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Barnsley Hospital NHS Foundation Trust

Quality Report

2022-2023

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Part 1: Statement on quality from the Chief Executive

Barnsley Hospital NHS Foundation Trust's Quality Report provides you with the details of the Trust's quality improvement journey over 2022-23. Once again, we celebrate our achievements but also acknowledge those areas where improvement is required. The quality priorities we have focused on during 2022-23 are a continuation of those we began working on in 2020-21 and are in line with our Quality Plan. As part of our reporting process the Trust has taken the opportunity to review all quality indicators for 2023-24. Details of these together with our achievements and challenges of 2022-23 can be found in part 3 of this report.

I am proud to share just a few of our key achievements over the last year:

- Throughout 2022-23 the Trust has continued to actively participate in clinical research focussing on growing our commercial portfolio and delivering more interventional research studies. Significant improvements have been made in relation to recruiting an agreed number of participants for a study within an agreed timeframe.
- As an organisation we continue to recognise the importance of data quality. A number of improvements have been made during 2022-23 to support operational teams to maintain and improve the quality of services they provide to our patients.
- This year has seen a continued focus on teams preparing for and engaging with external accreditation and peer review visits. Clinical Business Units (CBUs) and corporate services have completed self-assessment reviews and other benchmarking exercises against the Care Quality Commission's (CQC) key lines of enquiry and relevant professional and national standards.
- Throughout 2022-23 the Trust has been committed to further improving patient experience by participating in local and national surveys. We have identified innovative ways to obtain feedback from patients and their loved ones. Teams and services have implemented improvements to drive us on our journey of being a person-centred organisation.
- We continue to be an open and transparent organisation dedicated to learning and improvement. This has supported us to achieve our 2022-23 quality indicators relating to mortality, clinical audit, patient safety and patient experience.
- Throughout 2022-23 the Trust has been preparing for, and implementing national policies and best practice; examples include Just Culture, the Patient Safety Incident Response Framework (PSIRF), Recommended Summary Plan

for Emergency Care and Treatment (RESPECT) and the Learning from Patient Safety Events (LFPSE) reporting service.

- This year has seen continued pressures on our workforce. The Trust has responded robustly and dynamically and adapted quickly to different ways of working to ensure the safest staffing levels.
- We have built on our partnership working further developing our relationships with the Improvement Academy, Yorkshire and Humber Academic Health Science Network, the South Yorkshire Integrated Care System and across the Barnsley place.

There are some areas where we still feel there is scope for improvement and which we will continue to focus on through the coming year:

- The Trust remains committed to reducing all preventable patient harm in line with our culture of learning and improvement. In 2022-23 we did not achieve all of our quality indictors in relation to reducing the risk of inpatients suffering a fall or developing pressure damage. A Nursing Quality Forum has been established to provide senior support and oversight to the improvement work that is underway.
- Despite maintaining our focus on eliminating avoidable hospital-acquired infections we did not achieve our infection prevention and control quality indicators in 2022-23. In line with the national picture for the prevention of Clostridium difficile infection the Trust reported 42 cases against a threshold of 32 cases for the year. Due to national changes in the categorisation of hospital-acquired infections the regional Infection Prevention and Control team estimated that the proportion of healthcare associated infections would increase to around 65% of the total number of cases. As we did not achieve our quality indicators the Trust has sought advice from the regional Infection Prevention and Control and antimicrobial stewardship leads. The team were unable to identify any additional learning or improvements we could make.

As Chief Executive of Barnsley Hospital NHS Foundation Trust, I am proud of the achievements we have continued to make during 2022-23 in terms of maintaining high quality services. In 2023-24 we will continue to focus on delivering sustainable improvements to ensure our patients receive high quality, safe, person-centred compassionate care.

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. It provides a transparent picture of how patient safety, patient experience and quality improvement are key to the delivery of care here at Barnsley Hospital.

R. Jenkins

Dr Richard Jenkins, Chief Executive
Date: 28 June 2023

Part 2: Priorities for improvement and statements of assurance from the board

2.1(i) Quality Goals 2022-23 (cross reference to Section 3.0; Other information)

In 2022-23 our priorities for improving quality for our patients fell within four core goal areas:

- **Clinical Effectiveness** - We will deliver the best clinical outcomes
- **Patient Safety** - We will deliver safe care
- **Patient Experience** - We will provide patient centred services
- **Quality Improvement** - We will have a culture of improvement.

Section 3 of this report provides information on the further progress we have made in achieving the measurable indicators.

Clinical Effectiveness
It is our continued aim to deliver the best clinical outcomes, to establish standards against which we will continuously improve the care we provide. We said that we will:

- Ensure that our mortality indicators are within statistically expected confidence limits (see page 29)
- Use intelligence to understand unwarranted variation in outcomes to drive improvements in clinical services (see page 30)
- Implement systems to prevent avoidable harm (see page 32)

Patient Safety
Nationally set priorities and our continued commitment to provide harm free care has helped us shape our areas of focus for improving patient safety. These include:

- Ensuring plans are in place for safe staffing across all clinical areas (see page 33)
- Proactively implementing improvements to keep our patients safe (see page 34)
- Preventing avoidable patient deterioration (see page 37)

Patient Experience
Providing patient centred service has to be a priority for the Trust. The values of compassion, dignity and respect are essential when involving people in their own care. Details on our progress are outlined throughout section 3.3 and include how we:

- Provide care that is compassionate, dignified and respectful (see page 38)
- Ensure the patients voice is represented in the delivery of care, design and re-design (see page 41)

- Will develop a customer service mind-set across the organisation (see page 42)

Quality Improvement
We aspire to drive outstanding care, in collaboration with patients, carers and families, by empowering all staff to make changes that matter. Achieving this means we will have to be innovative and support each other. We must give everyone the skills and guidance to solve problems and test new ideas. To build an improvement culture we need to be open-minded and focus on what matters most to patients and staff. Together we can continue to make our services safer and more effective, and deliver a better experience for our patients and colleagues. Our priorities supporting us to do this include:

- Building improvement capability across the organisation (see page 44)
- Ensuring staff recognise the importance of patient and public representation in our improvement endeavours (see page 45)
- Working to accelerate the use of innovation (see page 45)

2.1(ii) 2022-23 Quality Priorities

The priorities selected against each of the four goals reflect quality improvement areas identified by national quality priorities and initiatives and are subject to an annual review based on local and national quality priorities. The proposed 2023-24 indicators are included in the tables in section 3 of this report.

Measurement, monitoring and reporting

All our quality improvement programmes follow a structure which monitors and measures performance. Progress is continuously monitored at both local Clinical Business Unit (CBU) level and at corporate level via the Trust's integrated performance report (IPR) which is reviewed on a monthly basis. Progress on the achievement of priorities will be reported through the Trust's quality, performance and governance structures.

2.2 Statements of Assurance from the Board

Information on Review of Services

During 2022-23 the Trust provided and/or sub-contracted 55 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2022-23 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2022-23.

Information on Participation in Clinical Audits

During 2022-23, 31 national clinical audits and three national confidential enquiries covered relevant health services that the Trust provides.

During that period the Trust participated in 100% 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 was eligible to participate in during 2022-23 are as follows. Please see table 1.0.

The national clinical audits and national confidential enquiries that the Trust participated in during 2022-23 are as follows. Please see table 1.0.

The national clinical audits and national confidential enquires that the Trust participated in, and for which data collection was completed during 2022-23, are listed in table 1.0, 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.

The reports of 100% of national clinical audits were reviewed by the provider in 2022-23. The Trust intends to take the following actions to improve the quality of healthcare provided; please see appendix A.

The reports of 100% of local clinical audits were reviewed by the provider in 2022-23. The Trust intends to take the following actions to improve the quality of healthcare provided; please see appendix B.

Table 1.0: All national clinical audits, national confidential enquiries and audits included on the quality account programme for 2022-23.

Key: table 1	
Area/national audit title	Includes details of the area of clinical care being reviewed and the audit/enquiry title.
NCA	Indicates if the project is included on the national clinical audit programme (NCAPOP).
QA	Indicates if the project is part of quality accounts (QA) and the allocated project number from NHS England (NHSE)
A1	Indicates if the project is applicable to the Trust
P1	Indicates if the Trust participated in the project and submitted (or is currently submitting) data.
% cases submitted	Where data collection was completed during 2022-23 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 are included.
Data collection complete	Details on the progress of data collection. Many national audits collect data on an ongoing basis and publish annual reports.

Programme count	Workstream count	Programme	NCA	QA	A1	P1	% cases submitted	Data collection complete?
1	1	Breast and Cosmetic Implant Registry NHS Digital	×	✓	✓	✓	100%	Ongoing
2	2	Case Mix Programme Intensive Care National Audit and Research Centre	×	✓	✓	✓	100%	Ongoing
3	3	Child Health Clinical Outcome Review Programme: National Confidential Enquiry into	✓	✓	✓	✓	100%	Yes

		Patient Outcome and Death: transition from child to adult health						
4	4	Cleft Registry and Audit Network Database Royal College of Surgeons - Clinical Effectiveness Unit	×	✓	✓	✓	All local identified cases are referred to Cleft Lip and Palate Association (CLAPA) who notify CRANE of all cases	
5	5	Elective Surgery: National PROMs Programme NHS Digital	×	✓	✓	✓	Unknown	Ongoing
6	Emergency Medicine QIPs: Royal College of Emergency Medicine							
	6	a. Infection Prevention and Control	×	✓	✓	✓	100%	Ongoing
	7	b. Care of Older People	×	✓	✓	✓	100%	Ongoing
	8	c. Mental Health Self-Harm	×	✓	✓	✓	100%	Ongoing
7	9	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Ongoing
8	Falls and Fragility Fracture Audit Programme:							
	10	a. Fracture Liaison Service Database	✓	✓	×	×	No local service	
	11	b. National Audit of Inpatient Falls	✓	✓	✓	✓	100%	Ongoing
	12	c. National Hip Fracture Database	✓	✓	✓	✓	100%	Ongoing
9	Gastro-intestinal Cancer Audit Programme:							
	13	a. National Bowel Cancer Audit	✓	✓	✓	✓	100%	Ongoing
	14	b. National Oesophago-gastric Cancer	✓	✓	✓	✓	100%	Ongoing
10	15	Inflammatory Bowel Disease Audit IBD Registry	×	✓	✓	×	-	-
11	16	LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme) NHSE and NHS Improvement	×	✓	✓	✓	100%	Yes

12	17	Maternal and Newborn Infant Clinical Outcome Review Programme University of Oxford / MBRRACE UK Collaborative	✓	✓	✓	✓	100%	Yes
13	18a	Medical and Surgical Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death: crohn's disease	✓	✓	✓	✓	100%	Yes
13	18b	Medical and Surgical Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death: community acquired pneumonia	✓	✓	✓	✓	100%	Yes
13	18c	Medical and Surgical Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death: testicular torsion	✓	✓	✓	✓	100%	Yes
14	19	Mental Health Clinical Outcome Review Programme University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health	✓	✓	×	×	Not applicable	
15	20	Muscle Invasive Bladder Cancer Audit The British Association of Urological Surgeons	×	✓	×	×	No local service	
16	**National Adult Diabetes Audit: NHS Digital**							
	21	a. National Diabetes Core Audit	✓	✓	✓	✓	100%	Ongoing
	22	b. National Diabetes Foot Care Audit	✓	✓	✓	✓	TBC	Ongoing
	23	c. National Diabetes Inpatient Safety Audit	✓	✓	✓	✓	92%	Ongoing
	24	d. National Pregnancy in Diabetes Audit	✓	✓	✓	✓	100%	Yes
17	**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Royal College**							
	25	a. Adult Asthma Secondary Care	✓	✓	✓	✓	78%	Ongoing
	26	b. Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	✓	✓	88%	Ongoing

