PROUD to care

NHS
Barnsley Hospital
NHS Foundation Trust

Barnsley Hospital NHS Foundation Trust

Quality Report 2023-2024

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Part 1: Statement on quality from the Chief Executive

Barnsley Hospital NHS Foundation Trust's Quality Report provides details of the Trust's quality improvement journey over 2023-24.

During the reporting year we have been able to celebrate many achievements in the organisations strive to provide the best possible care for patients and service users whilst acknowledging that there are still some areas where focus on continued improvement is required throughout 2024-25. The quality priorities we have focused on during 2023-24 reflect both local and national priorities, recognising our long-term ambition to be an 'outstanding' rated organisation.

Part three of this report shares the outcome of our improvement journey as we end 2023-24 and outlines the next steps we intend to take on our journey to provide the best possible care for the people of Barnsley and beyond at all stages of their lives.

Whilst we have much to celebrate I have selected a few of our key achievements from this past year to share with you:

- Throughout 2023-24 the Trust has continued to actively participate in relevant national clinical audits and national confidential enquiries supporting the originations aim to provide continuous safe and effective care.
- We continue to invest in supporting our clinical research team and the clinical research agenda ensuring the development of staff with research aspirations and interests as well as ensuring patient involvement and patient engagement in our clinical research programmes.
- In April 2023 maternity services were inspected as part of CQC's national maternity inspection programme with a focus on the safe and well-led key questions. The CQC rated safe as requires improvement and well-led as good. The overall rating of good for the Trust stayed the same. Any areas for improvement have been the focus of a detailed monitored action plan.
- By the end of March 2024 78 percent of key staff identified through appropriate role profile had received training in human factors and over 77 percent of all staff had undertaken the Proud to Improve Introduction to Quality Improvement training.
- During 2023-24, 99% compliance was achieved with venous thromboembolism risk assessment in all adult in-patient areas.
- Pressure ulcer and falls prevention audits have demonstrated high levels of compliance throughout the reporting year however, not all of our quality indicators aligned to reducing the risk of inpatients suffering a fall or developing pressure damage were achieved. These will remain a focus

throughout 2024-25 under the leadership of the Director of Nursing, Midwifery and AHPs.

- Over ninety percent of patients found to have suspected sepsis through screening received antibiotics within one hour of diagnosis in the ED and acute in-patient areas.
- Continued focussed recruitment to the role of Enhanced Support Volunteers has ensured that with the exception of three inpatient wards, all areas now have this level of support. Recruitment and development of this role will continue throughout 2024-25.
- Patient engagement is now firmly at the heart of all our improvement, design and re-design activity across the organisation supported by Patient and Carer Experience Leads aligned to each of the three Clinical Business Units.
- During the last six months of 2023-24 the organisation worked closely with NHS England supporting the development of the national Care Partner policy. We are proud to be one of the first organisations to have designed and implemented a local Care Partner Policy and Charter.
- We have proudly been able to ensure that all patients, families and carers have been offered feedback on the implementation of the improvements identified in serious incident and patient safety incident investigations.
- In November 2023 Barnsley Hospital implemented the Patient Safety Incident Response Framework supporting our transition from serious incident investigations to responding to patient safety incidents for the purpose of learning and improving patient safety.

Finally, I would like to acknowledge the work and commitment shown from all our teams and services across the organisation this year. In a climate of continuous NHS pressures and continued demands on hospital services the focus on providing the best and safest care for all has remained. As Chief Executive of Barnsley Hospital NHS Foundation Trust, I am proud of the achievements we continue to make and am proud of the ambition to be the best provider of care to our local community.

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 2023-24. I hope the report provides assurance to those reading it that patient safety, patient experience and quality improvement really are the drivers for all we set out to achieve here at Barnsley Hospital.

R. Jenkins

Dr Richard Jenkins, Chief Executive
Date: 26 June 2024

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

2.1(i) Quality Goals 2023-24 (cross reference to Section 3.0; Other information)

In 2023-24 our priorities for improving quality for our patients fell within the Trust's four core quality goals:

- **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 processes are in place to implement learning to improve care for future patients (see page 33)
- Use intelligence to understand unwarranted variation in outcomes to drive improvements in clinical services (see page 35)
- Implement systems to prevent avoidable harm (see page 36)

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 37)
- Proactively implementing improvements to keep our patients safe (see page 38)
- Preventing avoidable patient deterioration (see page 42)

Patient Experience

Providing patient centred service has to be a priority for Barnsley Hospital. 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 43)
- Ensure the patients voice is represented in the delivery of care, design and re-design (see page 45)
- Will develop a customer service mind-set across the organisation (see page 47)

Quality Improvement

We aspire to drive outstanding care, in collaboration with patients, carers & 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 49)
- Ensuring staff recognise the importance of patient and public representation in our improvement endeavours (see page 50)
- Working to accelerate the use of innovation (see page 51).

2.1 (ii) 2023-24 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 2024-25 indicators are included in the tables in section 3.0 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 2023-24 the Barnsley Hospital NHS Foundation Trust provided and/or sub-contracted 55 relevant health services.

Barnsley Hospital NHS Foundation 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 2023-24 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2023-24.

Information on Participation in Clinical Audits

During 2023-24, 25 national clinical audits and three national confidential enquiries covered relevant health services that the Trust provides.

During that period the Trust participated in 96% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2023-24 are as follows. Please see table 1.0.

