dignity & wellbeing	81.33	89.42	85.53	85.58%	100%	65.18%
Condition, appearance & maintenance (of buildings and facilities)	96.24	97.62	91.58	96.36%	100%	78.04%
Dementia (meeting needs)	75.81	84.12	78.94	83.66%	100%	61.37%
Disability (meeting needs)	80.41	86.31	80.67	85.02%	100%	59.26%

The National CQC Patient Experience Surveys for Acute Trusts

Maternity Survey 2024

The Maternity Survey was published in November 2024 and looked at the experiences of women who gave birth in February 2024. Questionnaires were sent out between May and August 2024 and responses were received from 124 people.

Questions were asked about labour and birth, staff caring for you and care in hospital after birth. The results were a combination of better than expected and about the same compared to other Trusts.

Urgent and Emergency Care Survey 2024

The Urgent and Emergency Care Survey was published in November 2024 and looked at the experiences of people who received care from Urgent and Emergency Care services in February 2024. Questionnaires were sent out between April – July 2024 and 308 people responded.

Questions were asked about arrival, waiting, privacy, doctors and nurses, care and treatment, tests, hospital environment and facilities, support recovery at home, leaving A&E, respect and dignity and experience overall. The results were about the same when compared to other Trusts.

Adult Inpatient Survey 2023

The Adult Inpatient Survey was published in August 2024 and looked at the experiences of patients who stayed at least one night in hospital as an inpatient during November 2023. Questionnaires were sent out between January and April 2024 and 448 people responded.

Questions were asked around admission to hospital, the hospital and ward, doctors, nurses, care and treatment, operations and procedures, leaving hospital, feedback on care, kindness and compassion, respect and dignity and overall experience. The results were about the same when compare to other Trusts.

Children and Young People's Survey

The Children and Young People's Survey was undertaken in 2024 with the results currently embargoed. These results are expected to be published later in 2025.

Learning and Improvement from Patient Experience Surveys

Throughout 2024/5, Care Groups 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.

Care Groups present their improvement work from patient experience each year at the Patient Experience Group. There is also an overarching Trust patient experience improvement plan.

Patient Experience Improvement 2024/5

Development and Opening of New Patient Advice and Liaison Service (PALS)

The new PALS situated near the main entrance to the hospital site started to function in August 2024 with a formal opening performed by the Chairman in November 2024.

PALS is open Monday – Friday 10am – 4pm and is a point of contact for any patient or relative wishing to resolve a concern. PALS contacts from the point of opening to year end were 1,645. While this has resulted in more contacts overall from patients and families, we have now seen a 50% reduction in the number of concerns logged by the Patient Experience Team.

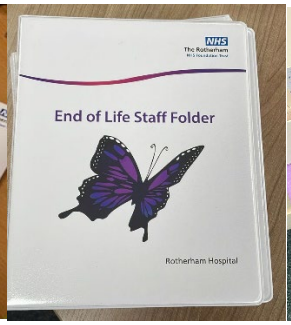
To complement the opening of PALS, new front line resolution training commenced for all Trust staff, through a new interactive monopoly board. This action-learning-set approach to teaching has upskilled 95 Trust staff in front line resolution during 2024/5.

The Patient Experience Team also led on the building of a new wheelchair store near the main entrance, complimented by meet and greet volunteers to ensure that issues around availability of wheelchairs were being proactively addressed.

Specialist Palliative and End of Life Care

Dying Matters week is a national campaign to create an open culture in which we are comfortable talking about death, dying and grief. The new Lead Nurse for Palliative Care led on a range of activities during Dying Matters Week 2024. This included the writing of a new End of Life staff resource folder, new bereavement book for bereaved families, the creation of a wind phone and post box for letters to loved ones. The team went on a roadshow across the acute site and Breathing Space, in partnership with Rotherham Hospice, NHS Blood and Transplant, and the Weston Park Purple Bus.

The newly revamped National Audit for Care at the End of Life (NACEL) also saw improvements in the feedback from families, case note audits and staff survey. The final improvements for 2024 were completed with the new Purple Butterfly Boxes, which included a range of resources for families, including the new memory boxes. The memory boxes were funded by the Hospital Charity but were designed to be tailored for individual family by the Lead Nurse for Palliative Care. The memory boxes include forget-me-not seeds, inkless finger print kits, somewhere to store a lock of hair and key rings. Thanks to a successful public campaign we can also include a donated knitted or crochet heart where one heart stays with the patient and one with family members. The Palliative Care Team support patients and families with the memory boxes as part of the End of Life Care given. The full update on Specialist Palliative and End of Life Care will be in the annual report to Board.


Carer/Care Partners Promise

The new Carer/Care Partners Promise was completed in October 2024. This piece of work was co-created with Carers at various forums across Rotherham and includes a publically declared promise. The promise was complimented by Carers lanyards or badges for people to wear if they choose.

This work was further promoted during Carers Rights Day in November where an event in the main entrance saw lots of community carers join us to promote the rights of Carers.

Communication Support

One of the largest forms of patient experience feedback is through compliments. The Trust received over 4000 compliments during 2024/5. Although these are shared with relevant teams at the time, we now have a regular' Feedback Friday' post on our Trust social media channels. Interactions from these posts are a boost to our teams as well as patients and families who take time to write in and thank us when care has gone well.

Calendar of Events

To support a continued focus on staff and patient engagement, a Calendar of events was developed for 2024/5. Three of these were for Inpatient Tea Parties where all patients get a scone with jam and cream and a prize to the best ward demonstrating reconditioning for patients. Other events involved Christmas presents and Easter eggs donated by people in the Rotherham community for patients. We also recognised the importance of extended visiting times for all people during the period of Ramadan.

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.

Cases of identified infections are reported to UK Health Security Agency (UKHSA) as part of the acute Trust mandatory surveillance programme.

Alert organism	Total cases	2024/5 trajectory
MRSA bacteraemia	1	0
MSSA bacteraemia	22	NA
C. difficile (all hospital associated cases, HOHA, COHA)	71	44
E.coli bacteraemia	71	46
Pseudomonas aeruginosa bacteraemia	19	9
Klebsiella species bacteraemia	25	17

The Trust Harm Free Care Panel continues to meet monthly 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.

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

MSSA bacteraemia

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

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

During winter months, there were higher than average numbers of patients presenting with influenza. This put 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.

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	2023/24	2024/25
Falls	741	799	796	892	921	1048	1044	1032	1019
Bed Days	144,505	145,153	132,557	158,207	118,098	151, 353	152,201	156,783	161,901
Falls Rate per 1000 Bed Days	5.12	5.50	6.00	5.63	7.79	6.92	6.85	6.58	6.29

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.

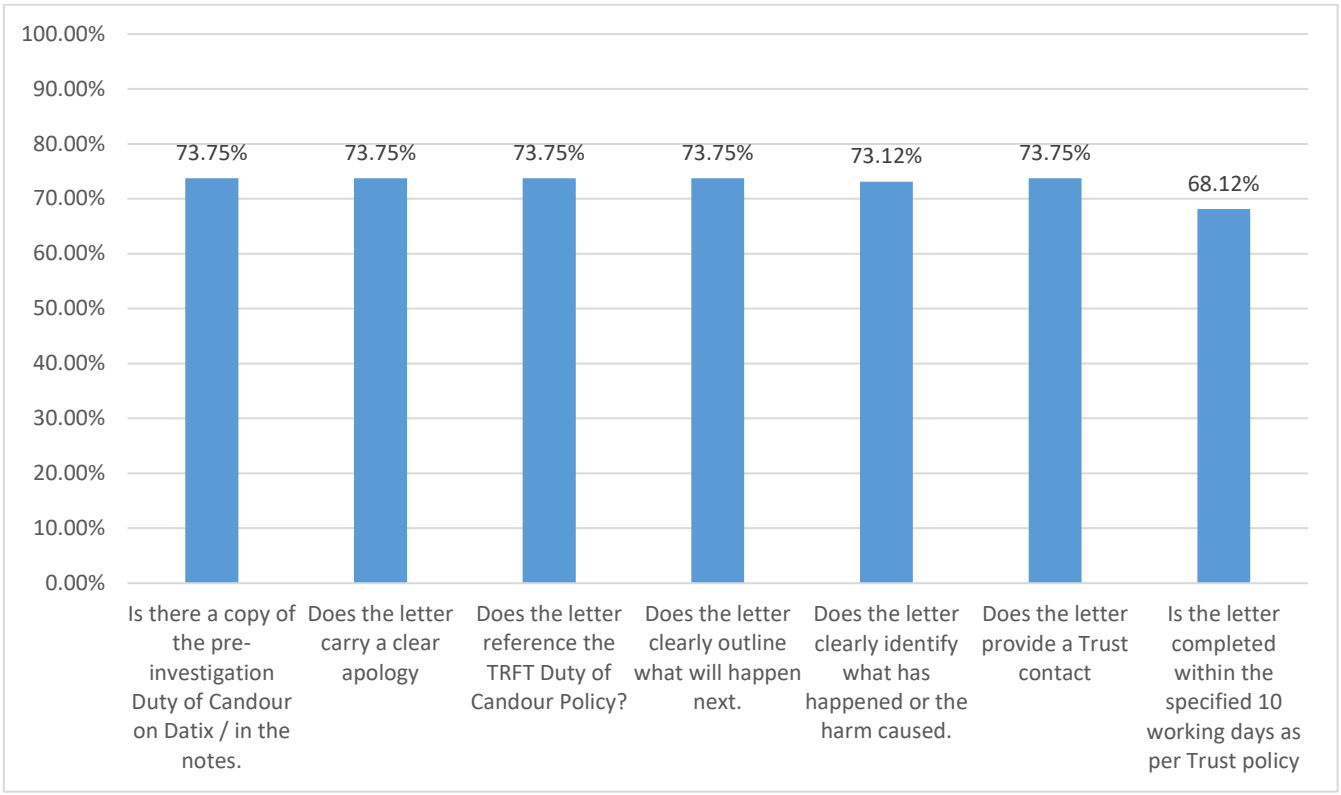
The Trust continues to participate in the mandatory National Inpatient Falls Survey, the results of which are used to inform the Falls Group action plan, which is continually being amended to reflect the most recent falls management initiatives.