	27	c. Paediatric Asthma Secondary Care	✓	✓	✓	✓	100%	Ongoing
	28	d. Pulmonary Rehabilitation Organisational and Clinical Audit	✓	✓	×	×	-	-
18	29	National Audit of Breast Cancer in Older Patients Royal College of Surgeons	✓	✓	✓	✓	NABCOP does not directly 'collect' patient data. Existing sources of patient data collected by national organisations	
19	30	National Audit of Cardiac Rehabilitation University of York	×	✓	×	×	-	-
20	31	National Audit of Cardiovascular Disease Prevention (Primary Care) NHS Benchmarking Network	✓	✓	×	×	-	-
21	32	National Audit of Care at the End of Life NHS Benchmarking Network	✓	✓	✓	✓	100%	Yes
22	33	National Audit of Dementia Royal College of Psychiatrists	✓	✓	✓	✓	98%	Yes
23	34	National Audit of Pulmonary Hypertension NHS Digital	×	✓	×	×	-	-
24	35	National Bariatric Surgery Registry British Obesity and Metabolic Surgery Society	×	✓	×	×	-	-
25	36	National Cardiac Arrest Audit Intensive Care National Audit and Research Centre	×	✓	✓	✓	100%	Ongoing
26	**National Cardiac Audit Programme: Barts Health NHS Trust**							
	37	a. National Congenital Heart Disease	✓	✓	×	×	-	-
	38	b. Myocardial Ischaemia National Audit Project	✓	✓	✓	✓	67%	Ongoing
	39	c. National Adult Cardiac Surgery Audit	✓	✓	×	×	-	-
	40	d. National Audit of Cardiac Rhythm Management	✓	✓	✓	✓	100%	Ongoing
	41	e. National Audit of Percutaneous Coronary Interventions	✓	✓	×	×	-	-
	42	f. National Heart Failure Audit	✓	✓	✓	✓	80%	Ongoing

27	43	National Child Mortality Database University of Bristol	✓	✓	✓	✓	100%	Ongoing
28	44	National Clinical Audit of Psychosis Royal College of Psychiatrists	✓	✓	×	×	Not applicable	
29	45	National Early Inflammatory Arthritis Audit British Society of Rheumatology	✓	✓	✓	✓	100%	Ongoing
30	46	National Emergency Laparotomy Audit Royal College of Anaesthetists	✓	✓	✓	✓	92%	Ongoing
31	47	National Joint Registry Healthcare Quality Improvement Partnership	×	✓	✓	✓	100%	Ongoing
32	48	National Lung Cancer Audit Royal College of Surgeons	✓	✓	✓	✓	100%	Ongoing
33	49	National Maternity and Perinatal Audit Royal College of Obstetrics and Gynaecology	✓	✓	✓	✓	100%	Ongoing
34	50	National Neonatal Audit Programme Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Ongoing
35	51	National Ophthalmology Audit Database The Royal College of Ophthalmologists	×	✓	✓	×	Service did not participate	
36	52	National Paediatric Diabetes Audit Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Yes
37	53	National Perinatal Mortality Review Tool University of Oxford / MBRRACE UK Collaborative	✓	✓	✓	✓	100%	Yes
38	54	National Prostate Cancer Audit Royal College of Surgeons (RCS)	✓	✓	✓	✓	100%	Ongoing
39	55	National Vascular Registry Royal College of Surgeons (RCS)	✓	✓	×	×	-	-
40	56	Neurosurgical National Audit Programme Society of British Neurosurgeons	×	✓	×	×	-	-
41	57	Out-of-Hospital Cardiac Arrest Outcomes University of Warwick	×	✓	×	×	-	-

42	58	Paediatric Intensive Care Audit University of Leeds / University of Leicester	✓	✓	×	×	-	-
43	59	Perioperative Quality Improvement Programme Royal College of Anaesthetists	×	✓	✓	×	Insufficient patients meet the criteria	
44	**Prescribing Observatory for Mental Health:**							
	60	a. Improving the Quality of Valproate Prescribing in Adult Mental Health Services	×	✓	×	×	-	-
	61	b. The Use of Melatonin	×	✓	×	×	-	-
45	**Renal Audits:**							
	62	a. National Acute Kidney Injury Audit	×	✓	✓	×	Local audit takes place	
	63	b. UK Renal Registry Chronic Kidney Disease Audit	×	✓	×	×	-	-
46	**Respiratory Audits:**							
	64	a. Adult Respiratory Support Audit	×	✓	✓	×	-	-
	65	b. Smoking Cessation Audit- Maternity and Mental Health Services	×	✓	✓	×	-	-
47	66	Sentinel Stroke National Audit Programme King's College London (KCL)	✓	✓	✓	✓	100%	Ongoing
48	67	Serious Hazards of Transfusion UK National Haemovigilance Scheme Serious Hazards of Transfusion	×	✓	✓	✓	100%	On-going
49	68	Society for Acute Medicine Benchmarking Audit Society for Acute Medicine	×	✓	✓	✓	100%	Yes
50	69	Trauma Audit and Research Network Trauma Audit and Research Network	×	✓	✓	✓	97%	Yes
51	70	UK Cystic Fibrosis Registry Cystic Fibrosis Trust	×	✓	×	×	-	-
52	71	UK Parkinson's Audit Parkinson's UK	×	✓	✓	✓	100%	Yes

Participation in Clinical Research
The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2022-23 that were recruited during that period to participate in research approved by a Research Ethics Committee was 512.

Significant improvements have been made in relation to recruitment to time and target. We are pleased to report that this currently stands at 80% for studies which closed in 2022-23 and 87% of studies still open are on track to meet target. This metric measures an agreed number of participants to be recruited to a study in an agreed timeframe from when the study is approved.

The Trust has achieved excellent recruitment to commercial studies this year with 63 patients recruited. This is significantly higher than other comparable Trusts within Yorkshire and Humber, ranking seventh among all 22 Trusts in the region and the second highest of non-teaching hospitals.

Efforts have been focused on developing two areas this year; growing our commercial portfolio as this brings in more income to the Trust and, delivering more interventional studies which are inevitably more complex, but also challenge us more as a department and provide greater research opportunities for our population.

Commissioning for Quality and Innovation (CQUIN) Framework
The Commissioning for Quality and Innovation (CQUIN) framework enables the Trust's commissioners to reward excellence, by linking a proportion of our income to the achievement of local quality improvement goals. Table 2.0a outlines the 2022-23 national CQUINs, which are applicable to NHS acute providers. Table 2.0b summarises the national CQUINs which will be the focus for the Trust during 2023-24.

Table 2.0a: 2022-23 national CQUINs

CCG1: Flu vaccinations for frontline healthcare workers: 90% uptake of flu vaccinations by frontline staff with patient contact
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+: 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
CCG4: Compliance with timed diagnostic pathways for cancer services: 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle: 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.

CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery: Anaemia screening and treatment for all patients undergoing major elective surgery
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
CCG8: Supporting patients to drink, eat and mobilise after surgery: Supporting patients to drink, eat and mobilise after surgery
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients: 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.

Table 2.0b: 2023-24 national CQUINs

CQUIN01: Flu vaccinations for frontline healthcare workers: 80% uptake of flu vaccinations by frontline staff with patient contact.
CQUIN02: Supporting patients to drink, eat and mobilise after surgery: 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria: 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.
CQUIN04: Compliance with timed diagnostic pathways for cancer services: 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways.
CQUIN05: Identification and response to frailty in emergency departments: 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service: 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.
CCG7: Recording of NEWS 2 score, escalation time and response time for critical care admissions: 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.
CQUIN12: Assessment and documentation of pressure ulcer risk: 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

Regulation and Compliance
The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is "registered without conditions". CQC has not taken enforcement action against the Trust during 2022-23.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Quality of Data
The Trust submitted records during 2022-23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) 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% for admitted patient care
99.9% for out-patient care and
99.6% for accident and emergency care

— which included the patient's valid General Medical Practice Code was:

100% for admitted patient care
100% for out-patient care and
100% for accident and emergency care.

Information Governance
The Trust's Information Governance Assessment Report overall score for 2022-23 was moderate-high. A snapshot from our auditors state there are no standards rated as 'unsatisfactory', and one or none rated as 'limited'. However, not all standards are rated as 'substantial'.

Clinical Coding
The Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2022-23.

The Data Security and Protection Toolkit audit undertaken covered a random sample of 200 episodes of care across the whole range of services covered by a mandatory PbR tariff. The 2022-23 audit was undertaken in February 2023. The results should not be extrapolated further than the actual sample audited.

	Correct (%) IG Toolkit 2022-23
Primary Diagnosis	86.5
Secondary Diagnosis	95.3
Primary Procedure	94.6
Secondary Procedure	92.3

Data Quality

The Trust will be taking the following actions to improve data quality:

- Continued quarterly validation of clock stops to maintain patient safety and care.
- A daily focus on referral to treatment (RTT) issues – long waiters and status errors, to maintain assurance in reporting. There are approximately 30 items to check on a daily basis.
- Ensure any new RTT guidance is discussed and any changes to recording are agreed.
- Monitoring the correct use of consultation method within the outpatient module. Currently the errors are awaiting a fix on the system to be able to correct the consultation method. An increase in virtual appointments has made how the appointment is recorded more detailed. The recording of the consultation method affects income.
- By reviewing RTT outcomes as this has been rolled out to all specialties.
- Ensuring the escalation process for long waiters is followed. Any issues or discrepancies around waiting times are discussed at the Data Quality group.
- Ensure the generic doctor ED is not used on the electronic patient record. A number of processes have been implemented in order to enable this; training on how to change the consultant on the record and correcting the consultants that have not amended on the record the day after the patient was admitted. This process has continued throughout the year, The use of the generic doctor ED has reduced over the year but does still occur daily. These are now reported on Datix.
- Reducing the use of generic consultants. These will only be used for specific areas where there are no other options.
- Using the Data Quality Maturity Index (DQMI) to highlight any data errors and creating processes and reports to improve accuracy. Our current score is just over 95%, due to an improvement in the Emergency Care Data Set (ECDS) data entry.
- Highlighting monthly any Bluespier records that are not recorded on CareFlow to the relevant team. The records will then be entered onto CareFlow. As the goal is to not have any of these records users are be retrained and educated in the processes.
- Community paediatrics will start to be recorded with an RTT clock. From April 2023 with the exception of autism and adoption the rest of community paediatrics will use a RTT clock for access to the service. Close monitoring of this will ensure that that waiting times are met in the service.
- Maternity data quality will continue to be monitored due to the number of inaccuracies across the income processes. The issues are reported on a central dashboard so people are aware of the internal problems and how these should be updated.
- Ensure the redeveloped outpatient review list gives the operational teams the information they need to manage their outpatients.
- Discharge times will continue to be audited as entering the incorrect time remains an issue. Improvement is required due to the implementation of the faster data flows, which transmits various discharge data daily to a central repository.

- Creating more than one finished consultant episode per specialty/ward will be investigated over the coming months and options reviewed as to any actions that may be required.
- Working with the services trustwide to help maintain communications and raising the importance of accurate data.
- Any high impact issues will be reported to the executive team meeting.
- The Information Governance group chairs log will feed into the Clinical Effectiveness group and any issues requiring clinical input will be prioritised.
- The Business Intelligence (BI) team continue to implement new reporting mechanisms to provide accurate and up to date data. This allows the Trust to compare with local Trusts and develop shared learning.

Learning from Deaths

(27.1) During 2022-23, 1262 of the Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
321 in the first quarter
261 in the second quarter
359 in the third quarter
321 in the fourth quarter

(27.2) By the 31 March 2023, 75 case record reviews and seven investigations have been carried out in relation to seven of the deaths included in item 27.1.

In seven cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
14 in the first quarter;
17 in the second quarter;
29 in the third quarter;
15 in the fourth quarter.

(27.3) Seven, representing 0.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:
Two representing 0.6% for the first quarter;
One representing 0.4% for the second quarter;
Two representing 0.6% for the third quarter;
Two representing 0.6% for the fourth quarter.
These numbers have been estimated using the numbers of requested Structured Judgement Reviews (SJR) (case record reviews) and the records held in the Datix reporting system on Serious Incidents (SI) (investigations).