The national clinical audits and national confidential enquiries that the Trust participated in during 2023-24 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 2023-24, 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 all national clinical audits were reviewed by the provider in 2023-24 and the Trust intends to take the following actions to improve the quality of healthcare provided. Please see appendix A.

The reports of all local clinical audits were reviewed by the provider in 2023-24 and 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 2023-24.

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 2023-24 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.

Area/national audit title		NCA	QA	A1	P1	% cases submitted	Data collection complete?
Clinical Business Unit 1: Medicine							
QA1	Adult Respiratory Support Audit British Thoracic Society	×	✓	✓	×	-	The service did not participate in 2023-24
QA9a	Emergency Medicine QIPs: a) Care of Older People Royal College of Emergency Medicine	×	✓	✓	✓	100%	Continuous data collection
QA9b	Emergency Medicine QIPs: b) Mental Health (Self Harm) Royal College of Emergency Medicine	×	✓	✓	✓	100%	Continuous data collection
QA12	Improving Quality in Crohns and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit] IBD Registry	×	✓	✓	×	-	The service did not participate in 2023-24
QA17a	National Adult Diabetes Audit: a) National Diabetes Footcare NHS Digital	✓	✓	✓	✓	100%	-
QA17b	National Adult Diabetes Audit: b) National Diabetes Inpatient Safety NHS Digital	✓	✓	✓	✓	100%	Continuous data collection
QA17d	National Adult Diabetes Audit: d) National Diabetes Core NHS Digital	✓	✓	✓	✓	100%	Continuous data collection
QA18a	National Asthma and COPD Audit Programme: a) COPD Secondary Care Royal College of Physicians	✓	✓	✓	✓	91%	Continuous data collection

Area/national audit title		NCA	QA	A1	P1	% cases submitted	Data collection complete?
QA18b	National Asthma and COPD Audit Programme: b) Pulmonary Rehabilitation Royal College of Physicians	✓	✓	×	×	-	-
QA18c	National Asthma and COPD Audit Programme: c) Adult Asthma Secondary Care Royal College of Physicians	✓	✓	✓	✓	100%	Continuous data collection
QA19	National Audit of Cardiac Rehabilitation University of York	×	✓	×	×	-	-
QA20	National Audit of Cardiovascular Disease Prevention in Primary Care NHS Benchmarking Network	✓	✓	×	×	-	-
QA23	National Audit of Pulmonary Hypertension NHS Digital	×	✓	×	×	-	-
QA26a	National Cardiac Audit Programme a) National Adult Cardiac Surgery Audit (NACSA) National Institute for Cardiovascular Outcomes Research [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	×	×	-	-
QA26c	National Cardiac Audit Programme c) National Heart Failure Audit (NHFA) National Institute for Cardiovascular Outcomes Research [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	✓	✓	87%	Continuous data collection

Area/national audit title		NCA	QA	A1	P1	% cases submitted	Data collection complete?
QA26d	National Cardiac Audit Programme: d) National Audit of Cardiac Rhythm Management (CRM) National Institute for Cardiovascular Outcomes Research [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	✓	✓	100%	Continuous data collection
QA26e	National Cardiac Audit Programme: e) Myocardial Ischaemia National Audit Project (MINAP) National Institute for Cardiovascular Outcomes Research [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	✓	✓	77%	Continuous data collection
QA26f	National Cardiac Audit Programme: f) National Audit of Percutaneous Coronary Intervention (NAPCI) National Institute for Cardiovascular Outcomes Research [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	×	×	-	-
QA28	National Clinical Audit of Psychosis Royal College of Psychiatrist	✓	✓	×	×	-	-
QA30	National Early Inflammatory Arthritis Audit (NEIAA) British Society for Rheumatology	✓	✓	✓	✓	100%	Continuous data collection
QA37	National Obesity Audit NHS Digital	✓	✓	×	×	-	-
QA41	National Vascular Registry Royal College of Surgeons of England	✓	✓	×	×	-	-
QA47	Sentinel Stroke National Audit Programme King's College London	✓	✓	✓	✓	100%	Continuous data collection
QA49	Society for Acute Medicine Benchmarking Audit Society for Acute Medicine	×	✓	✓	✓	100%	Yes
QA50	Trauma Audit & Research Network the Trauma Audit & Research Network / National Major Trauma Registry (NMTR)	×	✓	✓	✓	10%	Service suspended in June 2023. Relaunched in April

							2024 as NMTR
Area/national audit title		**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
QA51	The UK Transcatheter Aortic Valve Implantation Registry National Institute for Cardiovascular Outcomes Research (NICOR) [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	×	×	-	-
QA53	UK Renal Registry Chronic Kidney Disease Audit UK Kidney Association	×	✓	×	×	-	-
QA54	UK Renal Registry National Acute Kidney Injury Audit UK Kidney Association	×	✓	✓	✓	100%	Continuous data collection
Clinical Business Unit 2: Surgery							
QA2	BAUS Nephrostomy Audit: British Association of Urological Surgeons (BAUS)	×	✓	×	×	-	-
QA3	Breast and Cosmetic Implant Registry NHS Digital	×	✓	✓	✓	100%	Continuous data collection
QA4	British Hernia Society Registry British Hernia Society	×	✓	✓	×	-	The service will be participating from April 2024
QA5	Case Mix Programme (CMP) Intensive Care National Audit & Research Centre (ICNARC)	×	✓	✓	✓	100%	Continuous data collection
QA6	Child Health Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Juvenile Idiopathic Arthritis	✓	✓	✓	✓	Organisational questionnaire only, the clinical questionnaire was not applicable to the Trust	
QA8	Elective Surgery (National Patient Reported Outcome Measures Programme) NHS Digital	×	✓	✓	✓	Unknown	Continuous data collection
QA11a	Falls and Fragility Fracture Audit Programme: a) Fracture Liaison Service Database Royal College of Physicians	✓	✓	×	×	No local service	