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 2024/25. This included a number of key questions relating to the statutory and Trust standards for Duty of Candour.



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 at 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 continued to see an increase this year in the number of patients the team 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. The team continue to work with ICB partners to deliver the Oliver McGowan mandatory training for all clinical staff; we are implementing this over 3 years and have already achieved 80% at level 1 and over 20% at level 2 compliance.

This year we have continued with planned work to strengthen the workforce confidence with Mental Capacity Act Assessments, and delivered targeted interventions across the Trust. Working closely partner agencies as part of our Mental Health Steering Group we have progressed work to implement a new assessment tool for those attending with mental ill-health.

The safeguarding annual work plan, and activity relating to safeguarding and vulnerability is monitored through robust safeguarding governance arrangements, with the 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 some changes in the team, with further work continuing to strengthen the Think Family approach, and we have appointed a new Admiral Nurse to support our patients with dementia.

Safeguarding Mandatory and Statutory Training compliance has remained a priority across the organisation, with compliance across the organisation between 85% to 87% for children safeguarding, and 88%-90% for adult safeguarding, with 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. There is good compliance across the Trust with Mental Health (94%), Dementia (98%), and Prevent (92%) training, which forms part of the national CONTEST anti-terrorism strategy.

The safeguarding team are consistent and reliable partners across the Safer Rotherham Partnership (SRP), Rotherham Safeguarding Children's Partnership (RSCP), and Rotherham Safeguarding Adult Board (RSAB). TRFT is represented appropriately in all forums, including chairing of meetings and progressing several pieces of work with the RSCP including work to safeguard children around dogs, and working with the RSAB on homelessness and safeguarding.

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.

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. Our team is comprised of a Matron in Learning Disabilities and Autism, a 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. We hope in the future to expand and improve the service we are able to give to this group if people.

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, during inpatient stays, going through planned surgery, midwifery, UECC attendances where possible. Also including transitions of young people to adult services, the prevention of re-admissions to hospital. Focusing on community planning and signposting, whilst liaising with the wider community services and MDT 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:

Implementing 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 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.

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 Acute Medical Unit. 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 an 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.

We continue to champion the role of the Learning Disability Champion and Autism Champions on all wards and departments. There are over 50 staff members signed up for this role, who advocate and empower for this patient group. 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.

The Trust takes a proactive role in the LeDeR programme. This is the Learning from the Lives and Deaths of people with a learning disability (from the age of 4 years upwards) and people with Autism (from the age of 18 years onwards).

TRFT are represented at the LeDeR Assurance Panel by the Head of Safeguarding. This group reviews the completed reviews from across South Yorkshire and makes recommendations for improvements in services. Recent actions have included referrals to Safeguarding Adult Boards for consideration of reviews, and feedback to individual care providers regarding training or support. We are continually committed to implementing the learning from the reviews within the Trust.

Staff Experience and Engagement

The Trust had its second highest ever response to the national staff survey with 64% of colleagues completing it (-3% versus 2023), providing valuable feedback to the organisation as to how it can improve and make it a better place to work. Continuing on from 2023, Care Groups and corporate teams continued to use innovative ideas incentives, and a small element of competition to achieve the high response rates. This was visibly led by the Executive team who each sponsored a corporate action and supported with targeted

communications. In response to operational pressures we committed to continue to support our colleagues as we focus on operational efficiency and financial sustainability. 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 prioritise excellent patient care and be well at work.

In response to last year's survey, the Trust developed a We Said, We Did plan with a focus on key areas: quality appraisals, car parking, reasonable adjustments, sexual safety, and violence and aggression. 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 (Vivup), a dedicated menopause hotline, support through occupational health and ICB led initiatives and training both physical and online. The Health and Wellbeing work is aligned to the South Yorkshire Health & Wellbeing Roadmap, which in turn is aligned to the national NHS Health and Wellbeing diagnostic.

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. This includes the Health, Wellbeing and Retention Group at South Yorkshire ICB, the Deputy Human Resource Director's Network and other such groups.

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 2024 survey among Trust staff was 64% (2023: 67%).

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

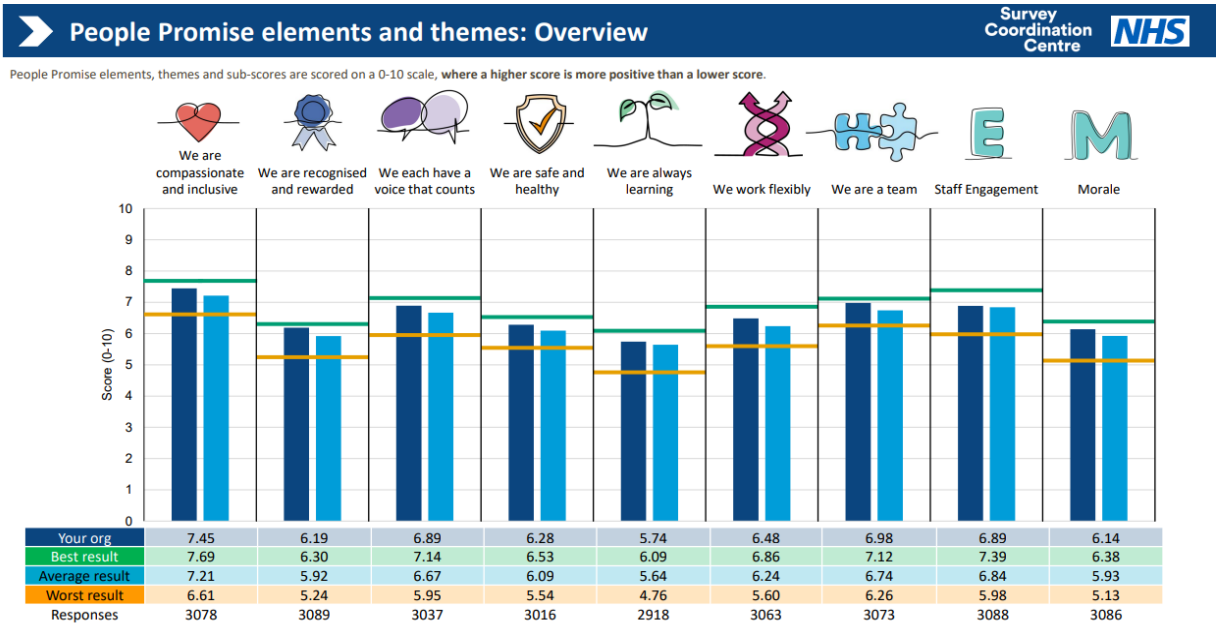
Indicators ('People Promise' elements and themes)	**2024**		**2023**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise				
We are compassionate and inclusive	7.46	7.23	7.53	7.24
We are recognised and rewarded	6.2	5.9	6.28	5.94
We each have a voice that counts	6.9	6.66	7.01	6.70
We are safe and healthy	6.3	6.1	6.27	6.06

We are always learning	5.73	5.61	5.94	5.61
We work flexibly	6.51	6.23	6.57	6.20
We are a team	6.99	6.74	7.07	6.75
Staff engagement	6.89	6.81	6.98	6.91
Morale	6.16	5.91	6.20	5.91

Although the Trust has stepped back slightly versus 2023, the overall performance is the second best that the Trust has posted. The benchmark group has declined year on year, but the Trust has still outperformed the benchmark average.