(27.4) A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths:
Themes from SIs include:

- A lying and standing blood pressure was not recorded in line with Trust policy. If a fall in blood pressure had been identified staff would have been given the

opportunity to explain this to the patient and reiterate the dangers of getting up without assistance.

- The falls risk assessment was not fully completed which led to missed opportunities for staff to consider further falls prevention interventions that would have reduced the patient's risk of falling.
- A bed rails risk assessment was not completed in line with Trust policy. If the use of bed rails had been discussed with the patient they may not have been used and the fall may have been avoided.
- When staff recognised that the patient was unable to use the nurse call buzzer there was a missed opportunity to consider transferring the patient into a more observable area of the ward.
- There was no guidance in place to support clinicians with the management of head injuries sustained by an in-patient.
- There was inconsistency in the completion of neurological observations and in the escalation of deteriorating NEWS2 scores.
- The admitting nurse was not aware of the patient's management plan, including the suggestion that the patient may need one to one nursing care.
- There are no speech and language therapy (SALT) policies to guide staff in their decision making.

Themes from SJRs include:

- Missed opportunities to recognise the deteriorating patient through visual or behavioural signs.
- Missed opportunities to escalate the deteriorating patient.
- A lack of review or follow up by a senior clinician.
- Lack of do not attempt cardiopulmonary resuscitation (DNACPR) discussion and/or completion of associated documentation.
- Delay in initiating end of life care.

(27.5) A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4):

Themes from SIs:

- Falls risk assessments including lying and standing blood pressure, bed rails assessment and post fall communications, must be completed and recorded in line with Trust policy.
- Neurological and NEWS2 observations must be completed, recorded and escalated in line with Trust policy.
- The Trust's falls policy should be reviewed to reflect the guidelines in place for the management of head injuries and communication about its relevance to in-patients should be shared with all staff.
- The falls prevention training compliance should be improved.
- Documentation transferred with patients from the Emergency Department (ED) to a ward should be complete, ensuring staff have all the relevant information available.
- Consideration should be given to swallowing assessments being carried out by nursing staff to allow patients with dementia to be screened on admission for swallowing difficulties.

Themes from the SJRs that did not lead to further investigation are shared as learning via a learning from deaths bulletin or a speciality level review takes place to provide speciality specific learning.

(27.6) An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

The impact of the actions put in place are assessed by a SI assurance review that is carried out six months after the closure of the full action plan in line with the Trust process. Any non-compliance found in the review is escalated through the Trust's governance framework. This process gives assurance to the Trust that learning is taking place and offers the opportunity to consider if any additional actions are required if the impact of the original action was not as expected.

All deaths are scrutinised by the Medical Examiner (ME) service and any concerns are escalated to the weekly Mortality Overview Group (MOG) where a decision is made to signpost the issues raised through either a specialty review, the complaints process or via a SJR. If required the cases are escalated for further investigation as a SI.

A learning from deaths bulletin based on learning from ME escalations and SJRs are shared trustwide and an electronic library is available of all SJRs and learning from deaths bulletins.
The MEs proactively seek any history of learning disability or severe mental illness in their reviews. A SJR is carried out on all these cases to identify any potential issues in care and to share positive care experiences. The SJRs are shared with the Safeguarding team to inform LeDeR programme.

A thematic review of all escalations from the learning from deaths process are shared through the Trust's governance framework for triangulation.

(27.7) Zero case record reviews and zero investigations completed after the reporting period which related to deaths which took place before the start of the reporting period.

(27.8) Zero representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the recorded number of inpatient deaths, the numbers of requested SJRs and the records held in the Datix reporting system on SIs.

(27.9) Zero representing 0% of the patient deaths which took place before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against Core Indicators

NHS foundation trusts are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

The core indicators are listed in the tables below. It is important to note that whilst these indicators must be included in the Quality Accounts the most recent national data for reporting is not always available for the most recent financial year. Where this is the case the time period used has been included in the table. It is also important to note that it is not always possible for the Trust to be able to provide the national average and best and worst performers for some of the indicators due to the way the data is provided to the Trust.

Table 3.0 Barnsley Hospital NHS Foundation trust performance against the NHS Outcomes Framework 2022-23 Indicators

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
SHMI value and banding October 2022 (latest available data)	102.37 (October 2022)	99.93	62.26	124.70	101.89	106.2	99.4
Trust Assurance Statement: Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons: • The mortality statistics are derived from data submitted by the organisation to HES. • The data is reviewed with an external informatics company to provide further assurance. Barnsley Hospital NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by: • Review disease specific mortality indicators and investigate any alerting conditions as agreed at the Learning from Deaths group. • To ensure delivery of the ME service and continuing to apply learning from SJR. • Continue our understanding of any identified failures through the SJR and ME process. • Work with the coding team to ensure all available coding sources are utilised. • Work with the external informatics company to ensure all avenues of potential improvements are identified.							

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
% of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	18.80%	39.83%	69.72%	9.76%	18.79%	17.18%	36.54%

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Significant work has continued through 2022-23 to ensure that there is a systematic and consistent methodology for the coding of patient deaths with the palliative care code.

Barnsley Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Working closely with the Specialist Palliative Care Team (SPCT), Patient Safety team and MOG to ensure that data is updated, is correct and reflects the SPCT input in the patient's care. This will be performed by double checking the SPCT database against the coded data and amending where necessary.
- We have amended the local policy from April 2023 for coding specialist palliative care to include some of the End of Life Care team and other specialist staff that perform specialist palliative care alongside the SPCT.

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
The Trust's responsiveness to the personal needs of its patients during 2022-23.	Data not available (awaiting CQC publication)	No comparable data available at time of reporting			78%	79%	76%

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust uses five patient experience quality indicator questions within the national inpatient survey, to monitor its responsiveness to the personal needs of patients. In 2021-22 two of these quality indicators identified the need for improvement based on the previous year. These included involvement in decisions around medication information at discharge and privacy and dignity. Data for 2022-23 will be published via the CQC website during late 2023.
- Intelligence gained from the national inpatient survey is used to inform service level action plans and local surveys to monitor service improvements across the Trust.

Barnsley Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Establishing an Inpatient Survey task and finish group to implement action plans and monitor improvement, with a whole team approach across medical and nursing services.
- Reviewing the patient discharge journey from start to finish via the Discharge and Patient Flow programme. This includes a pharmacy workstream with a focus the provision of patient information at the point of discharge.

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
% of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a safe place of care to their family or friends.	64.4%	61.9%	86.4%	39.2%	66.9%	72.9%	70.7%

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- It is taken from the annual staff survey responses for question 23d "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."

Barnsley Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Completing the actions that CBU leads identified as a result of the annual staff survey results.

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
28 day readmission rates for patients aged 0 to 14 during 2022-23.	17.92%	Data unavailable. Benchmarking for readmissions is several months behind real time so no comparable data available at time of reporting.			16.59%	11.64%	9.03%
28 day readmission rates for patients aged 15 or over during 2022-23.	9.53%	Data unavailable. Benchmarking for readmissions is several months behind real time so no comparable data available at time of reporting.			16.5%	11.2%	10.03%

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons (0-14):

- Patients attending the same day emergency care unit are recorded as non elective admissions with a zero length of stay, a number of these people re attend for follow up as an alternative to an overnight stay.

Barnsley Hospital NHS Foundation has taken the following actions to improve this percentage, and so the quality of its services, by (15 and over):

- A review of the way these patients are recorded to ensure an accurate reflection of the care pathway.

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
% of admitted patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during 2022-23. ***latest available published data January 2023.**	97.31%	Not available – data collection ceased 28 March 2020	Not available	Not available	98.2%	96.6%	97.80%

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is taken from our electronic observations system and from our electronic patient records and discharge summaries where questions about VTE risk assessment are recorded.

Barnsley Hospital NHS Foundation Trust has taken/will undertake the following actions to improve this percentage, and so the quality of its services, by:

- Carrying our root cause analysis (RCA) investigation on any patient who has a hospital acquired VTE.
- Review any contributory factors in our assessment process and take actions to address them.
- Continue to deliver VTE training on the importance of VTE assessment.
- Continue the monthly Thromboprophylaxis and Thrombosis committee meeting to ensure governance and sustainability.

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
Rate per 100,000 bed days of cases of C.difficile infection amongst patients aged 2 or over during 2022-23. **** rate unavailable at the time of completing this report.**	** 43 cases	Data unavailable from national source at the time of completing this report.			32	26	9.0

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Surveillance programmes and national reporting requirements in conjunction with local review supports the accuracy of the data.

Barnsley Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by:

- Reviewing and auditing practice, surveillance and education, thorough investigation and root cause analysis.

- The Trust has sought advice from NHSE North East and Yorkshire regional infection prevention and control team to ensure our current prevention and management strategies are satisfactory.
- The Trust has also benchmarked with other Trusts to identify if there is any shared learning.

Indicator	2022-23* BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
Number and rate of patient safety incidents reported during 2022-23. ***latest data available – number only (1 April 2022 to 31 March 2023).**	14,324	National data no longer provided			11,859 (Rate 73.9)	11,002 (Rate 74.0)	4,760 (Rate 73.5)

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The NHSE and Improvement Patient Safety team have moved to an annual publication schedule for the Organisation and National Level Patient Safety Incident Reports (OPSIR and NAPSIR). The annual publications covering the most recent financial year of data, data for April 2022 – March 2023 will be published in September 2023. The Trust's number of patient safety incidents reported has been taken from Datix, the rate of incident reporting will not be available until the annual report is published.
- The increase in the number of patient safety incidents reported demonstrates the Trust's open and positive approach to incident reporting to promote a culture of high quality and safe care for patients and staff.

Barnsley Hospital NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services, by:

- The Clinical Governance and Corporate Governance teams continue to support staff and CBUs to report and investigate patient safety incidents.
- The Clinical Governance team support staff and CBUs to ensure that appropriate learning from the incidents is identified and shared.
- The number of incidents reported, themes and trends, the number of open incidents and the learning and action taken following incidents is summarised in specialty and overarching CBU governance reports which are discussed by the Clinical Governance Facilitators at the monthly speciality and CBU governance meetings.
- Training is provided to staff on incident reporting and investigating incidents at bespoke study days and on the Trust's Passport to Management programme. One-to-one and training is also provided at individuals' request.

Indicator	2022-23 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2021-22 BHNFT	2020-21 BHNFT	2019-20 BHNFT
Number and rate of patient safety incidents reported during 2022-23 that resulted in severe harm or death.	Severe harm 24 (0.2%) Death 17 (0.1%)	National data no longer provided			Severe harm 32 (0.3%) Death 18 (0.2%)	Severe harm 12 (0.001%) Death 13 (0.001%)	Severe harm 6 (0.1%) Death 2 (0.0%)

Trust Assurance Statement:

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The NHSE and Improvement Patient Safety team have moved to an annual publication schedule for the OPSIR and NAPSIR. The annual publications covering the most recent financial year of data, data for April 2022 – March 2023 will be published in September 2023. The number and percentage of patient safety incidents that resulted in severe harm or death has been taken from Datix.
- During the period 1 April 2022 to 31 March 2023 the percentage of patient safety incidents that the Trust has reported that resulted in severe harm or death has reduced.
- The CQC updated their guidance for providers on Regulation 20 – the Duty of Candour in June 2022. This guidance gives a more specific explanation of what is defined as a 'notifiable safety incident.' The presence or absence of error on the part of the provider has no impact on whether something is defined as a notifiable safety incident. In line with this updated guidance the Trust records the actual level of harm the patient sustained as a result of the incident regardless of whether or not the investigation finds there to be any lapses in care.