QA11c	Falls and Fragility Fracture Audit Programme: c) National Hip Fracture Database Royal College of Physicians	✓	✓	✓	✓	100%	Continuous data collection
Area/national audit title		**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
QA24	National Cancer Audit Collaborating Centre - National Breast Cancer Audit Royal College of Surgeons of England (RCS)	✓	✓	✓	✓	100%	Yes
QA31	National Emergency Laparotomy Royal College of Anaesthetists	✓	✓	✓	✓	100%	Continuous data collection
QA33	National Joint Registry Healthcare Quality Improvement Partnership	×	✓	✓	✓	100%	Continuous data collection
QA38	National Ophthalmology Database Audit (National Cataract Audit) The Royal College of Ophthalmologists	×	✓	✓	✓	100%	Continuous data collection
QA45	Perioperative Quality Improvement Programme Royal College of Anaesthetists	×	✓	✓	×	Insufficient numbers required by the study for the minimum monthly recruitment target	
Clinical Business Unit 3: Women's and Children's							
QA7	Cleft Registry and Audit NEtwork (CRANE) Database Royal College of Surgeons of England (RCS)	×	✓	✓	✓	All local identified cases are referred to Cleft Lip and Palate Association (CLAPA) irrespective of being detected antenatally or postnatally. CLAPA notify CRANE of all cases	
QA10	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Continuous data collection
QA14	Maternal, Newborn and Infant Clinical Outcome Review Programme: University of Oxford / MBRRACEUK collaborative	✓	✓	✓	✓	100%	Continuous data collection
QA15	Medical and Surgical Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Endometriosis	✓	✓	✓	✓	50%	Continuous data collection

QA17c	National Adult Diabetes Audit: c) National Pregnancy in Diabetes NHS Digital	✓	✓	✓	✓	100%	Continuous data collection
Area/national audit title		**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
QA18d	National Asthma and COPD Audit Programme: d) Children and Young People's Asthma Secondary Care Royal College of Physicians	✓	✓	✓	✓	100%	Continuous data collection
QA26b	National Cardiac Audit Programme: b) National Congenital Heart Disease Audit (NCHDA) National Institute for Cardiovascular Outcomes Research [Hosted at NHS Arden and Greater East Midlands CSU]	×	✓	×	×	-	-
QA27	National Child Mortality Database University of Bristol	✓	✓	✓	✓	100%	Continuous data collection
QA35	National Maternity and Perinatal Audit (NMPA) Royal College of Obstetricians and Gynaecologists	✓	✓	✓	✓	No data available. Publication of NMPA clinical reports using recent data has been delayed due to significant delays in receiving English data from NHS England	
QA36	National Neonatal Audit Programme Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Continuous data collection
QA39	National Paediatric Diabetes Audit Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Continuous data collection
QA43	Paediatric Intensive Care Audit Network	✓	✓	×	×	-	-

QA44	Perinatal Mortality Review Tool University of Oxford / MBRRACEUK collaborative	×	✓	✓	✓	100%	Continuous data collection
Area/national audit title		**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
QA52	UK Cystic Fibrosis Registry Cystic Fibrosis Trust	×	✓	×	×	-	-
Nurse-led							
QA11b	Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls Royal College of Physicians	✓	✓	✓	✓	100%	Continuous data collection
QA21	National Audit of Care at the End of Life (NACEL) NHS Benchmarking Network	✓	✓	✓	×	No audit took place in the 2023-24 reporting period. A voluntary pilot study was undertaken in 2023 but the Trust made the decision not to participate	
QA22	National Audit of Dementia Royal College of Psychiatrists	✓	✓	✓	✓	100%	Yes
QA25	National Cardiac Arrest Audit (NCAA) Intensive Care National Audit & Research Centre	×	✓	✓	✓	100%	Continuous data collection
QA42	Out-of-Hospital Cardiac Arrest Outcomes University of Warwick	×	✓	×	×	-	-
Corporate							
QA13	Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR)	×	✓	✓	✓	100%	Continuous data collection

QA15	Medical and Surgical Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD) End of Life (EoL) Care	✓	✓	✓	✓	50% at the 3 April 2024	Continuous data collection
Area/national audit title		**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
QA16	Mental Health Clinical Outcome Review Programme: The University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	✓	✓	×	×	-	-
QA29a	National Comparative Audit of Blood Transfusion: a) 2023 Audit of Blood Transfusion against the National Institute for Health and Care Excellence (NICE) Quality Standard 138 NHS Blood and Transplant	×	✓	✓	×	The service did not participate in 2023-24	
QA29b	National Comparative Audit of Blood Transfusion: b) 2023 Bedside Transfusion Audit	×	✓	✓	×	The service did not participate in 2023-24 but are in the process of signing up for 2024-25	
QA32a	National Gastro-Intestinal Cancer Audit Programme: a) National Bowel Cancer Audit Royal College of Surgeons of England (RCS)	✓	✓	✓	✓	100%	Continuous data collection
QA32b	National Gastro-Intestinal Cancer Audit Programme: b) National Oesophago-Gastric Cancer Audit Royal College of Surgeons of England (RCS)	✓	✓	✓	✓	100%	Continuous data collection
QA34	National Lung Cancer Audit Royal College of Surgeons of England	✓	✓	✓	✓	100%	Continuous data collection
QA40	National Prostate Cancer Audit Royal College of Surgeons of England	✓	✓	✓	✓	100%	Continuous data collection
QA48	Serious Hazards of Transfusion UK National Haemovigilance Scheme Serious Hazards of Transfusion	×	✓	✓	✓	100%	Reported when required
Service not provided by the Trust							