Trust Response Rate (including current and historical performance)

	2018	2019	2020	2121	2022	2023	2024
Best	71.6%	76.0%	79.8%	79.4%	60.9%	69.5%	70.9%
TRFT	38.5%	48.0%	52.2%	59.7%	61.0%	67.0%	64%
Median	43.6%	46.9%	45.4%	51.1%	44.5%	45.2%	48.6%
Worst	24.6%	27.2%	28.1%	36.5%	26.2%	21.4%	29.1%



The 2024 national staff survey results are continuing to demonstrate that TRFT polls above the national average for similar Trusts, and although progress dipped versus last year, it is still the second best result that the Trust has ever posted. TRFT still performs above the Picker average for advocacy (questions 25a, 25c and 25d) however, again these have dipped slightly year on year.

	2020	2021	2022	2023	2024
Your org	6.76	6.33	6.29	6.75	6.68
Best result	8.15	7.86	7.70	7.78	7.90
Average result	7.09	6.78	6.60	6.74	6.70
Worst result	6.02	5.68	5.60	5.73	5.24
Responses	2259	2709	2837	3212	3063

Advocacy Scores by year

NHS Response Rate

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

The Trust had maintained engagement with the 2024 national staff survey, against a challenging backdrop of organisational change (moved from 6 Divisions to 4 Care Groups), Band 2/3 national role review, industrial actions, post-Covid backlog and financial pressures. 64% of colleagues responding to the questionnaire and providing their valuable feedback; this is the second highest return rate the Trust has ever achieved and well above the national average.

Advocacy / Engagement	2023			2024			Change
	%	Rank	Quartile	%	Rank	Quartile	+/-
Q25a Care of patients/service users is organisation's top priority	74%	68th	2nd q	72%	78th	3rd q	Ranking down 10 places but maintained position in 3rd quartile
Q25c Would recommend organisation as place to work	63%	43rd	2nd q	62%	47th	2nd q	Ranking down 4 places but maintained position in 2nd quartile
Q25d If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	90th	3rd q	58%	86th	3rd q	Ranking up 4 places, and position maintained in 3rd quartile
Engagement (Engagement, Involvement, Advocacy)	6.98	37th	2nd q	6.89	54th	2nd q	Ranking down 17 places

Future priorities and targets

Top 5 scores vs Organisation Average	Org	Sample Average
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	72%	66%
q14c. Not experienced harassment, bullying or abuse from other colleagues	88%	82%
q23a. Received appraisal in the past 12 months	90%	84%
q11a. Organisation takes positive action on health and well-being	61%	55%
q19d. Feedback given on changes made following errors/near misses/incidents	66%	60%

Most improved scores	Org 2024	Org 2023
q13d. Last experience of physical violence reported	75%	70%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	69%	65%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	77%	74%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	55%	53%
q12e. Never/rarely worn out at the end of work	21%	19%

Key Areas for Improvement and Future Priorities

Bottom 5 scores vs Organisation Average	Org	Picker Average
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	61%
q23b. Appraisal helped me improve how I do my job	23%	26%
q24b. There are opportunities for me to develop my career in this organisation	51%	54%
q2a. Often/always look forward to going to work	52%	54%
q12c. Never/rarely frustrated by work	20%	22%

Most declined scores	Org 2024	Org 2023
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	60%	65%
q3e. Involved in deciding changes that affect work	52%	56%
q24e. Able to access the right learning and development opportunities when I need to	59%	63%
q24d. Feel supported to develop my potential	57%	61%
q20a. Would feel secure raising concerns about unsafe clinical practice	73%	76%

Top 5 Priorities for 2024/25

Taking on board feedback from the 2024 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 will be discussed further by the Executive Team and streamlined into a set of priorities with each 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.

1. People feeling valued, included and supportive – and others setting out that they have been discriminated against

2. People feeling well managed – and others feeling underappreciated and questioning the recognition they receive for loyalty/long service
3. People citing that they can make improvement to work – and others feeling their suggestions are ignored and/or they are not communicated with well enough
4. People feeling, they are supported in their health and wellbeing – and others feeling stressed, burnout and identifying staffing shortages
5. People feeling, they can develop – and others expressing frustration as to the lack of development options or career progression
6. People feeling that they can work flexibly – and others citing inconsistency with policy application and debating the merits of flexible working for some roles
7. People identifying a positive team spirit and camaraderie – and others citing poor team dynamics, favouritism and feeling understaffed and overworked

This year, the Organisational Development team used Co-pilot (Microsoft's AI Tool) to analyse the data and summarise the above as well as feedback received. The next result was the following emergent themes (in no particular order):

- managerial support;
- team dynamics;
- job satisfaction;
- health and wellbeing;
- a quality experience of appraisal.

Further work will be carried out in April on this to develop the 2025/26 "We said, We did" priorities and a further report will be brought to Public Board in May 2025.

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) Guardian

<u>Introduction</u>

The Freedom to Speak Up (FTSU) initiative within The Rotherham NHS Foundation Trust (TRFT) is a cornerstone of our commitment to fostering a culture where staff feel

empowered to raise concerns without fear of retribution. This report provides an update and assurance on the FTSU activities and their impact within the Trust.

Background

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up (FTSU) Guardian were established following the recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). The report highlighted the need for cultural change within the NHS to support and encourage staff to speak up about concerns, ensuring that patients and workers do not suffer as a result of silence. The ambition across the NHS is to effect the cultural change that ensures speaking up becomes business as usual.

The FTSU role was first introduced at TRFT in July 2015, with the initial appointment of six FTSU Champions and a Guardian. In September 2016, a Lead Freedom to Speak Up Guardian (FTSUG) was appointed, enabling the separation of the FTSUG from the Human Resources function of the organisation. In March 2024, a new Lead FTSUG was appointed with increased hours to 0.6 Whole Time Equivalent. The Lead FTSUG is a standalone role that works alongside existing systems and processes for staff to raise concerns, such as directly with managers, Lead Clinicians or Tutors, Peer Groups, or other departments and staff groups like Human Resources, Quality Governance and Assurance Team, Staff Governors, Staff Networks, and the Staff Well-being Team. The FTSUG and Champions provide advice and support to staff who raise concerns, work to support a culture of speaking up, and provide appropriate challenge where required.

Freedom to Speak Up Guardian and Champions

Since the appointment of a National Guardian, there has been increased direction from the National Guardian's Office (NGO) regarding the role of the FTSUG. The regional network now meets virtually every two months, and the annual national event can be attended in-person or virtually; our FTSUG has been supported to attend.

FTSUG attendance at Trust-wide events, training, and activities such as Team Briefs, Preceptorship, Junior Doctor's Forum, Student Nurse's Induction, staff meetings, safety huddles, and Well Being Event Days continue to be a regular occurrence and are well received. Subsequent to the new FTSUG standalone role, there are now 13 FTSU Champions within TRFT, representing staff groups that may face additional barriers to speaking up, Care Groups, and across the workforce. All FTSU Champions are required to complete an Expression of Interest form with support from their line manager. This allows for the Champions to have pre-authorised time for one-to-ones with the FTSUG, attendance at FTSUG meetings, and for peer support from the Champion Network. The FTSU Champion role remains voluntary and is in addition to their substantive roles. TRFT has FTSU training for all workers as part of Mandatory and Statutory Training (MaST) with a three-yearly refresher period as recommended by the NGO. The Champions are required to complete the NGO training 'Listen Up - for all managers' online, which is in addition to the MaST FTSU training.

The FTSU Champions have clear distinctions in their role from that of the FTSUG, in line with the NGO's Guidance 'Freedom to Speak Up Champions and Ambassadors' published in November 2023. FTSU Champions raise awareness and promote the value of speaking up, listening up, and following up within TRFT. They actively role model the values and

behaviours associated with speaking up and provide useful signposts to staff of the various avenues for speaking up as outlined in the Trust's FTSU Policy.