Barnsley Hospital NHS Foundation Trust intends to take the following actions to improve this percentage and number, and so the quality of its services, by:

- The Trust's management of SIs policy ensures the investigation into incidents resulting in severe harm or death is led by an independent investigator from outside of the CBU where the incident has occurred.
- Appropriate specialist and professional input is sought to agree terms of reference for the investigation and to provide specialist support and knowledge to the investigating officer.
- Through identification of the relevant contributory factors to an incident allows the Trust to ensure that robust actions are put in place to improve the safety and quality of care patients receive.
- The Clinical Governance team and CBUs ensure that the learning from incidents resulting in severe harm or death is shared with the staff and the service directly involved in the incident, trust wide through a sharing the learning bulletin and through the Trust's governance framework.
- A quarterly thematic review of all serious incidents is undertaken to identify any trends in the types of incidents that result in severe harm or death and any trends in the findings and recommendations of completed investigations. This is reported through the Trust's governance framework.
- Triangulation of complaints, litigation, incidents and HM Coroners inquests is completed quarterly and reported to Patient Safety and Harm group.
- A serious incident assurance review is completed six months after the closure of all actions in the investigation. This is designed to assess the impact of the action plan on the safety and quality of care patients receive. The outcome of the serious incident assurance review is reported through the Trust's governance framework.
- The Trust's Patient Safety Specialists attend the NHSE and Improvement Patient Safety Specialist meetings to ensure that the Trust is on track to meet the requirements of the national patient safety strategy
- The patient safety incident response framework (PSIRF) implementation group is on track to meet the September 2023 transition date.

Patient Reported Outcome Measures (PROMs) reporting period: April 2022 to March 2023 (both provisional data and finalised data has not yet been published and there is no confirmed date for publication due to development issues at Public Health England that are yet to be resolved.

PROMs aim to measure improvement in health following certain elective (planned) operations. These are: hip replacement and knee replacement. Information is derived from questionnaires completed by patients before and after their operation and the difference in responses is used to calculate the 'health gain'. It is important that patients participate in this process, so that the Trust can learn how effective and how successful interventions have been.

Barnsley Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- Following implementation of updates and changes within the enhanced recovery pathway (ERP) and PROMs pathway the recently published results show that on the general health questions and visual analogue scale the Trust is above the national average and above the NHS England benchmark for improvement.
- There has been great improvement overall for total hip replacement surgery. However, on the oxford hip score the Trust continues to score less well. It is anticipated that this is due to patients scoring less well overall pre-operatively i.e. in more pain and struggling when doing daily activities like walking and shopping etc. The change or improvement overall post operatively is less, as the patients were in a worse position to start with.
- The Trust has no legible published data for performance in total knee replacement for the period 2020-21 however the last publication for 2019-20 shows that overall the Trust had shown signs of improvement compared to the data for 2018-19. Data to show if this improvement has continued or has deteriorated is not currently available.

Barnsley Hospital NHS Foundation Trust has taken the following actions to improve these indicators, and so the quality of its services, by:

- There are monthly meetings held for ERP and PROMs with a multidisciplinary approach from all areas involved across the patient pathway for total hip and total knee replacement surgery. Work has been ongoing within the ERP and PROMs pathway for some time to help improve the Trust's PROMs data, specifically the oxford scores for patients activities of daily living.
- Work has included introduction of the use of cyro-cuff, three-way wound closure, preservation of the fat pad at time of surgery and reduced tourniquet time in total knee replacements.
- The relaxation of hip precautions in primary total hip replacement surgery has taken place recently which the Trust anticipates will have a positive impact on patient experience and PROMs data.
- The pre-operative preparation of a patient has been reviewed and updates implemented via the patient booklets and joint school to best prepare the patients for their upcoming surgery and recovery. The multidisciplinary team aim to see patients on the ward on the day of their operation to assess their mobility and ongoing needs.
- The ERP protocol has been updated to help control and manage pain post-operatively and on discharge from the ward. Patients are seen in the outpatient gymnasium for physiotherapy within two weeks of surgery. The aim is for patients to be seen within one week in the future.
- There is a helpline available to patients for use once they are discharged from hospital and extra outpatient clinic appointments are available if required in between planned appointments.

2.4 Maternity Services

During 2022 – 2023 the Trust has continued to ensure that maternity services remain a focus at Board level. The Head of Midwifery presents at Board every month in line with the Perinatal Quality Surveillance Model, ensuring Board are cited and close to the detailed information the model requires. The Board level Maternity Safety Champions do monthly walkarounds to speak to staff and have also attended the maternity listening events implemented after the final Ockenden report was published.

Maternity governance processes were reviewed to ensure that the service is represented at all required Trust level meetings and that the assurance Maternity needs to provide is getting the required scrutiny.

The service has actively engaged and welcomed review by peers, the Local Maternity and Neonatal Systems (LMNS), CQC and the regional NHS team at different points in the year, seeking to learn at all opportunities. Additional deep dives and thematic analysis have been undertaken for assurance and for learning proactively following incidents, at the request of the Board, or following early identification of possible trends at the weekly incident review meeting. Any areas identified for improvement form part of the maternity safety and service improvement plan for 2023-24 and are monitored via the appropriate governance route.

The Trust achieved the CNST Maternity Incentive Scheme Year four standards, submitting to NHS Resolution in February 2023.

The Maternity Voices Partnership (MVP) in Barnsley is an area of strength with increasing amounts of work being co-produced and the service responding to the MVP around actions taken in a “you said, we did” style. The midwifery team lead on the delivery of a patient experience action plan that collates actions from a wide range of service user feedback mechanisms.

Key priorities for 2023-24 will include working towards delivery of the CNST Year five standards, including the implementation of Saving Babies Lives (Version 3). In addition, the Three Year Delivery Plan for Maternity and Neonatal Services will drive the continued improvements and transformation as set by NHS England.

Part 3: Other information

Trust performance against agreed 2022-23 priorities for improvement

The tables in this section of the report show the progress Barnsley Hospital NHS Foundation Trust has made against the priorities we set ourselves for 2022-23. The final column in each table confirms the indicators we have agreed against the quality priorities for 2023-24.

Goal 1

3.1 We will deliver the best possible clinical outcomes

3.1.1 Mortality

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will ensure that 90% of all relevant in-patient hospital deaths are reviewed by the ME service within five working days.	Achieved	For the period 2022-23 the ME service reviewed 98% of deaths. During August 2022 performance reduced to 66% due to sickness absence. Performance was 84% in March 2023 due to industrial action. A triage process was implemented to ensure any deaths with concerns were prioritised.	We will ensure that 90% of all relevant in-patient hospital deaths are reviewed by the ME service. Processes for coronial deaths will be confirmed with the national team.
We will have maintained SJRs for all relevant deaths and implement learning to improve care for future patients.	Achieved	Escalations from the ME service to the MOG are sent for SJR (if applicable).	We will have maintained SJRs for all relevant deaths and will implement learning to improve care for future patients.

Learning bulletins and SJRs will be shared within the SJR library.		Anonymised SJRs are stored and available to review within the SJR library on SharePoint.	Learning bulletins and SJRs will be shared within the SJR library.
We will ensure that any diagnosis groups alerting across multiple mortality metrics (HSMR/SHMI) will be acted upon.	Achieved	Investigated mortality alerts have been shared at the Learning from Deaths group and action plans completed. Mortality indicators remain within expected confidence limits.	We will ensure that any diagnosis groups alerting across multiple mortality metrics (HSMR/SHMI) will be acted upon.

Data source: local Trust data source, 2022-23.

3.1.2 Improvements in Clinical Services

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will benchmark our position across the high volume low complexity (HVLC) pathways and put plans in place where there are opportunities for improvement.	Partially achieved	HVLC best practice pathways and Getting It Right First Time (GIRFT) recommendations have been shared with teams. Services attend speciality regional gateway reviews; specifically for sharing improvements and benchmarking against other trusts. GIRFT Oversight groups (GOG) have been organised for services to report to against HVLC and other GIRFT priorities.	We will address areas of improvement identified via the high volume low complexity (HVLC) pathways and put plans in place.

		The Trust meets monthly with GIRFT representatives and South Yorkshire colleagues. Further work is required to track progress and will continue throughout 2023-24. GOG will support this.	
We will identify priority areas for improvement from our deep dives and/or national recommendation reports.	Partially achieved	National speciality reports have been shared with clinicians and service managers across the Trust. Services are involved with GIRFT deep-dive visits as and when requested from the national team. Services attend regional gateway reviews. Speciality working groups have been set up regionally to target improvements within services. Further work is required to track progress which we will continue throughout 2023-24 and GOG will support this along with identifying further priority areas.	We will continue to identify priority areas for improvement from our deep dives and/or national recommendation reports.
We will continue to use the best available evidence using clinical audit	Achieved	The department and Trust have improved the triangulation of clinical audit data across over-arching	We will continue to use the best available evidence using clinical

results, to provide assurance and improve quality of patient care.		governance groups including, Thromboprophylaxis and Thrombosis committee and Learning from Deaths group. The Trust has improved and embedded changes to the process for the monitoring of NICE guidance.	audit results, to provide assurance and improve quality of patient care.

Data source: local Trust data source, 2022-23.

3.1.3 Implementation of Systems to Prevent Avoidable Harm

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will facilitate effective team working by ensuring 70% of key staff identified through appropriate role profile receive training in HF.	Achieved	As at 31 March 2023 HF training compliance was 71%.	Seventy-five percent or above of key staff identified through appropriate role profile will receive training in HF.
We will maintain 95% or above compliance with VTE risk assessment in all adult in-patient areas.	Achieved	As at 28 February 2023 compliance with VTE risk assessment was 97.61%.	We will maintain 95% or above compliance with VTE risk assessment in all adult in-patient areas.
We will investigate any incidents of hospital acquired VTE to inform on any improvements needed.	Achieved	All hospital acquired VTE cases are discussed at the Trust's Thromboprophylaxis and Thrombosis committee and actions are monitored via this group.	We will investigate any incidents of hospital acquired VTE to inform on any improvements needed.

Data source: local Trust data source, 2022-23.

Goal 2

3.2 We will deliver safe care

3.2.1 Safe Staffing

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will have established safe minimum staffing levels (medical and nursing) which are monitored for compliance. Nursing establishment reviews will be conducted twice a year.	Partially achieved	<u>Nurse staffing</u> Safe staffing levels are monitored on a continual basis. Nurse staffing establishment reviews were completed in Autumn 2021. Due to the number of recommendations identified by these reviews and the time taken to progress these, the Spring 2022 reviews did not take place. Further reviews took place in Autumn 2022. Compliance with safe staffing levels continues to be reported monthly to the Quality and Governance committee. <u>Medical staffing</u> We have maintained high overall fill rates and rota compliance has been good. The number of extra capacity	We will have established safe staffing levels (medical and nursing) which are monitored for compliance. Nurse staffing establishment reviews will be undertaken and provide recommendations for any adjustments that are required. We will maintain high overall fill rates of >95% for medical staffing.

		areas open has been a challenge throughout 2022-23.	
We will continue to monitor exception reporting and work with the Guardian of Safe Working to ensure these continue to remain within set target levels.	Achieved	Effective rota management has resulted in relatively few exception reports over 2022-23. Minimal patient safety concerns have been identified. The vast majority of exception reports were associated with a minimal increase in hours worked. Time off in lieu (TOIL) or overtime payments were granted for these.	We will maintain a high level of performance with less than one exception report per day.

Data source: local Trust data source, 2022-23.

3.2.2 Proactively Implement Improvements to Keep our Patients Safe

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will ensure that all abnormal results are viewed and acted within seven days of receipt of test.	Partially achieved	ICE filing processes are now embedded, however we are not achieving targets for filing of abnormal results. At the time of the report the compliance of viewing and acting on abnormal results within seven days of receipt of test was: CBU1 62% CBU2 23% (This is recorded on the CBU2 risk register) CBU3 60%.	We will ensure that all abnormal results are viewed and acted within seven days of receipt of test.