QA46a	Prescribing Observatory for Mental Health (POMH): a) Use of Medicines with Anticholinergic (Antimuscarinic) Properties in Older People's Mental Health Services Royal College of Psychiatrists	×	✓	×	×	-	-
QA46b	Prescribing Observatory for Mental Health (POMH): b) Monitoring of Patients Prescribed Lithium Royal College of Psychiatrists	×	✓	×	×	-	-

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2023-24 that were recruited during that period to participate in research approved by a Research Ethics Committee was 654.

The Research and Development team have continued to focus on delivering high quality clinical research. Raising awareness and developing better communications about research opportunities has continued to be a priority. The team have worked to increase internal and external presence and visibility of research and development and the Barnsley Research Hub has been developed with neighbouring partners that allows collaborative working and better access to research for the population of Barnsley.

The team have diversified to develop staff with research aspirations and interests, including:

- 66 staff delivering research across CBUs
- 33 health care professionals as Principal Investigators
- 91 staff trained in good clinical practice

The team have refined working practices to create better approaches to patient engagement, including:

- 43 studies open in 16 specialties across the CBUs
- 3535 participants screened
- 654 participants recruited
- 1464 study visits undertaken

The 2023-24 performance is exceptional and something to celebrate. The team has achieved all of the Clinical Research Network (CRN) mandated objectives for 2023-24 and are proud to have recruited a UK first participant to a commercial trial in 2024.

Commissioning for Quality and Innovation (CQUIN) Framework

NHS England identified a small number of clinical priority areas where improvement is expected across 2023-24. Table 2.0 outlines the 2023-24 national CQUINs, which are applicable to NHS acute providers.

NHS England has paused the nationally mandated CQUIN quality incentive scheme for 2024-25.

Table 2.0: 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 and 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
CQUIN07: Recording of the National Early Warning Score (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

At the end of 2023-24 the Trust achieved compliance in five of the eight national CQUINs, which are applicable to NHS acute providers. The Trust did not achieve the CQUIN thresholds for CQUIN01, CQUIN05 and CQUIN12. Work to improve and achieve these CQUINs will continue into 2024-25 with monitoring of compliance via the trust-wide governance and performance frameworks.

Regulation and Compliance

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is "registered without conditions". The CQC has not taken enforcement action against the Trust during 2023-24.

In April 2023 the maternity services at the Trust were inspected as part of CQC's national maternity inspection programme. The programme was aimed at providing an up-to-date view of hospital maternity care across the country as well as providing the CQC with insight into maternity services to support learning and improvement at a local and national level.

The short notice focused on-site inspection of the maternity service took place on the 18 April 2023, looking only at the safe and well-led key questions. The CQC rated safe as required improvement and well-led as good. The overall rating of good for the Trust stayed the same.

The maternity service has a detailed action plan in place to address the key findings from the 2023 inspection which will be closely monitored for implementation and sustainability through the Trust-wide governance processes.

Quality of Data

Barnsley Hospital NHS Foundation Trust submitted records during 2023-24 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:

99.90% for admitted patient care (data to March 2024)
99.96% for out-patient care and (data to March 2024)
99.53% for accident and emergency care (data to March 2024)

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

99.99% for admitted patient care (data to March 2024)
99.99% for out-patient care and (data to March 2024)
99.96% for accident and emergency care (data to March 2024)

Information Governance

Barnsley Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2023-24 was unavailable at the time of completing this report.

Clinical Coding

The Trust was not subject to the Payment by Results (Per) clinical coding audit during 2023-24.

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 2023-24 audit was undertaken in February 2024. The results should not be extrapolated further than the actual sample audited.

	Correct (%) Data Protection Audit Toolkit 2024
Primary Diagnosis	92.0
Secondary Diagnosis	94.0
Primary Procedure	94.0
Secondary Procedure	89.0

Data Quality

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

- Ongoing quarterly validation of clock stops will be conducted to uphold patient safety and care standards.
- Continue to report the most recent LUNA results to the Data Quality group (DQG) to support the identification of duplicate pathways.