Oversight of Concerns Raised to the FTSUG

The FTSUG Lead has direct access to the Chief Executive and other Board members and is line managed by the Chief Nurse. They have regular one-to-ones with the Chief Executive, Non-Executive Director responsible for FTSU, and Executive Director of Workforce. Robust reporting systems are in place through which the FTSUG Lead delivers the Quarterly FTSU report to the People and Culture Committee and Board.

The annual report is presented to the Audit and Risk Committee and in-person to the Board of Directors. Themes identified by the FTSUG from concerns raised are shared with Senior Leaders and Board members for transparency when delivering reports.

All concerns receive an initial response within 5 working days. If colleagues wish to meet with the FTSUG 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 FTSUG are contacted three months after a concern is raised to see if they have suffered disadvantageous treatment as a result. The wellbeing check also requests feedback from individuals that have raised concerns on the service provided by the FTSUG. To date, feedback has been positive, with colleagues finding it easy to contact the FTSUG and pleased with the support that has been received.

During 2024/25, the FTSUG received 38 concerns. The majority of the concerns have related to inappropriate attitudes and behaviour, with colleagues being supported through informal processes, directed to existing HR processes and support, or union support for further advice. The number of concerns shows an increase on previous years, which may be linked to the increased time dedicated to the FTSUG and its function now being a standalone role. Positive staff experiences from those who have accessed the service may have also contributed. Key learning from national reviews and cases raised locally have informed the content of our current approach.

The FTSU initiative within TRFT continues to evolve, with increased engagement and support for staff to speak up. The Trust remains committed to fostering a culture of openness and transparency, ensuring that speaking up becomes business as usual.

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

In 2024, 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.

759 nominations were received for the 2024 Proud Awards. The event was held at Magna and hosted by Stephanie Hirst from Hits Radio with around 400 colleagues in attendance, alongside partner organisation representatives and sponsors. In addition to the nominated award categories, seven colleagues were recognised for achieving 40 years of service to the NHS.

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

The 2024 winners were:

Chairman's Award
Clinical Haematology (Care Group 1)

Chief Executive's Award
Laura Mumby, Health Informatics (Corporate)

Public Recognition Award
Dermatology team and Tara Lees (Care Group 1)

Non-Clinical Team of the Year
Orthopaedic Operational Team and Schedulers (Care Group 2)

Inspiring Leader
Chris Hammond-Race, Audiology (Care Group 4)

Diversity and Inclusion Award
Sri Kakarlapudi, Dietetics (Care Group 4)

Learner of the Year
Billy Ferguson, Procurement (Corporate)

Quality Improvement Award
Andy Woods, Children and Young People's Services (Care Group 3)

Unsung Hero
Billy Bell, Security (Corporate)

Clinical Team of the Year
Virtual Ward and Urgent Community Response (Care Group 4)

Governors' Award for Living the Values
Danijela Preradovic, Ward A1 (Care Group 1)

Outstanding Volunteer Award
B5 volunteers

Excellence Award - Team of the Year
Education and Development Team (Corporate)

Excellence Award - Individual of the Year
Lucy Richardson

Excellence Award - Public Excellence
Maternity (Care Group 3)

Awards

The Chief Nurse was shortlisted for The Queen's Nursing Institute (Qni) William Rathbone X Annual Award for Excellence in the Executive Nurse Leadership of Community Nursing Services 2024. This annual award provides the recognition of the impact of excellent strategic nursing leadership, support for staff and the consequent positive outcomes for patient experiences in the delivery of community nursing services.

The Rotherham NHS Foundation Trust, Nutrition and Dietetics Team were winners in the Place-based Partnership and Integrated Care Award category for their Care Homes Hydration Project, alongside NHS South Yorkshire ICB Medicines Management Team.

The Trust were shortlisted for three Nursing Times Awards. These were for Care of Older People, Infection, Prevention and Control and Learning Disability Nursing.

The Trust was shortlisted for three Nursing Times Workforce Awards in 2024. These included the Best UK Employer for Nursing Staff, Diversity and Inclusion, Reward and Recognition.

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

Resident 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 9.79%, the equivalent of 17.7 posts out of an establishment of 180.8 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 Care Groups. 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 (Agile Workforce), 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 (Agile Workforce), 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 resident doctor 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 resident 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 Resident Doctor Forum, chaired by the Director of Medical Education, and attended by resident doctors across the Trust, along with management representatives and representatives from Medical Workforce/Rota Co-ordination Team.

External Agency Visits, Inspections or Accreditations

During 2024/25 there have been 15 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

The Trust did not meet the national expectation of 78% for all patients that attend the UECC to be seen, admitted or discharged within the 4 hour access standard. The Trust achieved 64.25% for the year. 2024/25 saw unprecedented demand through our UECC – with an 8% increase on 2023/24.

In addition to the 4 hour access standard the Trust has remained focussed on improving Time to Initial Assessment (TTIA), Time to see a clinician and total time in department. Despite seasonal variation the Trust has seen positive improvements in these key metrics. These metrics alongside the National Patient Survey for UEC are all key indicators of quality within our urgent care pathways and whilst we have seen some improvement there is still opportunity to go further and improve care and outcomes for our patients. The Trust has remained committed to working with Yorkshire Ambulance Service to ensure that ambulance handover delays are timely ensuring that ambulances are free to respond to the people out in the community. The teams in UECC have used digital technologies to enhance patient experience and all patients that register and have a mobile phone are sent regular updates whilst they are in the department, enhancing our communication with patients whilst they are waiting.

The Trust's urgent and emergency care improvements are monitored through the Acute Care Transformation Group and have focussed this year in internal ways of working in UECC, Yorkshire Ambulance co working, ambulatory care and digital solutions. Looking ahead into the new financial year the focus of the Acute Care Transformation programme will be on the UECC capital build, flow (which will include bed reconfiguration) and ambulatory care (SDEC). The UECC capital build will increase minor injuries and urgent primary care environment and will provide the Trust with a dedicated medical SDEC.

Elective Care

The national ambition for patients waiting for elective care was to eliminate all patients waiting over 65 weeks by September 2024. Within the Trust, intensive improvement work was carried out to ensure additional outpatient and theatre capacity was available to achieve this ambition. This took a phenomenal effort from all colleagues involved, and it is testament to their dedication to our patients that we were able to deliver this ambition in September 2024 and maintain the achievement for 5 of the 7 remaining months of the year. However, with increasing operational pressures almost monthly during the winter period, this became a more challenging target to deliver nationally than anticipated, and the Trust reported 2 breaches in January and February 2025.

The number of patients waiting over 52 weeks for their treatment continued to grow throughout 2024/25 despite a 4.9% improvement in Referral-to-Treatment times, and a reduction in the overall waiting list. The number of patients waiting over 52 weeks for their treatment started to reduce towards the end of the year, however remains well above where we want it to be, with five specialties continuing to present the most significant challenges as we head into next year.

The Trust has set a number of targets in line with national guidance for elective care delivery in 2025/26 in order to ensure we deliver significant reductions in waiting times for our patients. Despite the ongoing challenges we delivered some significant changes in 2024/25 which will support improvements in 2025/26. These included embedding of a internally-designed intelligent solution to theatre scheduling, implementation of patient-initiated follow-up pathways in all major specialties, rollout of automated text messaging for

patients awaiting first outpatient and follow-up appointments and our place as one of twenty sites selected for the Getting it Right First Time Further Faster Programme.

Cancer Care

During 2024/25, the Trust continued to embed the three new national cancer standards, which have enabled a much more targeted focus on performance. The Faster Diagnosis Standard remained paramount, while a new 62-day combined standard also became a clear priority nationally. These were introduced from October 2023, and as such these three metrics became our primary measure of cancer performance for 2024/25.

Performance against the Faster Diagnosis Standard has shown continuous improvement across the year, with the Trust consistently meeting both the 77% national standard throughout the whole year, and the 80% stretch target towards the end of the year. This step-change improvement in performance in 2024/25 is the result of a number of initiatives which include the introduction of straight-to-test pathways for Skin, Urology and Lower Gastrointestinal, the introduction of Good News Clinics for Gynaecology, Skin, Urology, Lung and Upper Gastrointestinal, and robust operational management with a focus on validation and data quality process improvement.

The national standard for the new, combined 62-day metric remains at 85%. However, the national ambition for 2024/25 was to deliver 70% performance. The Trust achieved this throughout the year, and also achieved the stretch target of 77% in six months of the year, however, performance worsened in the second half of the year due to some of the operational pressures experienced, so this will need further focus going into 2025/26 as the national expectation increases.