We will ensure 85% completion of D1 discharge summaries within 24 hours of discharge.	Achieved	The Trust has maintained consistently high performance against this target, achieving over 85% throughout 2022-23.	We will ensure 85% completion of D1 discharge summaries within 24 hours of discharge.
We will achieve and sustain 90% trust wide compliance on Perfect Ward pressure ulcer prevention audits.	Partially achieved	This was achieved for six out of twelve months. The remaining six months compliance was between 85% and 90%. The audits are predominantly undertaken by the Tissue Viability Nursing (TVN) team where there have been ongoing vacancies. Over the last three months the practice educators have been supporting the TVN to complete the Tendable audits pressure ulcer prevention audits.	We will achieve and sustain 90% trust wide compliance on Tendable pressure ulcer prevention audits
We will achieve and sustain 90% trust wide compliance on patient's risk level to pressure ulcers being reassessed on transfer to the ward.	Partially achieved	This was achieved for four out of twelve months. The remaining eight months compliance was between 79% and 90%. Feedback is provided at ward level and discussed in the relevant forums. Education is provided by TVN team and practice educators.	We will achieve and sustain 90% trust wide compliance on patient's risk level to pressure ulcers being reassessed on transfer to the ward.
We will ensure that 90% of patients receiving enhanced care will have enhanced care risk assessments completed.	Achieved	The compliance of 90% was achieved for eleven out of twelve months. Compliance in December 2022 was 88%. In December 2022 there were significant operational	We will ensure that 90% of patients receiving enhanced care will have enhanced care risk assessments completed.

		pressures with many wards caring for additional patients.	
We will achieve 90% trust wide compliance on Perfect Ward falls prevention intervention audits.	Achieved	The trust achieved at least 95% compliance throughout 2022-23.	We will achieve 90% trust wide compliance on Tendable falls prevention intervention audits.
We will ensure that 90% of patients over 65 years have a lying and standing BP recorded within 24 hours of admission.	Partially achieved	The compliance of 90% was achieved for two out of twelve months. The remaining eight months compliance was between 79% and 90%. Staff education on the importance of why lying and standing BP is required, clinical conditions where a drop in BP may be seen and how it can reduce the risk of falls continues.	We will ensure that 90% of patients over 65 years have a lying and standing BP recorded within 24 hours of admission.
The threshold for 2022-23 is 34 cases of CDI. CDI reduction actions will form part of the Trust's infection prevention and control (IPC) annual programme of work.	Not achieved	Despite achieving identified actions, the Trust failed to meet the threshold. The Trust sought advice from the regional infection prevention and control team and the regional antimicrobial stewardship lead. No additional actions were identified.	The Trust will continue to strive to meet the thresholds set by NHSE using the post infection review process and benchmarking with other trusts to identify possible work streams The threshold for 2023-24 has not yet been confirmed.
We will continue to embed IPC practices to minimise MRSA bloodstream infections.	Not achieved	Despite achieving identified actions, the Trust failed to meet the threshold. Post infection reviews did not identify any additional learning.	The provisional target 2023-24 is zero. The reduction of MRSA bacteraemia will form part of the Trust's annual infection prevention and control plan.

Data source: local Trust data source, 2022-23.

3.2.3 Prevent Avoidable Patient Deterioration

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will demonstrate 90% of patients with acute kidney injury (AKI) have their AKI status documented as part of their care records.	Achieved	One hundred percent of patients AKI status documented via CareFlow Vitals.	We will continue to demonstrate 90% of patients with AKI have their AKI status documented as part of their care records.
We will demonstrate that pharmacy are made aware of 90% of patients who have AKI alerts to inform medication reviews.	Achieved	CareFlow Vitals is utilised by pharmacy to inform medication reviews with AKI alerts.	There is no indicator for 2023-24 as pharmacy are working towards having the AKI status incorporated into the pharmacy patient prioritisation dashboard.
We will reduce the physical and emotional side effects of sepsis by ensuring that 90% or more of patients found to have suspected sepsis through screening receive antibiotics within one hour of diagnosis in the ED and acute inpatient settings.	Partially achieved	Compliance with 90% or more of patients found to have suspected sepsis through screening receiving antibiotics within one hour of diagnosis in the ED and acute inpatient settings have been reported for; Quarter 4 2022-23 as: - Trust – 90.22% - Inpatients – 92.86% - ED – 87.93% (This is recorded on the CBU1 risk register).	We will reduce the physical and emotional side effects of sepsis by ensuring that 90% or more of patients found to have suspected sepsis through screening receive antibiotics within one hour of diagnosis in the ED and acute inpatient settings.
We will demonstrate 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18 years and over, have a NEWS2 score, time of escalation and time of clinical response recorded*.	Achieved	An average of 94.64% compliance of unplanned admissions from non-critical wards to intensive care had been appropriately managed in the previous 24 hours with recording of	We will achieve 30% of all unplanned critical care unit admissions (of patients aged 18 years and over) from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and

*(excludes pregnant women and end of life patients).		NEWS2, escalation and response was achieved throughout 2022-23.	response times recorded in clinical notes*. *(exclusion criteria applies).

Data source: local Trust data source, 2022-23.

Goal 3

3.3 We will provide patient centred services

3.3.1 Compassionate, Dignified and Respectful Care

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will continue to focus on targeted recruitment of Enhanced Support Volunteer (ESVs) for areas identified as needing this support.	Partially achieved	Recruitment to the new ESV role continues with 50 ESVs now in active volunteering work across 13 of a potential 18 inpatient ward areas and the Emergency Department. Recruitment to the ESV role continues.	We will continue to focus on targeted recruitment of ESVs with a focus on areas identified as needing this support but who don't currently have ESVs assigned.
We will continue to work through the End of Life Care steering group and through education to support earlier recognition of patients in the last hours or days of life. The national audit will be repeated in 2022-23.	Partially achieved	The latest National Audit of End of Life Care (NACEL) identifies that the Trust recognises patients in the last hours or days of life later than the national average. There are numerous work streams in place looking at advanced care	We will continue to work through the End of Life Care steering group and through education to ensure that the advanced care planning needs of patients needs are understood and addressed.

		planning as a way of addressing individual patients needs earlier. Education remains an ongoing priority to the End of Life Care steering group, by examining the barriers to both earlier identification and My Care Planning completion. A multifaceted approach to awareness and education continues.	The national audit will be repeated in 2023-24.
We will ensure that bereaved relatives views are sought to enhance the national audit of care at the end of life through the work of the End of Life Care steering group.	Partially achieved	The NACEL audit continues to identify the need to seek the views of bereaved families and loved ones. The Trust recognises that this is an essential part of understanding future concerns and compliments, to enable improvements to take place.	The End of Life Care steering group will continue to discuss the themes and views of those closest to the deceased to assist us in our action plan for 2023-24 requirements.
We will work collaboratively with other healthcare professionals to provide a supportive non-judgemental confidential listening ear to all, and support any pastoral, spiritual or religious needs to all in our care.	Achieved	Chaplains are trained and have interpersonal skills and pastoral analysis offering professionals as a resource to deepen understanding about the pastoral, spiritual and religious needs of the health care population. The Trust's hospital chaplains are available Monday to Friday between 09:00 and 17:00 hours. Wherever possible, patients should have access to a chaplain of their religion	We will continue to ensure that all people, be they religious or not, have the opportunity to access pastoral, spiritual or religious support when they need it during their inpatient stay.

		or belief to ensure appropriate pastoral, spiritual or religious care.	
We will work with clinical teams to provide appropriate referrals to the Chaplaincy team in a timely manner.	Partially achieved	Work has been undertaken to support clinical teams to make timely referrals to the chaplaincy team for pastoral, spiritual or religious support as required both on hospital admission and throughout the inpatient hospital stay.	We will continue to demonstrate proactive engagement with staff and continue to deliver Spiritual Assessment Training ensuring staff awareness of how to access chaplaincy services which includes the availability of non-religious pastoral and spiritual support.
We will continue to provide pastoral and spiritual care to persons throughout times of personal crisis, whether it be due to injury, illness, life changes, or other areas of distress.	Achieved	Pastoral, spiritual and religious care is provided in the context of illness which addresses the expressed spiritual, pastoral and religious needs of patients, staff and service users. These needs are likely to include • ways to support recovery • issues concerning mortality • religious convictions, rituals and practices • non-religious convictions and practices • relationships of significance • a sense of the sacred • exploration of beliefs	We will continue to provide pastoral and spiritual care to all individuals requesting support throughout times of personal crisis, whether it be due to injury, illness, life changes, or other areas of distress.
We will continue to support or facilitate requests for any particular religious ceremonies such as blessing and baptism, Holy Communion, anointing of the sick, last rites and blessing at	Achieved	Throughout 2022-23 we have been able to meet 100% of requests for religious ceremonies or blessings.	We will continue to identify and support request for any religious ceremony or blessing where appropriate.

marriage ceremonies during critical times.			
We will continue to identify patients' beliefs, practices, and values, through spiritual screening, communicate them to the rest of the team, and seek ways to respect and integrate those beliefs and practices into how the person is cared for.	Achieved	The hospital chaplaincy multi-faith team has met all requests for support related to any particular religion or belief.	We will continue to work collaboratively with staff to ensure that information pertaining to patients' beliefs, practices and values is identified on admission to hospital.

Data source: local Trust data source, 2022-23.

3.3.2 Engagement in the Delivery of Care, Design and Re-design

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will ensure that the patient engagement and involvement toolkit is available to support the delivery of care, design and re-design workstreams.	Achieved	The patient engagement and involvement toolkit has been developed and distributed trustwide. Patient engagement activity within the Trust has increased.	We will ensure that patient engagement and involvement is considered at the start of any improvement, design and re-design activity within the Trust.
We will continue to demonstrate proactive engagement with service users' carers in the delivery of all future service design and re-design.	Achieved	Links have been established with Barnsley Carers, BIADS (Barnsley Independent Alzheimer's and Dementia Support Group) Talkin Tarn (SEND and Autism), Cloverleaf (self-advocacy group for adults living with a learning disability, autism or both), Barnsley Beacon (support for carers who support people with substance misuse, disabilities, mental health, dementia, or who are elderly), DIAL	We will continue to engage with patients and service users when co-designing pathways, services and environmental changes which will include priorities in the health inequalities action plan.

		(supporting people with learning disabilities, their family and carers) and the Mental Health Forum. These links have been utilised for service user engagement in trustwide service design and redesign.	
We will continue to recruit to the Patient Panel to ensure that each relevant service is appropriately represented.	Partially achieved	We continue to promote recruitment to the Patient Panel via our social media and membership channels.	We will continue to recruit to the Patient Panel and utilise the diversity panel to ensure that each relevant service is appropriately represented.

Data source: local Trust data source, 2022-23.

3.3.3 Customer Service Mind-Set

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will introduce methods for key staff and managers to actively view feedback and be reactive to concerns raised in real-time.	Partially achieved	SMS has been rolled out across inpatient services and the Emergency Department for FFT Test feedback. Dashboards to highlight themes or concerns and facilitate real time patient feedback have not yet been developed to within this information. There remains a requirement to roll out SMS supporting FFT in maternity, children's services and outpatients is yet to be rolled out.	We will introduce tools supporting real time patient feedback.
We will continue to demonstrate and broaden the scope of our response to	Achieved	Links have been established across a wide range of Carer Forums. A	We will continue to demonstrate and broaden the scope of our response

feedback from patients, families and carers through collaborative focussed improvement working.		'Hearing the Voice' event took place in November 2022 to understand the challenges faced when those caring for someone living with dementia bring them in to the hospital setting.	to feedback from patients, families and carers through collaborative focussed improvement working and to embed the Always Events identified through service user feedback and engagement. We will implement a local care partner policy and charter.
We will ensure that 100% of patients, families and carers are offered feedback on the implementation of the improvements identified in serious incident investigations from quarter three 2022-23.	Achieved	One hundred percent of patients, families and carers have been offered feedback on the implementation of the improvements identified in serious incident investigations from quarter three 2022-23	We will ensure that 100% of patients, families and carers are offered feedback on the implementation of the improvements identified in serious incident investigations.
We will ensure that feedback is offered for 100% of high risk, upheld complaints from quarter three 2022-23.	Achieved	In 2022-23 there were no high risk upheld complaints.	We will ensure that feedback is offered for 100% of high risk, upheld complaints.