- To monitor that the type of outpatient consultation is recorded is recorded for every appointment.
- Daily oversight of referral to treatment (RTT) issues, particularly focusing on long wait times and status errors, to ensure reporting reliability. This involves reviewing approximately 40 items daily, including newly added maternity-specific reports.
- Review new RTT guidelines and agree any changes in recording procedures will be agreed upon.
- Agree any changes required to the current patient system to support RTT guidelines.
- Ensure escalation processes for long waiters and waiting time discrepancies are in place to facilitate DQG oversight.
- Ensure ongoing training and awareness to reduce the use of the generic doctor identifier in the electronic patient record system.
- Utilise the Data Quality Maturity Index (DQMI) to identify data errors and implement processes for accuracy improvement.
- Ensure the continuous monitoring of maternity data quality due to income-related inaccuracies, with issues reported on a central dashboard for awareness and updates.
- Auditing discharge times to address the issue of incorrect entries.
- Identify issues with discharge ready dates to support trust-wide patient flow.
- Ensure the escalation of any high-impact issues to executive team meetings.
- Ensure the timely escalation of relevant information from the Information Governance group to the Clinical Effectiveness group.
- The Business Intelligence team will continue to implement new reporting mechanisms for accurate and timely data, facilitating comparisons with local Trusts and fostering shared learning.

Learning from Deaths

(27.1) During 2023-24, 1158 of the Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
276 in the first quarter;
252 in the second quarter;
296 in the third quarter;
334 in the fourth quarter.

(27.2) By the 31 March 2024, 90 case record reviews and seven investigations have been carried out in relation to the deaths included in item 27.1.

In three cases a death was subjected to both a case record review (structured judgement review (SJR)) and an investigation (serious incident (SI) or patient safety incident investigation (PSII)). The number of deaths in each quarter for which a case record review or an investigation was carried out was:

17 (15 SJR and two SI) in the first quarter;
28 (28 SJR) in the second quarter;
28 (27 SJR and one PSII) in the third quarter;
24 (20 SJR and four PSII) 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 0.7% for the first quarter;
Zero representing 0.0% for the second quarter;
One representing 0.3% for the third quarter;
Four representing 1.2% for the fourth quarter.

These numbers have been estimated using the numbers of requested SJRs and the records held in the Trust's incident reporting system on SIs and PSIIs.

(27.4) Learning from completed SIs and PSIIs include:

- Improvements in antimicrobial stewardship should be made.
- Preventing delays in sending specimens for testing for suspected healthcare associated infections.
- Junior medical staff should actively seek support from senior colleagues, when medical imaging is required out of hours for patients who have experienced a deterioration in condition.
- Clinical record keeping and accurate communication is fundamental to effectively managing patient care. All entries made in the patient's record should be reviewed and entries should be recorded in the correct section of the patient's record.
- Patients with a learning disability (LD) should always be referred to and receive support from the learning disability liaison nurse during the course of their admission.

Themes from SJRs include:

- Failure to recognise small bowel obstruction early.
- Failure to recognise the deteriorating patient.
- Lack of senior clinical review or failure to follow up.
- Delay in requesting or accessing diagnostic testing.
- 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):

Actions from completed SIs include:

- The Infection Prevention and Control (IPC) team have delivered training on the recognition and management of suspected healthcare associated infections.
- The Medical Imaging department are raising awareness of the process for accessing the support of the imaging team out of hours.

- The Trauma and Orthopaedic service will ensure that all patients have a review by a consultant post operatively and the review is documented in the patient's record.

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. In addition to address the lack of do not attempt cardiopulmonary resuscitation (DNACPR) discussion and/or completion of associated documentation found in the last reporting period, the organisation has adopted the Resuscitation Council UK ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) in the place of DNACPR orders.

(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, and in future a PSII 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.

A learning from deaths bulletin based on learning from Medical Examiner (ME) escalations and SJRs are shared trust-wide and an electronic library is available of all SJRs and learning from deaths bulletins.

The MEs proactively seek any history of LD 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 Trust's incident 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 2023-24 Indicators

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
SHMI value and banding November 2023 (latest available data)	97.02	100.33	71.95	125.64	102.29	101.89	106.2

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.
- Ensure delivery of the ME service.
- Continue to apply learning from SJRs.
- 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	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
% of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. **December 2022 – November 2023 (latest available data)**	36.65%	42.34%	66.52%	15.92%	18.80%	18.79%	17.18%

Trust Assurance Statement:

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

- Significant work has continued through 2023-24 to ensure that there is a systematic and consistent methodology for the coding of patient deaths with the palliative care code.

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

- Continuing to work closely with the Specialist Palliative Care team (SPCT), the Patient Safety team and the Mortality Oversight Group (MOG) to ensure that data is updated, is correct and reflects the SPCT input in the patient's care. This will be performed by reviewing the SPCT database against the coded data and amending where necessary.

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
The Trust's responsiveness to the personal needs of its patients during 2023-24.	Data not available (awaiting CQC publication)	No comparable data available at time of reporting			83%	78%	79%

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 2023-24, the quality indicator question 'patients given enough information about medicine at discharge' was highlighted as requiring improvement based on the PICKER average. The remaining four indicator questions demonstrated a level of improvement based on previous year data.
- Intelligence gained from the national inpatient survey is used to inform service level action/improvement plans. The Friends and Family Test data-set supports monitoring and effectiveness of service improvement 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:

- Undertaking a multi-disciplinary team approach to proactively establish improvement workstreams across the Trust. These include, noise at night, discharge and patient flow and 'Always Events'.
- Assigning Patient and Carer Experience Leads to CBUs to support service improvement workstreams.
- Reviewing trust-wide governance structures to develop a robust process for reporting and ensuring effective monitoring of service improvement initiatives.