Diagnostic Waiting Times

The Trust continues to benchmark exceptionally 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. As a result, the Trust remains one of the top performing organisations nationally, consistently benchmarking in the top decile of acute and community providers.

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 step up or step down pathways, in addition the bringing together of some of our community based services into our Transfer of Care Hub 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 2024/25 including the implementation of a discharge to assess model, embedding of our urgent community response and expanding pathways on 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 the commitment to continuous improvement interwoven into the Quality agenda.

A CQC inspection has not taken place this year, however, the Governors would welcome an inspection and feel confident that the Exemplar Accreditation Programme provides a robust assessment platform for patient safety, experience, clinical effectiveness and quality improvement.

Governors look forward to improvements in the next CQC ratings for the Trust Hospital services, with particular focus on the well led rating.

The Governors supported the focus on three quality priorities for 2024/25, allowing for more in-depth focus in these areas, and noted the linkage to PLACE priorities through the attention on Diabetes Management. The Governors have maintained oversight through the Quality Committee reporting to the Council of Governors, detailing the progress made, key metrics, impact on patients and lessons learnt. The Governors are delighted with the improvements of patient outcomes via the diabetes management program.

The impact of intense operational pressures was a prominent theme of discussions at the Council of Governors throughout the year to seek assurance that the impact on quality was mitigated as much as possible, keeping patient outcomes at the forefront of conversations. The effect on staff was also a key area of focus for Governors, mindful of the consequence of the sustained increase in attendances on capacity, sickness and morale, linking back to the impact on patient care.

The Governors were kept informed of the Patient Experience Improvement Plan with the strands interlinked with QI projects and new initiatives. Part of the improvement plan was the new Patient Liaison Service (PALS) which several Governors have visited the services the feedback has been positive from service users, and staff. The Governors were impressed by the innovation and enthusiasm of staff within the new PALS facility.

The Governors would like to express their gratitude to the Trust, hospital staff, and community colleagues for their unwavering dedication to providing compassionate, high-quality care to the people of Rotherham. We look forward to the ongoing progress and to achieving our goal of becoming an outstanding trust in the future.

Geoffrey Berry

Statement from NHS South Yorkshire ICB

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

TRFT Quality Annual Account

I'm very pleased to be writing my response for The Rotherham Foundation Trust (TRFT) Quality Account for the second year, along with Andrew Russell, the chief nurse for Rotherham and Doncaster Places within South Yorkshire Integrated Care Board (SYICB), as my co-signature.

TRFT has made a significant number of improvements across the year, highlighted by the 203 local and 58 national clinical audits that have taken place all of which will provide important learning within the organisation. Participation in over 70 Clinical Research studies also shows how TRFT is a leader in terms of healthcare for the future.

Learning from Deaths is a sad part of hospital work but is vital to improve the education of all staff and helps to improve patient safety, and TRFT's work in this area is to be commended, including incorporating the new Medical Examiner role.

There have been no CQC visits this year to comment on, but I'm sure that the team within TRFT is ready for any visits and keen to improve on some of the areas in which they are not currently regarded as "good".

SYICB is happy to provide support to TRFT in reducing its waiting lists, initially so no patient is waiting longer than 52 weeks, and we continue to work in a collaborative way on the 4 hour target for patients to be seen in the Urgent and Emergency Care Centre (UECC). We commend the work being done on flow through the hospital and all the way through to discharge to enable the hospital to be as efficient as possible. I'm very excited to see the new improvements to the UECC which have just started.

The opening of the new PALS service shows TRFTs commitment to patients and making sure their experience is as good as it can be, and the reduction of reported concerns is pleasing. TRFT is also seen as a pleasant place to work despite a slight dip in the staff survey, and that will continue to help patient experience and safety by providing a stable workforce.

TRFT has been near the top of diagnostic performance for several years and continues to do so. This is great news for patients as the waiting period without knowing what is happening is often the most frustrating. The patient journey is accelerated by this great

work. The Virtual ward is also highly successful, both in preventing admissions, so allowing people to have treatment in their own home which might previously have required admission, but also helping people get back to their homes earlier after a hospital stay.

There is always more to do, but TRFT shows that is has the plans in place to make improvements continuously. It has been a good year for TRFT and I look forward to the ICB continuing to support TRFT with that ongoing improvement.

Yours sincerely,

Dr Jason Page
Medical Director
NHS SY ICB Rotherham Place

Andrew Russell
Director of Nursing for Doncaster and Rotherham Place NHS SY ICB

Statement from Healthwatch Rotherham

Healthwatch Rotherham Response to TRFT Quality Account 2024/25

Healthwatch Rotherham appreciates the opportunity to review this report and extends our gratitude to the dedicated staff at The Rotherham NHS Foundation Trust. Despite a year of national changes with local implications, the Trust has remained steadfast in its commitment to service improvement.

This year has seen notable advancements in home-based care, facilitated by partnerships with other NHS trusts. These initiatives have driven quality improvements through standardised training, fostering patient safety, transparency, and a culture of continuous learning and improvement.

We acknowledge the leadership transition at the Rotherham site, with Bob Kirton now directing operations. Healthwatch Rotherham is confident in his commitment to patient-centred care, valuing lived experiences as a foundation for future service development. His engagement with Healthwatch ensures that community perspectives remain central to service improvements.

We commend the Trust for successfully achieving two of its three priorities for 2024/25—enhancing pain management for hospitalised patients and significantly reducing Type 1 Diabetes incidents through targeted medication and management strategies. While the frailty care target remains in progress, substantial strides have been made in delivering holistic care, and we welcome the Trust's commitment to achieving this goal in collaboration with partners.

The opening of the new Patient Advice and Liaison Service (PALS) department marks an important milestone. The increased accessibility for patients and families has led to a significant reduction in concerns logged by the Patient Experience Team. Healthwatch Rotherham remains confident in the Trust's dedication to listening and acting on patient feedback. We value our continued participation in the Patient Experience Committee, where collaborative improvements are consistently realised.

Looking ahead to 2025/26, we are pleased to see a strong commitment to improving cancer care for patients, families, and caregivers. We eagerly anticipate the Trust-level cancer strategy, which aims to optimise service efficiency and enhance patient experiences.

Healthwatch Rotherham looks forward to further collaboration with The Rotherham NHS Foundation Trust, ensuring that patient voices remain at the heart of service improvements for all communities in Rotherham.

Kym Gleeson
Healthwatch Manager

Statement of the Health Select Commission – Rotherham Metropolitan Borough Council

Members of Health Select Commission welcome the opportunity to comment on TRFT's draft Quality Account for 2024/25. They also wish to extend thanks to TRFT officers and staff who have attended scrutiny during the course of the municipal year and provided valuable insights into the Trust's continuing efforts to improve patient safety, patient experience and clinical effectiveness across key areas of importance to Rotherham residents.

Having reviewed the draft document provided, Members highlighted a number of areas of positive performance. Most notably the Trust's ranking as second out of 126 trusts for cancer diagnostics is a phenomenal achievement, and one which demonstrates the level of performance TRFT are capable of delivering in priority service areas. They are keen to seen learning from this, and the other successes it had noted such as the 80% reduction in patient harms and 30% reduction in readmissions cited within the Diabetes Management section of the report under the patient safety domain, harnessed in order to drive forward improvements in other areas where challenges remain, such as in Urgent and Emergency Care for example, where disappointingly the CQC grading of 'inadequate' persists and where patient experience remains an issue for Rotherham Residents based on representations to Members.

The Health Select Commission are sighted on an ambitious programme of work to improve Urgent and Emergency Care facility, and the development of the Same Day Emergency Care centre and intend to monitor developments in this area and the resultant impact on overall performance, patient safety, experience and clinical effectiveness in those service areas during the coming municipal year and are keen to see swift progress towards marked improvement.

Members were encouraged by the strong consistent theme of quality improvement referenced throughout the document, and noted that improved responsiveness and pace around learning from deaths with respect to Structured Judgement Reviews was symptomatic of the Trust's approach to Quality Improvement. They welcomed the production and distribution of 'Thematic Analysis Reports' which aim to promote the design and implementation of new or altered health care processes that will prevent problems reoccurring and promote good practice. However, they felt they would have benefitted from examples of where this had been reflected in practice and/or data that quantified the impact of the initiative in terms of a quantifiable reduction in the overall number of preventable deaths, or a quantifiable reduction the incidence of poor care as a factor in deaths.