Data source: local Trust data source, 2022-23.

Goal 4

3.4 We will have a culture of improvement

3.4.1 We Will Build Improvement Capability Across the Trust

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will have delivered the Proud to Improve Introduction to QI training module to 70% of all staff by April 2023.	Partially achieved	As at 31 March 2023 QI introduction training compliance was 66.7%. The target was on track at the end of quarter three 2022-23. Staff turnover has resulted in the reduction of compliance. On average 61 members of staff complete the introduction training each month. An average of 38 staff who have completed the training leave the organisation each month.	We will have delivered the Proud to Improve Introduction to QI training module to 75% of all staff by April 2024.
We will keep an inventory of improvement work and make it accessible across the organisation.	Achieved	An inventory of all proposed, ongoing and closed QI project work is available on the QI intranet page.	We will keep an inventory of improvement work, make it accessible across the organisation and link the projects to the Trust objectives.
We will provide accreditation to staff who are actively involved in the progression or completion of improvement work using our improvement framework.	Achieved	QI pin badges are awarded to staff along with information placed on our hall of fame, which is accessible via the QI intranet page.	No indicator for 2023-24.

Data source: local Trust data source, 2022-23.

3.4.2 We Will Ensure Staff Recognise the Importance of Patient and Public Representation in our Improvement Endeavours

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will build patient engagement into all patient pathway improvement projects.	Achieved	The importance of patient and public representation within improvement work continues to be covered in all levels of training and as part of the support for QI projects.	We will continue to build patient engagement into all patient pathway improvement projects.
We will engage with patients and/or the public during our Proud To Improve journey.	Achieved	The team has the support of a QI volunteer who has actively supported teams with their patient and/or public engagement during their improvement work.	We will provide service user quality improvement training from 2024.
We will seek out potential external partners and work with them to update and consolidate the use of patient partners in improvement methodology.	Achieved	The team continue to work with NHSE, the Improvement Academy and are part of an Integrated Care Board (ICB) QI Improvement Network	No indicator for 2023-24.

Data source: local Trust data source, 2022-23.

3.4.3 Innovation

Indicator	2022-23 achievement	Highlights and exceptions	Proposed 2023-24 indicator
We will continue to increase the number of innovations implemented by the Trust.	Partially achieved	In 2022-23 an unmet needs exercise was completed which resulted in 14 areas to review.	We will repeat the unmet needs exercise and continue to increase the number of innovations implemented by the Trust.
We will seek to ensure continued engagement and implementation with	Achieved	The Trust meets monthly with the AHSN and have forged relationships with P4SY. A for reviewing	We will seek to ensure continued engagement and implementation

the annual MedTech funded developments through the AHSN.		proposed innovations has been developed. The Trust has also formed links with other organisations in the region to share how they are considering innovation.	with the annual MedTech funded developments through the AHSN.
We will report on findings where we have implemented change as a result of research development.	Achieved	The progress in relation to innovation at the Trust is reported via the senior leaders meeting.	We will report on findings where we have implemented change as a result of research development.

Data source: local Trust data source, 2022-23.

Performance against national indicators 2022-23

The Trust aims to meet all national indicators. We have provided an overview of the national indicators and minimum standards including those set out within the NHS Improvement indicators framework below. Further indicators can be found in Section 2 of the Quality Report.

National Indicator	BHNFT 2020-21	BHNFT 2021-22	BHNFT 2022-23	National Target 2022-23
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	64.25%	71.2%	64.30%	-
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	92.56%	93.4%	83.14%	-
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	71.20%	85.8%	79.70%	-
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	84.6%	68.7%	61.80%	95%
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	80.9%	74.6%	67.1%	85%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	76.6%	83.7%	82.0%	90%
All cancers: 31-day wait from diagnosis to first treatment	98.3%	95.7%	93.7%	96%
Cancer: two week wait from referral to date first seen, comprising all urgent referrals (cancer suspected)	96.9%	90.7%	92.6%	93%
Cancer: two week wait from referral to date first seen, comprising for symptomatic breast patients (cancer not initially suspected)	96.7%	79.8%	91.0%	93%
Maximum 6-week wait for diagnostic procedures	52.8%	26.4%	11.1%	1%
Clostridium (C.) difficile – variance from plan	26	32	42	-

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Barnsley Healthwatch comments on BHNFT Quality Report 2022-23

Thank you for giving Healthwatch Barnsley the opportunity to comment on your Quality Report for 2022-23.

We are very pleased to see the improvements on quality and safety you have achieved this year. This was all the more remarkable considering all the pressures the hospital was under this year.

We have no specific comments to make on the report this year. We have no intelligence or evidence that provides any concerns about the contents, data or conclusions in this annual Quality Report.

South Yorkshire Integrated Care Board comments on BHNFT Quality Account 2022-23

Re: BHNFT Draft Quality Report 2022/23

Thank you for giving us the opportunity to review and comment on the draft Barnsley Hospital NHS Foundation Trust's (BHNFT) Quality Report 2022/23.

General Comments

The Integrated Care Board (ICB) welcomes this report which demonstrates Barnsley Hospital NHS Foundation Trust's ongoing commitment to quality improvement and addressing key issues.

The Report provides a detailed account of BHNFT's activities in 2022/23. Overall, the document provides a fair reflection of the quality of services provided by BHNFT and clearly demonstrates the Trust's commitment to quality and patient safety.

The Quality Report includes all essential elements and covers the formal requirements for quality accounts. To the best of my knowledge, the report is factually correct.

We noted the improvements made to data quality and the commitment to undertake national clinical audits, national confidential enquiries, and audits.

Priorities

We consider that the priorities that BHNFT has identified are appropriate areas to target for continued improvement.

We would like to see continued focus on reducing preventable harm and safe staffing levels.

Overall, we welcome the Trust's 2022/23 Quality Report and look forward to another year of working together to improve the quality of services provided to Barnsley patients.

BHNFT Council of Governors comments on BHNFT Quality Account 2022-23

The Council of Governors have considered the Trust’s draft Quality Report for 2022-23. Overall, we believe it fairly reflects the Trust's position over the period.

Overview and Scrutiny Committee comments on BHNFT Quality Account 2022-23

The Committee would like to thank Barnsley Hospital NHS Foundation Trust for the services they have provided to the residents of Barnsley during 2022-23, and for the opportunity to contribute to the Quality Account for this year.

Priorities 2022-24

The Committee are satisfied that the priorities cover the expected four areas of:

- Clinical Effectiveness
- Patient Safety
- Patient Experience
- Quality Improvement

Whilst the Committee commends the Trust for the great deal of progress made against its goals for 2022-23 to ensure that residents are cared for, safe, and involved in shaping service delivery, it has noted that some elements are still outstanding and the Committee expect that rapid progress will be made against these, particularly those relating to safe care such as fall and pressure damage prevention and hospital-acquired infections. The Committee will be interested to see how the improvement work for the coming year impacts upon the year-end performance metrics for 2023-24.

The Committee is pleased to see that the Trust has identified ways to improve outcomes and the experience for patients undergoing total knee and hip replacements, particularly striving to improve the oxford scores for patient's activities of daily living.

The expectation that 90% of patients over 65 have a lying and standing blood pressure recorded within 24 hours of admission was only achieved for two out of the 12 months. Once the importance of this and the associated implications have been embedded within practices, we would hope that this target is achieved for all twelve months in 2023-24, particularly as it was identified as a theme from a serious incident investigation as outlined in the Quality Account.

Given that there is an expectation that all abnormal results are viewed and acted upon within seven days of a test, it is concerning that only 23% of these are being achieved by CBU2 and although this is recorded on the risk register, the Committee would like assurances that work is being done to understand and address the reasons for poor performance in this area.

Despite COVID-19 having a detrimental impact upon the maximum 6-week wait for diagnostic procedures, it seems that great inroads have been made into improving performance in this area. The Committee would assume that this has been aided by

the introduction of the Community Diagnostic Centre in the Glass Works and hopes that the facility continues to prove successful in supporting a further reduction in wait times in the coming year.

There has been a substantial drop in performance for the 62 day wait for first treatment from urgent GP referral for all suspected cancer, particularly when compared to referrals from the NHS Cancer Screening Service, which remains much higher despite a nominal variance in expectations. The committee would be very much interested to understand how these pathways vary, why there is such a variance between the two, and what can be done to improve performance for GP referrals.

Important Omissions

There does not appear to be any important information missing from the report.

Patient & Public Engagement

The Trust continues to engage with a wide variety of service users and carers which seems to have played a significant part in the delivery of care, design and re-design of a number of service developments throughout 2022-23. As with all areas within the NHS, the Committee would like to the Trust to continue to be mindful that patient engagement must be of sufficient quality and quantity to ensure that it is fully representative of the communities that it serves.

Work of the Overview & Scrutiny Committee (OSC) in 2022-23

In April 2023, the OSC looked at the work of the Hospice and palliative/end of life care. The Committee will watch with interest the progress made in the coming year by the Trust to support earlier recognition of patients in the last hours or days of life and would hope that the next National Audit of End of Life Care (NACEL) shows an improved picture when compared to the national average.

The Trust have attended as witnesses at the following Overview & Scrutiny Committee sessions during 2022-23:

- Barnsley Safeguarding Adults Board Annual Report 2021-22
- Barnsley Safeguarding Children's Partnership Annual Report 2021-22
- Progress on the Development of Integrated Care in Barnsley
- Access to Primary Care

In addition, the Chair of the Committee regularly meets with the Chief of Delivery and Deputy Chief Executive Officer of the Trust and will continue to do so in the coming year to discuss matters of mutual concern and seek assurances as outlined above.

The Committee would like to thank the Trust for their contribution to their work and look forward to working together again during the 2023-24 municipal year.

Part 4: Glossary

Acute Kidney Injury (AKI)	AKI has now replaced the term acute renal failure. AKI is characterised by a rapid reduction in kidney function.
Antimicrobial Stewardship	Systems and processes for effective antimicrobial medicine use.
Avoidable Harm	A harm occurring to a patient which could have been prevented.
Bluespier	The electronic database used in operating theatres.
CareFlow Vitals	An electronic system used in the Trust to record a variety of patient observations and assessments.
Care Plans	A document which records the outcomes from a care planning discussion, including any actions agreed.
Care Quality Commission (CQC)	The independent regulator of all health and social care services in England.
Clostridium Difficile (C.difficile)	A type of bacterial infection that can affect the digestive system.
Clinical Business Unit (CBU)	A clinical unit responsible for the day to day management and delivery of services within their area of responsibility.
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.
Commissioning for Quality and Innovation (CQUIN)	The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
Clinical Audit	A process that measures a clinical outcome or a process, against well-defined standards set on the principles of evidence-based medicine in order to identify the changes needed to improve the quality of care.
Council of Governors	An elected group of local people who are responsible for helping to set the direction and shape the future of the Trust.

D1 Discharge Summary	A summary provided to the patient and their GP on discharge from an inpatient stay
Data Quality Maturity Index (DQMI)	The DQMI is a monthly publication about data quality in the NHS, which provides data submitters with timely and transparent information.
Datix	A web-based incident reporting and risk management software system used by the Trust.
Emergency Care Data Set (ECDS)	The national data set for urgent and emergency care.
Enhanced Recovery Pathway (ERP)	A pathway of recovery that is evidence-based and helps people recover more quickly after having major surgery.
Enhanced Support Volunteer	Ward based volunteer providing an enhanced level of support to patients and families
Getting It Right First Time (GIRFT)	A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.
Governance Structures	The systems and processes by which the Trust, directs and controls their functions, in order to achieve organisational objectives.
High Volume Low Complexity (HVLC) Programme	An initiative launched in the NHS in 2021 and designed to help drive down waiting lists for elective surgery led by the GIRFT team.
Hospital Episode Statistics (HES)	A data warehouse containing details of all admissions, outpatient appointments and Emergency Department attendances at NHS hospitals in England.
Hospital Standardised Mortality Ratios (HSMR)	The HSMR measures whether or not the mortality rate at the hospital is higher or lower than expected. A measure that is too high or too low would warrant further investigation.
Human Factors (HF)	Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.
ICE	ICE is the software system used within the Trust for reporting most test results.