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
% of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	67.23%	63.32%	88.82%	44.31%	64.4%	66.9%	72.9%

Trust Assurance Statement:

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

- The Trust is aiming to be a compassionate and inclusive place to work in an environment of psychological safety for our people where they can raise concerns.
- The Trust provides excellent care because of the quality of its people; through being well-resourced in comparison to other Trusts with relatively low vacancy levels.
- It is shared in regular colleague communications such as Team Brief that care of patients/service users is the Trust's top priority.

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

- In response to the Staff Survey and other listening activity, there has been key learning and drivers for change in areas such as looking after colleague wellbeing; developing leadership capability and developing teamwork.
- Trust-wide and local action plans have been developed. For example, in response to feedback about colleague wellbeing, an organisational wellbeing Survey has been launched and a benchmarking exercise undertaken to better understand strengths and opportunities in this area.
- The wellbeing offer is being promoted and more resources are being applied to violence and aggression management.
- In response to feedback about leadership, the Trust has communicated leadership expectations and is focussed on a compassionate leadership approach.
- All CBUs have been tasked with sharing results of the survey and involving their teams in identifying actions appropriate to them. CBUs are expected to share their action plans at the People Engagement group meeting, chaired by the Director of People. Examples of local actions include time outs, improvement in communication and recognition activity and listening sessions.
- The Trust seeks to inform our people of the quality of care we provide by sharing high level Trust performance in monthly team brief; celebrate success through frequent recognition of colleague performance and promote multiple channels through which to raise concerns.

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
28 day readmission rates for patients aged 0 to 14 during 2023-24.	15.82%	Data unavailable. Benchmarking for readmissions is several months behind real time so no comparable data available at time of reporting.			17.92%	16.59%	11.64%
28 day readmission rates for patients aged 15 or over during 2023-24.	9.33%	Data unavailable. Benchmarking for readmissions is several months behind real time so no comparable data available at time of reporting.			9.53%	16.5%	11.2%

Trust Assurance Statement:

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

- Patients attending SDEC 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:

- A review of the way these patients are recorded to ensure an accurate reflection of the care pathway.
- The Trust has an embedded Discharge to Assess (D2A) process for assessments in patients own homes with a safety net in place.
- The Trust works to a 'home-first' ethos as patients have better outcomes in their own environment.
- The Trust has strong working relationships with community partners to offer support on discharge including virtual wards.

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
% of admitted patients who were admitted to hospital and who were risk assessed for venous thromboembolism during 2023-24	98.1%	Not available – data collection ceased 28th March 2020	Not available	Not available	97.4%	98.2%	96.6%

Trust Assurance Statement:

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

- The data is taken from the Trust's electronic observations and more recently electronic prescribing system, from 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 maintain this percentage, and so the quality of its services, by:

- Reviewing any contributory factors in the 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	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
Number of C.difficile infections amongst patients aged 2 or over during 2023-24.	54 cases	data unavailable from national source at the time of completing this report.			42	32	26

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 number and rate, and so the quality of its services, by:

- Reviewing and auditing practice, surveillance and education, thorough system-based investigations.
- The Trust has sought advice from NHSE North East and Yorkshire regional IPC team to ensure our current prevention and management strategies are satisfactory.
- Secured an external review regarding the prevention and management of *C.difficile* infection.
- Agreed separate *C. difficile* reduction and antimicrobial stewardship action plans. These will be monitored by the IPC group and reported to the Quality and Governance committee.

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
Number of patient safety incidents reported during 2023-24.	14,419	National data no longer provided			14,322	11,859	11,002

Trust Assurance Statement:

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

- NHSE have paused the publication of the monthly and annual data of the number of patient safety incidents reported to the National Reporting and Learning System.
- The number of patient safety incidents reported has been taken from the Trust's incident reporting system, Datix.
- 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 team continues to support staff to report and investigate patient safety incidents.
- The Clinical Governance team continues to 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	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2022-23 BHNFT	2021-22 BHNFT	2020-21 BHNFT
Number of patient safety incidents reported during 2023-24 that resulted in severe harm or death.	Severe harm 24 (0.17%) Death 13 (0.09%)	National data no longer provided			Severe harm 24 (0.2%) Death 17 (0.1%)	Severe harm 32 (0.2%) Death 18 (0.1%)	Severe harm 12 (0.001%) Death 13 (0.001%)

Trust Assurance Statement:

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

- NHSE have paused the publication of the monthly and annual data of the number of patient safety incidents reported to the National Reporting and Learning System.
- The number of patient safety incidents reported that have resulted in severe harm or death has been taken from the Trust's incident reporting system, Datix.

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 Patient Safety Specialists attend the NHSE Patient Safety Specialist meetings to ensure that the Trust meets the requirements of the national patient safety strategy.
- The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) on the 1 November 2023.
- Incidents resulting in severe harm and death and incidents that meet the criteria for a PSII in line with the Trust's Patient Safety Incident Response Plan (PSIRP) are discussed at the Trust's weekly Patient Safety Panel.
- PSIIs are investigated by an independent investigator from outside of the CBU where the incident has occurred who has undergone training on systems-based investigation.
- 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.
- All PSIRF learning responses are supported by a Clinical Governance Facilitator.
- A systems-based approach to investigating all patient safety incidents identifies the relevant learning allowing 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 PSIIs 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.
- Triangulation of complaints, litigation, incidents and HM Coroners inquests was completed quarterly and reported to Patient Safety and Harm group.
- A SI/PSII assurance review is completed six months after the completion 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 assurance review is reported through the Trust's governance framework.