The Health Select Commission noted a lack of quantifiable evidence supporting statements in several sections of the Quality Account, notwithstanding that in some cases this was due to data not being available at the time the draft document was shared, and in other cases, a lack of descriptive narrative in support of large data sets. A further example of this was the section of the Quality Account pertaining to participation in clinical audits during 2024/25, which referenced anomalously low number of case submission rates in some areas of importance to Rotherham residents in the context of the Joint Strategic Needs Assessment (JSNA) and known health inequalities including just 6% of cases for the National Heart Failure Audit (NHFA) and 20% of cases for the National Child Mortality Database (NCMD) Programme.

Moreover, as Rotherham Council marks its Childrens Capital of Culture year, whilst ensuring Children's needs, voices, health and wellbeing are prioritised at all times, this represents an ideal opportunity to advocate for Rotherham's youth communities and ensure their needs are truly represented. As such, the 'requires improvement' CQC ratings for Children and Young People's Services both in hospital and community settings is below what Members want to see in order to protect and preserve those who represent the Borough's future. As such, the commission is keen to explore the ways in which TRFT intends to improve upon this position over the coming year through its scrutiny function, as no information concerning progress made since the last formal inspection visit or improvement plans implemented to address sub-optimal areas of performance were outlined within the draft Quality Account Reviewed.

At the opposite end of the spectrum, Members were disappointed that the Quality Account reflected that TRFT did not collect feedback concerning quality of care and communication carers in relation to Dementia Care, and that only 10% of Dementia patients had personal information documents. The Health Select Commission plan to consider Dementia Care provision in more detail during the coming municipal year to obtain further reassurance and updates on the quality of care in this important area.

The Health Select Commission commends TRFT on achieving the highest possible rating that can be achieved for the seventh year running (level three – Advisory) for Information Governance, which will give Rotherham residents great comfort that the most sensitive personal data held about them is accurate, complete and secure. In the modern world, this of ever-increasing importance, and this demonstrates a consistent and sustained level of performance.

Members acknowledge the priorities set out for 2025/26, and the consultation processes outlined below, and whilst the Commission supports those priorities and their relevance to Rotherham Communities, more background information concerning other potential priorities considered and discounted to allow a more considered endorsement would be beneficial, particularly given the known challenges around reducing waiting times.

Finally, the Health Select Commission acknowledges the challenging operating environment for NHS Trusts and is wholly supportive of TRFT's commitment to ongoing improvement and the important and innovative work it is doing to reimagine and reshape service delivery. Members look forward to continuing to work with TRFT over the coming year as they progress their improvement journey, which has already delivered impressive results in critical areas.

As always, the Health Select Commission extends sincere thanks on behalf of the people of Rotherham to all at TRFT for the hard work and countless hours spent caring for residents in times of greatest need.

Councillor Eve Keenan,
Chair, Health Select Commission
Rotherham Metropolitan Borough Council

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

The Directors are required under the Health Act 2009, subsequent Health and Social Care Act 2012 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 2024/25
- 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 2024 to 31 March 2025
    - papers relating to quality reported to the Board over the period April 2024 to 31 March 2025
    - feedback from Governors dated 12 May 2025
    - feedback from NHS South Yorkshire ICB received 16 June 2025
    - feedback from local Healthwatch organisation dated 12 May 2025
    - feedback from Health Select Commission received 2 May 2025
    - the Trust's complaints report (included within the Patient Experience and Inclusion Annual Report) published under Section 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009, dated April 2025
    - the latest national Inpatient survey published 21 August 2024
    - the latest national Urgent and Emergency Care survey published 21 November 2024
    - the latest national Maternity survey published 28 November 2024
    - the latest national Staff Survey 2024 published 13 March 2025
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated June 2025 (approved at Audit and Risk Committee on 23 June 2025 and Board of Directors on 26 June 2025)
    - 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.