Improvement Academy	The Improvement Academy was established in 2013 as part of the Bradford Institute for Health Research to support innovation and improvement in delivery of health care services.
Information Governance	The way in which the NHS handles all of its information, in particular the personal and sensitive information relating to patients and employees.
Integrated Care Board (ICB)	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
Integrated Performance Report (IPR)	A single report which provides information on quality and performance data to the Trust Board.
Learning Disabilities Mortality Review (LeDeR) Programme	A programme set up as a service improvement programme to look at why people with a learning disability are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities.
Medical Examiner (ME)	Senior medical doctors that are trained in the legal and clinical elements of death certification processes.
Methicillin-Resistant Staphylococcus Aureus bacteraemia cases (MRSA)	A type of bacterial infection that is resistant to a number of widely used antibiotics.
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	A set of national clinical audits, registries and outcome review programmes which measure healthcare practice on specific conditions against accepted standards.
NEWS2	NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness. It is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness.
NHS England (NHSE)	NHSE leads the National Health Service (NHS) in England. They set the priorities and direction of the

	NHS and encourage and inform the national debate to improve health and care.
NHS Friends and Family Test (FFT)	An important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
NHS Improvement (NHSI)	Responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NHS Digital	The national information and technology partner to the health and social care system using digital technology to transform the NHS and social care.
NHS Outcomes Framework	Sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in health outcomes.
NHS Staff Survey	Each year NHS staff are offered the opportunity to give their views on the range of their experience at work.
National Institute of Health and Care Excellence (NICE)	NICE's role is to improve outcomes for people using the NHS and other public health and social care services by developing, producing and providing a range of information in the form of various guidance documents.
Patient Safety Incident Response Framework (PSIRF)	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Payment by Results (PbR)	Payment by Results (PbR) is the payment system for treatment within the NHS in England.
Precision Medicine Accelerator South Yorkshire (P4SY)	A programme supporting up to 50 companies in the South Yorkshire region focusing on bringing UK health and medtech companies to market.
Pressure Ulcers	A type of injury that breaks down the skin and underlying tissue. Caused when an area of skin is placed under pressure.
Palliative Care	A multidisciplinary approach to specialised care for people with serious illnesses. It focuses on providing

	patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness, whatever the diagnosis.
Patient Reported Outcome Measures (PROMs)	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.
Perfect Ward (now Tendable)	A smartphone application for healthcare inspections which assists nursing teams to monitor the quality of care.
Provider	A health care provider is a person or company that provides a health care service.
Quality Improvement	Quality improvement refers to the use of systematic tools and methods to continuously improve the quality of care and outcomes for patients.
Readmission	Readmission is an episode when a patient who had been discharged from a hospital is admitted again within a specified time interval.
Referral to Treatment (RTT)	In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.
Root Cause Analysis (RCA)	A method of problem solving used for identifying the root causes of faults or problems.
Secondary Uses Service (SUS)	The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
Sentinel Stroke National Audit Programme (SSNAP)	The single source of stroke data in England, Wales and Northern Ireland.
Sepsis	A potentially life-threatening condition triggered by an infection.
Serious Incident	An incident where one or more patients, staff members, visitors or members of the public experience serious or permanent harm, alleged abuse or where a service provision is threatened.

Stakeholders	A person, group or organisation that has interest or concern in the Trust.
Structured Judgement Review (SJR)	A process to effectively review the care received by patients who have died. It also aims to improve learning and understanding about problems and processes in healthcare that are associated with mortality and share best practice.
Surgical Site Infection (SSI)	A type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure.
Summary Hospital-level Mortality Indicator (SHMI)	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the hospital and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It also includes patients who have died up to 30days after discharge from hospital.
Trust Board	A body of appointed members who are responsible for the day to day management of the hospital and is accountable for the operational delivery of services, targets and performance.
Venous Thromboembolism (VTE)	A collective term for both deep vein thrombosis (DVT) and pulmonary embolism (PE).
Yorkshire and Humber Academic Health Science Network	One of 15 innovative networks established by NHS England to transform healthcare by ensuring new technologies and services reach the clinic quicker and faster.

Appendix A – Examples of actions agreed following the review of national audit results at BHNFT.

Project title: 1918 National Pregnancy in Diabetes (NPID)	
Purpose	This project measures the quality of care and pregnancy outcomes for women with pre-gestational diabetes who are pregnant.
Performance	A total of 60 women were included for those that were diagnosed with pre-gestational diabetes that are pregnant and deliver their babies from the 1 January 2018 to the 31 December 2020. Our hospital is above the national and regional average for four of the five national standards measured: • Glucose control in early pregnancy • Glucose control in the third trimester • Folic acid supplementation prior to pregnancy • Babies admitted to a neonatal care unit
Reviewed by	Women's Business and Governance Group on the 21 October 2022 CBU3 Business and Governance Group on the 30 November 2022
Actions	• Work is to be undertaken with colleagues in Primary Care and the Diabetes Clinic to ensure that pre-conception and first trimester care information is standardised and appropriately provided in order to provide the best service for our patients. The Specialist Lead Midwife for Diabetes will continue to develop a relationship with the ICB and the Best Start Partnership in order to emphasise and to promote the importance of pre-conceptual care for women with diabetes. • The Specialist Lead Midwife for Diabetes will continue to work with the community midwife team, GPs and support workers in order to support a more rapid/effective referral for confirmation of pregnancy. • To ensure multidisciplinary team involvement/working between maternity and the diabetes service (including endocrinologists), the relevant Service Managers will support the development of regular meetings with maternity and diabetes service health professional in order to drive improvements for patients to attend endocrinology and obstetric reviews in early pregnancy. • Specialist Lead Midwife for Diabetes to continue to review women and babies postnatally to ensure appropriate management to prevent neonatal hypoglycaemia.

Project title: 1922 National Neonatal Audit Programme (NNAP)	
Purpose	The purpose of the audit is to assess whether babies admitted to neonatal units (NNU) receive consistent high-quality care in relation to the NNAP audit standards of care and to identify areas for improvement in relation to the delivery and outcomes of care.
Performance	Overall local performance against the standards measured by NNAP and shows improvements in nine out of the ten measurable standards, compared to the previous year's data. The hospital performs above national cumulative results on: antenatal magnesium sulphate, deferred cord clamping, consultation with parents, screening for retinopathy of prematurity (ROP), and follow-up at two years of age. The hospital is also almost in line with the national average for: antenatal steroids, temperature on admission and parents present for ward rounds. Nationally there is further work and improvements required against the standard around babies having breast milk on discharge. Our unit has been successful in securing funding from the United Nations Children's Fund (UNICEF) and are now working towards the Neonatal Baby Friendly Initiative (BFI) accreditation (over the next three years). The NNU team strongly believe, this will have a positive impact on our breast milk rates.
Reviewed by	Paediatric Business and Governance Group on the 9 September 2022 CBU3 Business and Governance Group on the 30 November 2022
Actions	• Continue staff education, including simulations and posters to prompt and remind the Neonatal, Midwifery and Obstetric staff to practice deferred cord clamping. • Continue to educate staff on the importance of the normothermic temperature, by utilising safety huddles, and ward meetings to escalate any learning from admissions. • Ensure all medical trainees have an update on aseptic none touch technique as part of their Barnsley Hospital Induction. • Continue to deliver the bespoke infant feeding training package for all nursing/midwifery staff. • Develop bespoke neonatal infant feeding training for staff with the awarded funding supported from UNICEF (to gain the neonatal BFI standards).

Project title: 2427 Cirrhosis and fibrosis tests for alcohol dependent patients (CQUIN 2022-23 CCG9 Q3)	
Purpose	The aim of this project is to increase the number of patients, aged 16+ admitted for at least a one-night stay with a primary or secondary diagnosis of alcohol dependence, to have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis. This project supported the 2022-23 CQUIN scheme as a quality improvement goal. The purpose is to promote continuous quality improvement and to deliver better outcomes for patients. target is for 35% of all unique inpatients
Performance	Current quarter four compliance is running at 75% from a baseline of 3% in quarter one. Following facilitation of a pathway review, a referral document was introduced into the pathway. This document now records referrals in the patients' notes and raised awareness of the standard with the Alcohol Care Team. To improve the results further, the following actions were undertaken by the Alcohol Care Team: • Fibroscan has been added to the Alcohol Care Team paperwork • The team received daily reminders via email to refer included patients for Fibroscan • Communicated the referral process to all staff to highlight the importance of making the referrals.
Reviewed by	CBU 1 Overarching Group on the 24 March 2023
Actions	To continue to review compliance to identify any areas for improvement

Project title: 1727/1977 Intensive Care National Audit and Research Centre Case Mix Programme (ICNARC)	
Purpose	ICNARC's aim is to foster improvements in organisations and practice of adult critical care (intensive and high dependency care) to improve patient care and outcomes. ICNARC reviews the care and outcomes of all patients who were admitted to critical care. This data period included the 1 April 2019 to the 31 March 2021.
Performance	There are 11 measures used in the audit. In the first 12 months of data collected and analysed, the hospital achieved compliance within the expected range against eight of the eleven measures. There were three measures shown to be outside the expected range: • non-clinical transfers to another unit, • risk-adjusted acute hospital mortality, and • risk-adjusted acute hospital mortality - predicted risk < 20%. The report for this time period was drawn up from the start of the COVID-19 pandemic and during that period the department experienced extreme bed pressures with very sick patients. This was a national theme, affected mortality rates and increased the need to transfer patients out to other hospitals. In the 2020-21 data period, all eleven measures achieved compliance within the expected range and this indicates that the hospital had adjusted to the pressures of the COVID-19 pandemic ensuring that patients were offered high quality care.
Reviewed by	Anaesthetics and Critical Care Governance Group on the 21 April 2022
Actions	As the hospital is achieving compliance against all measures, no additional recommendations and actions were required following the 2020-21 data results. However, our hospital continues to participate in this audit to review the care and outcomes for these patients.

Project title: 2252 National Audit of Breast Cancer in Older Patients (NABCOP)	
Purpose	This project evaluates the quality of care provided to women aged 50 and over by NHS breast cancer services in England and Wales. It does this by using existing sources of patient data collected by national organisations, such as the National Cancer Registrations and Analysis Service (NCRAS) in England.
Performance	Women diagnosed with breast cancer from the 1 January to the 31 December 2019 were included in the audit. The hospital performs in line with or above the national average for 19 of the 23 measures. Further review is required for the following four measures to ensure that we are achieving the same high standards for these groups. There were also 18 new measures included for this data period. Our hospital's outcomes compared similar to, or better than, national average for all measures except for endocrine therapy (ET) recorded from 2014-19 for women with estrogen receptor (ER) positive invasive breast cancer. This is recorded well on the Primary Care Prescription Database (PCPD) but not on the Cancer Outcomes and Services Dataset (COSD). Whilst our hospital performs, well actions have been agreed to identify any areas where further improvements can be made.
Reviewed by	Breast Steering Group on the 20 October 2022 CBU2 Overarching Governance Group on the 25 January 2023 Cancer Performance and Improvement Group on the 9 February 2023
Actions	• Carry out an audit to identify any areas where improvements can be made to reduce the number of re-operations. (Audit 2607 complete, no concerns identified). • Contact the data warehouse developer to discuss the data for recorded recurrence and data available on the COSD.