Table 4.0: Patient Reported Outcome Measures (PROMs) reporting period: April 2022 to March 2023 not yet available

PROMs aim to measure improvement in health following certain elective (planned) operations. These are total hip replacement (THR) and total knee replacement (TNR). 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 therefore important that patients participate in this process, so that the Trust can understand how effective and how successful our interventions have been.

For THR surgery:

- The Trust continues to be above the national bench mark with the EQ5D general health questions, and the EQVAS (visual analogue) scale.
- The Trust remains below the national bench mark for the Oxford hip score however, has made significant improvements.

For TKR surgery:

- The Trust continues to be above the national bench mark with the EQ5D general health questions, EQVAS (visual analogue) scale and Oxford knee scores.

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

- Improvements for both THR and TKR PROMs data are as a result of the implementation of the enhanced recovery pathway (ERP) and PROMs multi-disciplinary team (MDT) approach.
- As part of a QI project to enhance patient care and experience a review of patient pathways has been undertaken.
- The use of cryo-cuff, three-way wound closure, preserve the fat pad at time of surgery and reduced tourniquet time in TKRs has continued.
- The relaxation of hip precautions in primary THR has had a positive impact on patient experience and PROMs data.
- The focus on a shorter length of stay and enhanced recovery is explained to patients and provided in written patient information.
- "Sip until send" has been implemented on the elective ward to help keep pre-operative fasting to a minimum.
- The service has developed and implemented a new patient information leaflet that guides patients on the use of pain relief at home.
- The Trust continues to provide a "helpline" for patients to access once discharged from hospital, if required.

Part 3: Other information

Trust performance against agreed 2023-24 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 2023-24. The final column in each table confirms the indicators we have agreed against the quality priorities for 2024-25.

Goal 1

3.1 We will deliver the best possible clinical outcomes

3.1.1 Mortality

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
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.	Achieved	All relevant in-patient hospital deaths have received a medical examiner scrutiny.	We will ensure that 100% of all relevant in-patient hospital deaths are reviewed by the ME service or referred to HM Coroner. [Processes for coronial deaths will be confirmed once statutory status is implemented by parliament]. We will ensure feedback from the designated next of kin is

			recorded and informs the ME scrutiny.
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.	Achieved	SJRs have been completed for all relevant deaths and either escalated for further investigation or learning shared via bulletins. The SJR library has been established and anonymised SJRs are available for learning.	We will continue to maintain SJRs for all relevant deaths and will implement learning to improve care for future patients. We will address health inequalities by ensuring an SJR is carried out for any deceased in-patient with learning disabilities and/or autism and any deceased patients with serious mental illness.
We will ensure that any diagnosis groups alerting across multiple mortality metrics (HSMR/SHMI) will be acted upon.	Achieved	Any diagnosis groups that have alerted across multiple metrics have been actioned.	We will ensure mortality statistics remain within confidence limits.

Data source: local Trust data source, 2023-24.

3.1.2 Improvements in Clinical Services

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will address areas of improvement identified via the high-volume low complexity (HVLC) pathways and put plans in place.	Achieved	Getting It Right First Time (GIRFT) Oversight group meetings have been established and HVLC specialities have reported progress against GIRFT action plans. Improvements have been seen against associated metrics.	We will benchmark against all applicable services against the Further Faster Programme (FFP) improvement checklists and make improvements where applicable. This will be monitored and reported via Clinical Effectiveness group, Efficiency and Productivity group (EPG) and GIRFT Oversight group meetings.
We will continue to identify priority areas for improvement from our deep dives and/or national recommendation reports.	Achieved	GIRFT Oversight group meetings have been established and specialities have reported progress against GIRFT action plans including recommendations from deep dives and national reports. Positive action and improvement have been shared via this process.	We will continue to learn from other Trusts and utilise benchmarking data to identify improvements and embed best practice.
We will continue to use the best available evidence using clinical audit results, to provide assurance and improve quality of patient care.	Achieved	The Trust continues to participate in a large proportion of clinical audits included on the national clinical audit programme and the Quality Account list.	We will respond to increased frequency from the national clinical audits. We will ensure that there are

		The local clinical audit programme focusses on the Trusts priorities and is driven by local intelligence e.g. patient safety concerns and incidents. Reporting, monitoring and planning for improvement are key parts of the Trust audit process.	processes in place to identify and agree improvements plans where required.

Data source: local Trust data source, 2023-24.

3.1.3 Implementation of Systems to Prevent Avoidable Harm

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2023-24 indicator
Seventy percent or above of key staff identified through appropriate role profile will receive training in Human Factors (HF).	Achieved	Seventy eight percent of key staff identified through appropriate role profile received training in HF.	Eighty 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	During the reporting period the Trust achieved 99% compliance with risk assessment in all adult in-patient areas.	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 improvements are monitored via this group.	We will investigate incidents of hospital acquired VTE where the patient has died or required Level 2 or above care (as a result of VTE), as well as a sample of other patients to

			inform on any improvements needed.

Data source: local Trust data source, 2023-24.