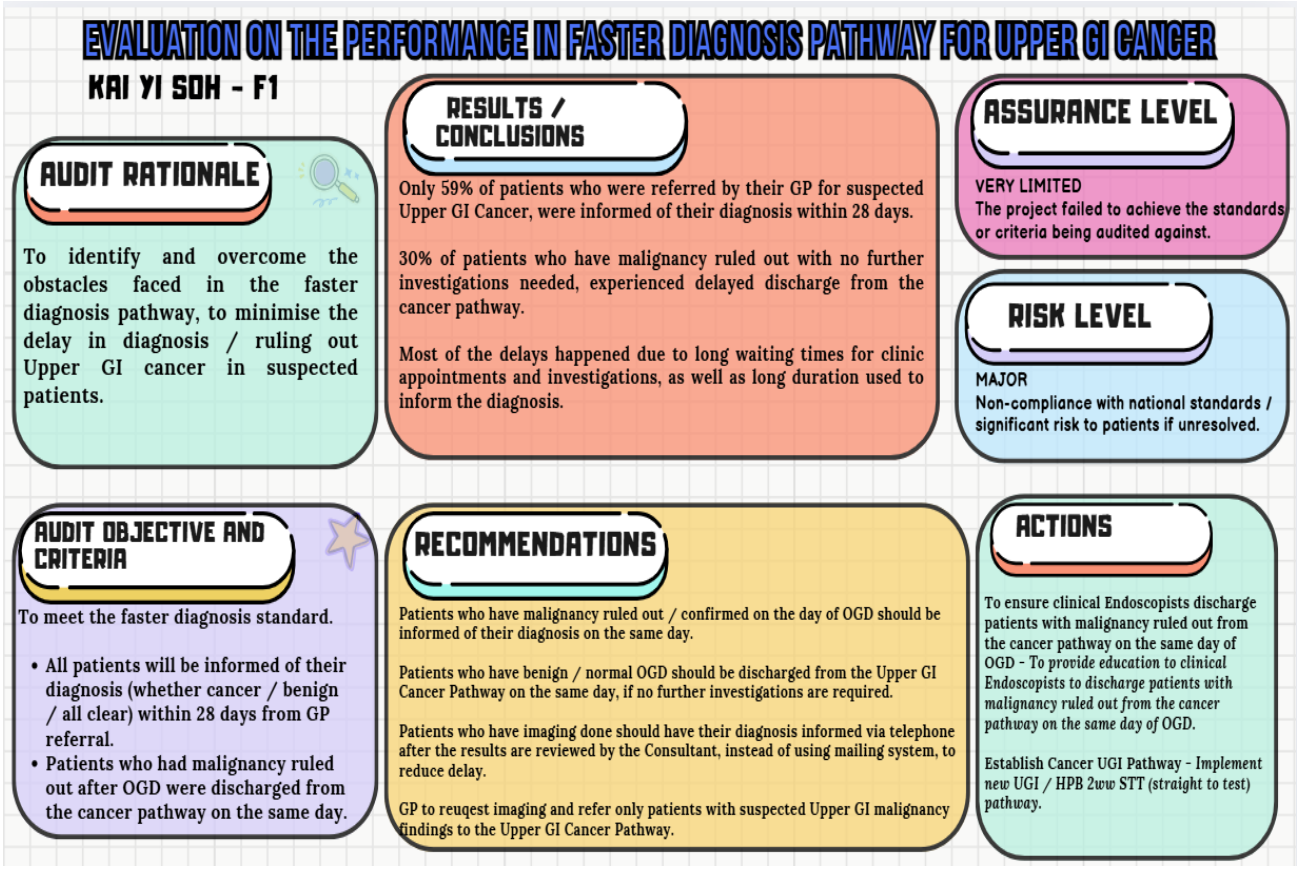
By order of the Board

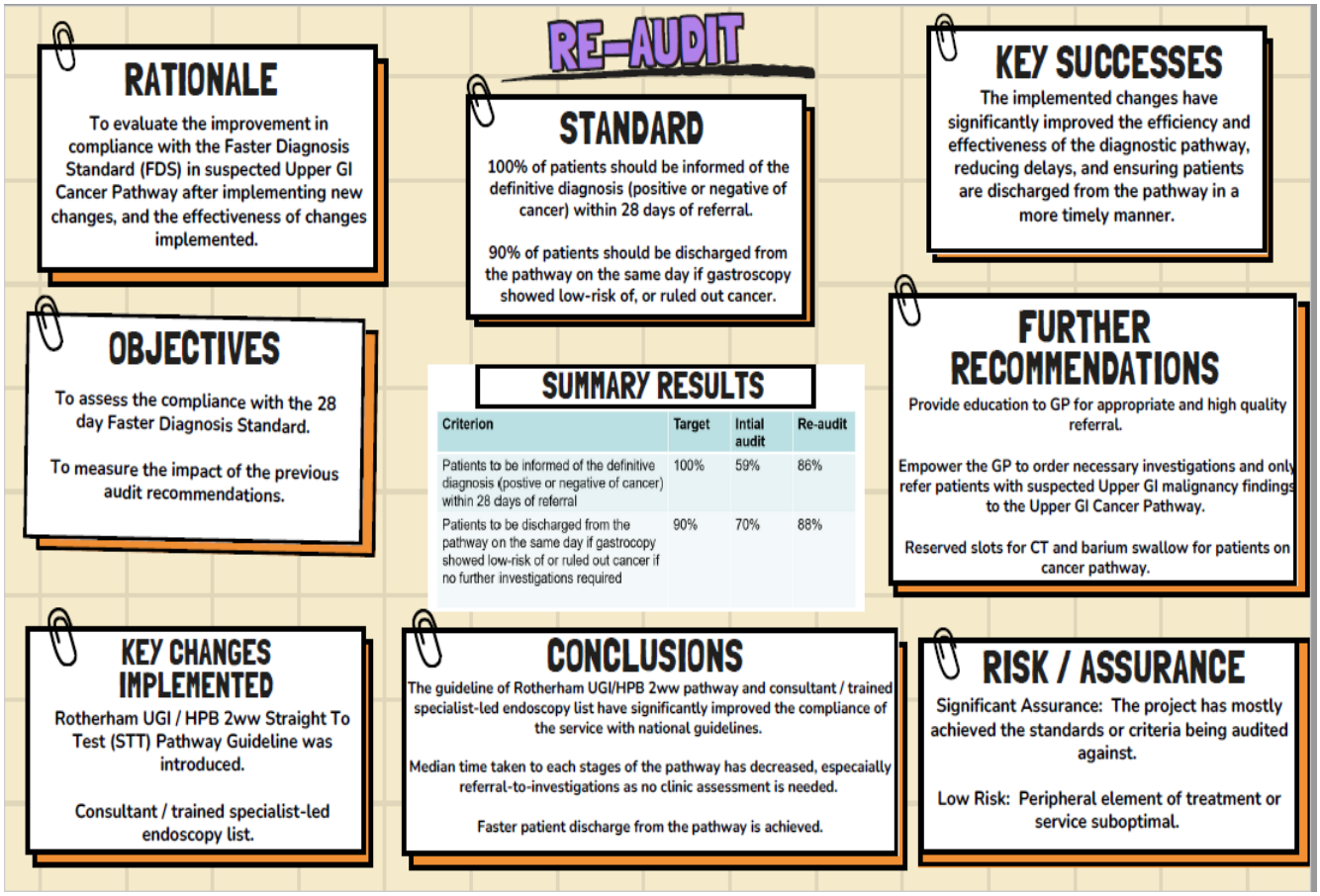
Dr M Richmond
Chair
June 2025

Dr R Jenkins
Chief Executive
June 2025

Appendix 1: Review of Local Clinical Audits

The outcomes of 203 Local Clinical Audits were reviewed by the provider in 2024/25. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which are detailed below:




RE-AUDIT
RATIONALE
To evaluate the improvement in compliance with the Faster Diagnosis Standard (FDS) in suspected Upper GI Cancer Pathway after implementing new changes, and the effectiveness of changes implemented.
STANDARD
100% of patients should be informed of the definitive diagnosis (positive or negative of cancer) within 28 days of referral.
90% of patients should be discharged from the pathway on the same day if gastroscopy showed low-risk of, or ruled out cancer.
KEY SUCCESSES
The implemented changes have significantly improved the efficiency and effectiveness of the diagnostic pathway, reducing delays, and ensuring patients are discharged from the pathway in a more timely manner.
OBJECTIVES
To assess the compliance with the 28 day Faster Diagnosis Standard.
To measure the impact of the previous audit recommendations.
SUMMARY RESULTS
Criterion | Target | Intial audit | Re-audit
Patients to be informed of the definitive diagnosis (postive or negative of cancer) within 28 days of referral | 100% | 59% | 86%
Patients to be discharged from the pathway on the same day if gastrocopy showed low-risk of or ruled out cancer if no further investigations required | 90% | 70% | 88%
FURTHER RECOMMENDATIONS
Provide education to GP for appropriate and high quality referral.
Empower the GP to order necessary investigations and only refer patients with suspected Upper GI malignancy findings to the Upper GI Cancer Pathway.
Reserved slots for CT and barium swallow for patients on cancer pathway.
KEY CHANGES IMPLEMENTED
Rotherham UGI / HPB 2ww Straight To Test (STT) Pathway Guideline was introduced.
Consultant / trained specialist-led endoscopy list.
CONCLUSIONS
The guideline of Rotherham UGI/HPB 2ww pathway and consultant / trained specialist-led endoscopy list have significantly improved the compliance of the service with national guidelines.
Median time taken to each stages of the pathway has decreased, especaially referral-to-investigations as no clinic assessment is needed.
Faster patient discharge from the pathway is achieved.
RISK / ASSURANCE
Significant Assurance: The project has mostly achieved the standards or criteria being audited against.
Low Risk: Peripheral element of treatment or service suboptimal.

VTE Prophylaxis in Elective Knee Replacement: Improving Compliance with NICE Guidelines

Rationale

To ensure that the proper drug (aspirin) is prescribed immediately following elective knee surgery

Results

92% of patients were prescribed Aspirin, as per NICE Guidelines.

Only 57% of patients started Aspirin in a timely manner (i.e. same day / post-op day 1) due to late ordering on Meditech.

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

13 of the 25 patients had post-operative plans that specified Aspirin to be served. The remaining 12 did not specify the drug given.

Assurance Level

Significant

The project mostly achieved the standards or criteria being audited against.

Risk Level

Low

Peripheral element of treatment or service suboptimal.

Objectives

1) To evaluate the adherence of Trust Doctors / ACPs to the established guidelines for VTE prophylaxis.

2) To improve adherence to the NICE guidelines, if found to be lacking.

Conclusions

- There is no need to routinely serve Tinzaparin to patients with elective knee surgery, before switching to Aspirin.
- All elective knee replacement patients should be served Aspirin for 14 days - starting the day after their surgery (unless there is a specific contraindication to this).
- We suggest that the orthopaedic team be the ones to prescribe the VTE Prophylaxis.
- Suggestion to update Meditech with an option to prescribe Aspirin at the end of the VTE assessment form.

AUDIT AIMS

To ensure prescription of appropriate VTE prophylaxis following NICE guidelines.

To ensure this correct prophylaxis is served in a timely manner.

To reduce the risk of morbidity and mortality from VTE

AUDIT STANDARD: NICE GUIDELINES

Offer VTE prophylaxis to people undergoing elective knee replacement surgery whose VTE risk outweighs their risk of bleeding. Choose any of: Aspirin (75/150mg) for 14 days; LMWH for 14 days combined with anti-embolism stockings until discharge; Rivaroxaban, within its marketing authorisation, is recommended as an option for the prevention of VTE in adults having elective total hip replacement surgery or elective total knee replacement surgery.

RESULTS

100% of patients were prescribed Aspirin as per NICE guideline (Full Compliance)

However, noted partial compliance (88% for same day / POD1) to starting Aspirin in a timely manner - Aspirin ordered late on Meditech.

2 patients given Aspirin on Day 2 post op and no other form of VTE for 36 hours.

RE-AUDIT

COMPARISON OF RESULTS WITH PREVIOUS AUDIT

	Last Cycle	This Cycle
Total Patients included in audit	25	32
Percentage who were prescribed Aspirin	92%	100%
Aspirin Given Day 1 post op	78% (18) +2 on the same day	94% (30)
Aspirin Given Day 2 post op	13% (3)	6% (2)
Prescribed Tinzaparin	44% (11)	12.5% (4)
Given Tinzaparin	11	1
Aspirin specified in Op Note	52% (12)	75 % (24)

KEY SUCCESSES

Patients who were prescribed Aspirin post operatively was 100%, compared with 92% in the previous audit.

Only 1 patient was given Tinzaparin post operatively, compared with 11 in the previous audit.

94% f patients had their Aspirin started on day 1 post operatively, compared with only 67% in the previous audit.

CONCLUSIONS

Overall improvement in all measured parameters.

Improvement in operatives documentation has been forwa4rded to the Clinical Director of Orthopaedics.

During the presentation, there was emphasis on operating teams to prescribe VTE prophylaxis so it would be given on time and to avoid delays.

RECOMMENDATIONS

Explicitly name Aspirin on post-op notes / template.