Project title: Audit ID 2212: National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (Year 4)	
Purpose	The aim of this project is to assess the provision, impact and outcome of care for people with Early Inflammatory Arthritis (EIA). The project determines whether the care provided is consistent with current recommended best practice defined by NICE Quality Standard 33; Rheumatoid Arthritis in over 16s. It provides information with a view of improving quality of care, service delivery and outcomes.
Performance	The NEIAA published the fourth annual report in October 2022 and focussed on data collected from the 1 April 2021 to the 31 March 2022. Data collection was suspended by the Healthcare Quality Improvement Partnership (HQIP) across national audit programmes at the start of the pandemic in March 2020 and was reinstated in May 2021. Overall the hospital results are encouraging and practice is in line with national results. It is fair to note the increase in compliance for Quality Statement two; assessment delays. as in 2020 our hospital received an outlier notification due to patients not being seen within three weeks of referral. At that time our hospital's performance was 39% however with the introduction of a number of new processes and efforts by the Rheumatology Departments efforts to improve compliance, the results for this standard has improved significantly to 78.7% against the national average of 42%. Work continues to ensure patients with a diagnosis of Rheumatoid Arthritis (RA) pattern EIA are established on a DMARD within six weeks of referral by monitoring the patients journey closely.
Reviewed by	Rheumatology Sub-Specialty Meeting on the 24 March 2023
Actions	• All Rheumatologists to undertake timely vetting of all referrals of suspected EIA • Additional DMARD nurse clinic slots are to be scheduled • Local data validation to be undertaken around standard 7; annual reports

Project title: Round 3 National audit of Care at the End of Life (NACEL)	
Purpose	The aim of the audit is to improve the quality of care of people at the end of their life in acute hospitals
Performance	This project was initially planned to take place in 2020 but, due to the pandemic, was postponed until late 2021. Overall our hospital achieved above the national summary score in eight of the key themes. The results showed that we are good at communicating with patients and their families and involving them in decision making. Areas for further improvement were around the recognition of possible imminent death with the hospital achieving 77.5% against the national standard of 87.1% and staff support of which we achieved a summary score of 6.2 against a national summary score of 6.4.
Reviewed by	End of Life Steering Group on the 19 April 2022 and the 21 June 2022 Clinical Effectiveness Group on the 17 August 2022
Actions	• Education and training to be provided to all appropriate staff regarding end of life care and communication skills to ensure patients are recognised as dying as early as possible allowing them to be fully informed and involved in their own care going forward. • My Care Plan to be amended to record discussions relating to side effects of medication, for example, drowsiness • Promote awareness of the importance of participating in the staff reported measure to enable to the Trust to have greater understanding of staff needs when caring for patients and their loved ones at the end of life.

Appendix B - Examples of actions agreed following the review of local audit results at BHNFT.

Project title: 2117 Fetal Monitoring	
Purpose	The national report Saving Babies Lives version two highlights the need for improvements in the management of fetal monitoring, in particular: • The risk assessment undertaken when deciding which form of fetal monitoring to use in labour • Hourly fresh eyes when a patient is on a cardiotocograph (CTG) in labour. This involves the interpretation/review of the tracing by more than one person and should be performed every hour by someone other than the midwife giving ongoing care and undertaking the hourly assessment. • Correct recorded assessment and categorisation of a CTG • Correct recorded escalation and management of care in labour of a suspicious/pathological CTG All these factors can impact on the morbidity and mortality of the newborn and mother.
Performance	The audit results demonstrate excellent compliance against the four standards measured with a high number of patients' risk assessed appropriately and monitored closely during their labour. Results: Appropriate risk assessment performed 97% Hourly Fresh Eyes approach undertaken 81.5% Appropriate classification documented 83% Patients appropriately escalated 93% Three out of the 30 babies reviewed were admitted to the Neonatal Unit (NNU) requiring a period of extra care and are doing well.
Reviewed by	Women's Business and Governance Group on the 18 March 2022 CBU3 Business and Governance Group on the 30 March 2022
Actions	• Embed the new guideline utilising the new classification stickers in practice in order to improve compliance with correct classification, fresh eyes and escalation. • Ensure that women are provided with up to date information regarding options for fetal monitoring. • Ensure that the results and learning from this audit are shared at all appropriate forums.

Project title: 2101 Medical Management of Ectopic/Unknown pregnancy with Methotrexate	
Purpose	The purpose of the re-audit is to ensure the Royal College of Obstetrics and Gynaecology and NICE guidance is being followed and is effective in practice.
Performance	The results demonstrate that all standards performed well at 75% and above. Compliance shows improvement from a previous audit in three standards measured: • Third beta human chorionic gonadotropin (bHCG) documented as discussed with consultant • Discharge pathway complete • Gynaecology outpatient department (GOPD) follow-up arranged There are no major weaknesses or unmanaged risks identified but further work to improve against three measures will continue: • Documented patient information leaflet (PIL) given to patient • Documented that contraception advice given to patient • GOPD follow-up attended (three patients did not attend their follow up appointment. All three patients had appointments scheduled, however the patients failed to attend) An action plan to drive improvements further has been developed. The training issues, documentation on the patient information leaflet and contraception advice with staff has already been addressed.
Reviewed by	Women's Business and Governance Group on the 20 May 2022 CBU3 Business and Governance Group on the 29 June 2022

Actions	• Further emphasis to be provided during teaching sessions to doctors that patients must be discussed with a consultant after the patient's third bHCG. • Emphasise to staff the importance of providing the patient information leaflet and completing the required documentation when it is given. • Raise with staff the importance of providing contraceptive advice to the patient and completing all the required documentation appropriately. • Ensure that the Trust 'Policy for the Management of Missed Outpatient Appointments and Non-Engagement with Health Professionals, for Adult Patients' is followed in GOPD.
Project title: 2548 Joint Advisory Group (JAG): Gastric Ulcer (April-September 2022)	
Purpose	This project audits the compliance with the standard to re-scope all patients with a gastric ulcer within 12 weeks, unless they have had a clinical review ruling out gastric cancer. This is to ensure there are no unexpected or poor outcomes for patients. The results from this audit is used as evidence and to give assurance for future JAG assessments for accreditation. Accreditation provides independent and impartial recognition that a service demonstrates high levels of quality. This means that patients can feel confident in their endoscopy service and be assured of receiving high quality consistent care.
Performance	Compliance with the standard to rescope patients within 12 weeks following identification of a gastric ulcer has improved significantly from previous audits; 36% (April-September 2020) to 80% (April-September 2022). This improvement follows facilitation of a pathway review and the implementation of changes to improve the systems in the pathway. Although four patients did not have their appointment within the 12 weeks required, two of these patients chose to delay their appointments. Reassuringly there were no adverse outcomes for any of these patients as a result of the delayed appointments.
Reviewed by	Endoscopy User Group on the 20 September 2022
Actions	Ensure all patients requiring rescope have a follow-up procedure booked before leaving the endoscopy department. Email all endoscopists to remind them that it is the scoping clinicians' responsibility to complete a rescope referral for both inpatients and outpatients.
Project title: 2508 Joint Advisory Group (JAG): Small Bowel Capsule Endoscopy (SBCE)	

Purpose	This project audits the effectiveness of the small bowel capsule endoscopy (SBCE) procedure against key indicators. The results from this audit will be used as evidence and to give assurance for future JAG assessments for accreditation.
Performance	The audit demonstrated a safe and effective service is provided to our patients and all minimum targets required by JAG were achieved. The aspirational targets for indications for procedure and capsule retention rate were also achieved. Caecal visualisation/complete small bowel examination was achieved for 94% (132/140) of patients. The minimum target is >80% and the aspirational target is >95%. All patients that had a procedure, which was not completed due to poor caecal visualisation, were offered a repeat procedure if deemed appropriate. There is no risk to having a repeat procedure and no complications were identified during the audit. Capsule retention is a known risk which occurs in 1.7% of all patients. There were no capsules retained during this audit time period.
Reviewed by	Endoscopy User Group on the 14 September 2021.
Actions	To increase Capsule clinics to enable the service to provide more procedures and manage the increased demand of the colon capsule NHS England research programme and to offer the service over five days: • Additional capsule clinics have been scheduled. • A second capsule endoscopy Endoscopy Clinical Nurse Specialist (CNS) has been appointed. • Consultant reading and reporting sessions have been increased to provide a quick turnaround of reporting procedures. • Iron Deficiency Anaemia (DA) clinics moved from morning to afternoon to further support the expansion of the service. • New member of staff on secondment has enabled capsule endoscopy slots to be increased to eight per day.

	Barnsley hospital are providing a small bowel capsule service for Mid Yorkshire and are also accepting referrals from Rotherham Hospital. Improve compliance with the standard for Caecal visualisation/complete small bowel examination. Compliance is excellent (94%) however, this could further improve. A band five nurse will be appointed to assist with the capsules and to provide support calls for patients.
Project title: 2340 Cataract complication rates	
Purpose	This project is an annual review of all cataract surgeries performed at our hospital. It includes all surgeons and reviews individual complication rates. All surgical procedures have recognised complications that are explained and discussed during the consent process. This project reviewed each surgeon and the category of complications rates to ensure that our service is provided safe and effective care.
Performance	A total of 1126 patients attending the hospital for cataract surgery between the 1 January and the 30 September 2021 were reviewed. The overall complication rate was recorded as 0.98%.
Reviewed by	Ophthalmology Governance Group on the 22 September 2022
Actions	To continue to perform annual review of surgical practice, patient care and outcomes.
Project title: ID2608 Annual Do Not Attempt Resuscitation (DNACPR) Audit 2022	
Purpose	The audit determines the level of compliance to the DNACPR policy in terms of the completion of the DNACPR order and if relevant discussions are taking place with the patient and/or relatives. The audit is undertaken on an annual basis and forms part of the hospital's mandatory annual audit programme
Performance	Although the audit offers increased assurance that a DNACPR form is being completed correctly and appropriate discussions documented, we are not fully compliant against all required standards set out in the DNACPR policy. Previous audits have identified where improvements can be made around documenting the decision/discussions and completing the form. All DNACPR decisions and the discussions surrounding them should be clearly documented in the patient's medical notes and re-enforced using the formal completed DNACPR pro-forma.

Reviewed by	Deteriorating Patient Group and Learning from Mortality Group on the 11 January 2023
Actions	• Education and training will continue to be delivered to staff during 2023. • A new process called the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is due to be implemented in March 2023. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. The process is intended to respect both patient preferences and clinical judgement and will eventually replace the DNACPR process. It is anticipated that an audit of both systems will be conducted as part of the 2023-24 audit programme.
Project title: ID 2314: The Management and Treatment of Urinary Tract Infections (UTI) in the Elderly	
Purpose	To determine the adherence to regional guidelines for the diagnosis, management and treatment of UTIs in the elderly.
Performance	The audit demonstrated that the number of patients fulfilling regional guidance for diagnosis of UTI was low and although experiencing no signs or symptoms, 64% of patients were prescribed antibiotics. Regional guidance for the treatment of UTI in the elderly suggests that patients should have two or more symptoms in order to suspect a UTI. Of the thirty patients diagnosed with UTI only 13.3% fulfilled regional criteria for diagnosis. SIGN also advises that a urine sample should be collected for culture and sensitivities in all cases when the diagnosis has been made based on symptoms and signs. Of the cases reviewed, 50% of the patients suspected to have a UTI did not have a urine sample sent for culture and sensitivities. Urine dipsticks should not be used to diagnose UTI in patients over 65 years or catheterised patients, due to frequency of bacteriuria found in these specific groups. On measuring our compliance against this standard it was noted in 33% of cases review a urine dipstick had been used.
Reviewed by	Acute Medical Unit Governance Group on the 20 January 2022 Care of the Elderly Governance Group on the 22 February 2022
Actions	• Further emphasis to be provided during teaching sessions to both nursing and medical staff around awareness of current UTI guidelines • UTI guideline flowcharts to be displayed on wards and included in local induction packs • Link in with the Quality Improvement Team to review potential strategies to help reduce overdiagnosis and overtreatment of a UTI