Standardising who's responsibility it is to prescribe VTE Prophylaxis (especially for late finish cases).

Should VTE be prescribed pre-emptively by Rockingham ACP / SHO?

RISK AND ASSURANCE LEVELS

Full Assurance: The project has fully achieved the standards or criteria being audited against.

Low Risk: Peripheral element of treatment or service suboptimal.

Trust Consent Audit - Orthopaedics

RATIONALE / OBJECTIVES

Valid consent to treatment is essential for all forms of healthcare, from providing personal care to undertaking major surgery. Not all consent needs to be written, but where it is required written consent should provide evidence that consent has been appropriately discussed with the patient.

The audit looked at:-

Measuring compliance with the TRFT Consent to Examination or Treatment Policy.

To identify poor compliance within areas of consent.

Identify any clinical risks associated with poor consent taking.

Raise staff awareness of the legal requirements and audit standards of gaining patient consent.

Help improve communication between staff and patients.

CRITERIA

No new criteria have yet been set for e-Consent.
The previous criteria for paper consent is being used.
There are 26 questions and their sub-questions.

Data collection:-
20 patients undergoing elective total knee replacement surgery, during the month of October 2024.

CONCLUSIONS

The information leaflet was found to be out of date (expired March 2024). It was provided to the patient in 90% of cases.

100% e-Consent target was not achieved until at least October 2024.

Some modifications in the e-Consent form, such as responsible Consultant, job titles, are needed.

The patient leaflet is out of date and requires updating.

15% of patients are still being consented on the day of the surgery.

Colleagues need to pay attention to the blood transfusion column.

FURTHER ACTIONS

To inform the e-Consent team regarding the relevant modifications needed.

To update the TKR information booklet.

Target 100% consent clinic appointment for elective surgery (at least arthroplasty).

Re-audit in 6 months.

RISK / ASSURANCE LEVELS

Significant Assurance: the project has mostly achieved the standards or criteria being audited against.

Minor Risk: Single failure to meet internal standards / minor implications for patient safety if unresolved.

EVALUATION ON THE PERFORMANCE IN FASTER DIAGNOSIS PATHWAY FOR UPPER GI CANCER

KAI YI SOH - F1

AUDIT RATIONALE

To identify and overcome the obstacles faced in the faster diagnosis pathway, to minimise the delay in diagnosis / ruling out Upper GI cancer in suspected patients.

RESULTS / CONCLUSIONS

Only 59% of patients who were referred by their GP for suspected Upper GI Cancer, were informed of their diagnosis within 28 days.

30% of patients who have malignancy ruled out with no further investigations needed, experienced delayed discharge from the cancer pathway.

Most of the delays happened due to long waiting times for clinic appointments and investigations, as well as long duration used to inform the diagnosis.

ASSURANCE LEVEL

VERY LIMITED
The project failed to achieve the standards or criteria being audited against.

RISK LEVEL

MAJOR
Non-compliance with national standards / significant risk to patients if unresolved.

AUDIT OBJECTIVE AND CRITERIA

To meet the faster diagnosis standard.

- All patients will be informed of their diagnosis (whether cancer / benign / all clear) within 28 days from GP referral.
- Patients who had malignancy ruled out after OGD were discharged from the cancer pathway on the same day.

RECOMMENDATIONS

Patients who have malignancy ruled out / confirmed on the day of OGD should be informed of their diagnosis on the same day.

Patients who have benign / normal OGD should be discharged from the Upper GI Cancer Pathway on the same day, if no further investigations are required.

Patients who have imaging done should have their diagnosis informed via telephone after the results are reviewed by the Consultant, instead of using mailing system, to reduce delay.

GP to reuqest imaging and refer only patients with suspected Upper GI malignancy findings to the Upper GI Cancer Pathway.

ACTIONS

To ensure clinical Endoscopists discharge patients with malignancy ruled out from the cancer pathway on the same day of OGD - *To provide education to clinical Endoscopists to discharge patients with malignancy ruled out from the cancer pathway on the same day of OGD.*

Establish Cancer UGI Pathway - *Implement new UGI / HPB 2ww STT (straight to test) pathway.*

Appendix 2: Readmissions within 30 days

Emergency Re admissions within 30 days of discharge from Hospital		
Age Bands	**1st April 2023 - 31st March 24**	**1st April 2024 - 31st Jan 2025**
Age 0- 15 years	12.98%	9.21%
Age 16 years and above	9.07%	6.61%

Data source: TRFT Data Warehouse SQL Server Reporting Services - Re admissions
The latest readmissions data available from NHS Digital covers the period 2011/12. As a result, all readmissions reporting for Board reports, Care Groups, Clinical Support Units, and Service Line Monitoring is based on data from the internal TRFT Data Warehouse.

To ensure consistency, TRFT internal data has been aligned with national benchmarking tools, specifically Model Hospital. Model Hospital is an NHS Improvement (NHSI) tool that uses Hospital Episode Statistics (HES) data and applies additional methodology for reporting readmissions.

In 2020, the internal reports were updated to align with national methodology. These reports now include indicators such as INO, same-day readmissions, and readmissions within 30 days. They also capture instances where a patient has multiple readmissions within the reporting period, provided they fall within the defined timeframe. This is in line with national standards.

It is important to note that the reports measure readmissions based on the same Treatment Function Code (TFC), that is, readmissions to the same TFC as the original admission. From April 2022, the methodology was further refined to exclude all Day Cases from the denominator, a change from previous reports which included them up to March 2022.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2024/25

Detail of Visits	Date of Visit
UKAS QMS and Antenatal Sickle Cell & Thalassemia Surveillance 3	20 – 23 January 2025
UKAS Microbiology Surveillance 3	29 – 30 January 2025
UKAS Haematology & Blood Transfusion Surveillance 3	29 – 30 January 2025
UKAS Biochemistry Surveillance 3	30 – 31 January 2025
UKAS Clinical Haematology & Blood Transfusion Surveillance 3	30 January 2025
UKAS Clinical Immunology Surveillance 3	30 January 2025
UKAS Biochemistry Extension to Scope	3 February 2025
UKAS Microbiology Extension to Scope	6 – 7 February 2025
UKAS Haematology Extension to Scope	6 – 7 February 2025
UKAS Andrology Surveillance 3	14 February 2025
UKAS Immunology Surveillance 3	28 March 2025
Medical Physics Department - Environmental Permitting Regulations - Environment Agency	22 January 2025
Radiopharmacy MHRA inspection	12 - 13 February 2025
Patient-Led Assessments of the Care Environment (PLACE)	6 November 2024
Operational Delivery Networks - Paediatric Surgery	27 January 2025

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Acronyms

A&E	Accident & Emergency Department
APC	Admitted Patient Care
CAF	Cyber Assurance Framework
C-DIFF	Clostridium Difficile
CFS	Clinical Frailty Score
CGA	Comprehensive Geriatric Assessment
CHKS	Comparative Health Knowledge System
COHA	Community-onset healthcare-associated
COPD	Chronic Obstructive Pulmonary Disease
CSDS	Community Services Data Set
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DIPC	Director of Infection Prevention and Control
DKA	Diabetic Ketoacidosis
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
HES	Hospital Episode Statistics
HOHA	Hospital-onset healthcare-associated
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
LFPSE	Learning from Patient Safety Events
MaST	Mandatory and Statutory Training
MDT	Multi Disciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSc	Master of Science
MSDS	Maternity Services Data Set
MSSA	Meticillin Sensitive Staphylococcus Aureus
NACEL	National Audit for Care at the End of Life
NCAP	National Cardiac Audit Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NGO	National Guardian's Office
NHS	National Health Service
NHSE	NHS England

NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
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
Qni	Queen's Nursing Institute
QR	Quick Response
RPA	Radiation Protection Advisor
SDEC	Same Day Emergency Care
SHMI	Summary Hospital level Mortality Indicator
SJR	Structured Judgement Review
SQL	Structured Query Language
SUS	Secondary Uses Service
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent and Emergency Care Centre
UKAS	United Kingdom Accreditation Service
UKHSA	UK Health Security Agency
VTE	Venous Thromboembolism
YTD	Year To Date

Glossary

Acute Services	Include treatment for a severe injury, period of illness, urgent medical condition, or to recover from surgery. In the NHS, it often includes services such as accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery.
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.
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 ICB'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.
Oliver McGowan Training	The Oliver McGowan Mandatory Training on Learning Disability and Autism is the government's preferred and recommended training for health and social care staff.
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 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.
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.