Goal 2

3.2 We will deliver safe care

3.2.1 Safe Staffing

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
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.	Achieved	Nurse staffing levels are monitored continuously with huddles and matron oversight and escalation plans are in place. Nursing establishment reviews were undertaken and reported to the Executive Team meeting and Quality and Governance committee. For medical staffing we have achieved high overall fill rates consistently throughout the year. We have maintained safe staffing on wards with limited gaps,	We will have established safe staffing levels (medical and nursing) which are monitored for compliance. The updated Safer nursing care tool will be utilised for nursing establishment reviews; this will include the Emergency Department. Medical staff investment plans will be proposed to increase optimum numbers of doctors across wards within medical specialties ensuring that medical staffing is in line with

		supported through locum and bank workers.	the Royal College of Physicians (RCP) guidance.
We will maintain a high level of performance with less than one exception report per day.	Not achieved	Throughout the reporting year the Trust has averaged 1.7 exception reports per day. Achievement of this indicator has been affected by significant sickness following summer 2023 and the impact of the national doctor strikes.	We will maintain a high level of performance with less than one exception report per day.

Data source: local Trust data source, 2023-24.

3.2.2 Proactively Implement Improvements to Keep our Patients Safe

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will ensure that all abnormal results are viewed and acted within seven days of receipt of test.	Not achieved	Following review with the Medical Director and the CBU Clinical Directors, the seven-day performance indicator was deemed unachievable. The Trust has revised its policy with a new standard for this indicator.	We will ensure that all abnormal results reported through the ICE System (e.g. blood, microbiology, radiology), are viewed and acted on within 14 days of receipt of test. Performance against this indicator will remain under the review and responsibility of the CBU leadership.
We will ensure 85% completion of	Achieved	During 2023-24 we achieved	We will ensure 90%

hospital discharge summaries (D1) within 24 hours of discharge.		over 90% completion of D1s within 24 hours of discharge.	completion of hospital discharge summaries (D1) within 24 hours of discharge.
We will achieve and sustain 90% Trust- wide compliance on Tendable pressure ulcer prevention audits.	Partially achieved	The Trust achieved 90% for five out of twelve months. The remaining seven months compliance was between 85% and 90%. The audits are predominantly undertaken by the Tissue Viability Nursing (TVN) team and have been supported by ward areas. Each month there is a focus on the lowest scoring indicators to support improvement.	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	The Trust achieved 90% compliance for seven out of twelve months. The remaining five months compliance was between 83% and 90%. The Trust adopted a new risk assessment tool in October 2023	We will achieve and sustain 90% Trust-wide compliance on patient's risk level to pressure ulcers being reassessed on transfer to the ward.

		(Purpose-T). The move to Purpose -T impacted on the performance between October 20233 and December 2023. Since January 2024 90% compliance has been achieved.	
We will ensure that 90% of patients receiving enhanced care will have enhanced care risk assessments completed.	Achieved	The Trust achieved at least 98% compliance throughout 2023-24. A number of wards have been trialling an alternative enhanced risk assessment which will be implemented throughout 2024-25.	We will ensure that 90% of patients receiving enhanced care will have enhanced care risk assessments completed.
We will achieve 90% Trust-wide compliance on Tendable falls prevention intervention audits.	Achieved	The Trust achieved at least 95% compliance throughout 2023-24.	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 blood pressure (BP) recorded within 24 hours of admission.	Partially achieved	The Trust achieved 90% compliance for seven out of twelve months. The remaining five months compliance was between 76% and 90%. Staff education on the importance of undertaking lying and standing BP, clinical	We will ensure that 90% of patients over 65 years have a lying and standing blood pressure (BP) recorded within 24 hours of admission.

		conditions where a drop in BP may be seen and how this can reduce the risk of falls, continues.	
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.	Partially achieved	The Trust achieved zero MRSA bacteraemia infections. Nationally, reduction thresholds for *Clostridioides difficile* infection continue to be challenging. The Trust did not achieve the agreed reduction threshold of 33 cases. In 2023-24 54 patients were identified as having *C.difficile* infection. In addition to the Trust's IPC action plan a *C.difficle* reduction action plan and an antimicrobial stewardship action plan have been developed. The action plans have different executive and clinical leads and will be monitored by the IPC group and assurance provided to the Quality and Governance committee.	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 reduction of MRSA bacteraemia	Achieved	The MRSA bacteraemia	The reduction of MRSA

will form part of the Trust's annual infection prevention and control plan.		reduction strategy formed part of the Trust's 2023-24 IPC action plan. All actions were achieved.	bacteraemia will form part the Trust's 2024-25 IPC action plan.

Data source: local Trust data source, 2023-24.

3.2.3 Prevent Avoidable Patient Deterioration

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will continue to 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 acute kidney injury (AKI) have their AKI status documented as part of their care records.
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 in-patient settings.	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 in-patient settings at Quarter 4 2023-24 was: • Trust-wide – 92.06% • In-patients – 94.79% • ED – 90.25%	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 in-patient settings.

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 response times recorded in clinical notes*. *(exclusion criteria apply).	Achieved	Compliance at Quarter 4 2023-24 was 56.58%.	NA

Data source: local Trust data source, 2023-24.

Goal 3

3.3 We will provide patient centred services

3.3.1 Compassionate, Dignified and Respectful Care

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will continue to focus on targeted recruitment of Enhanced Support Volunteers (ESVs) with a focus on areas identified as needing this support but who do not currently have ESVs assigned.	Partially achieved	There are currently 60 active ESVs providing support across the Trust. There are just three inpatient areas requiring an ESV and will be a focus of the Voluntary Services team in 2024-25.	We will support the development of a patient passport for people with Autism and Learning Disabilities.
We will continue to work through the End of Life Care (EOLC) steering	Achieved	The EOLC steering group has met throughout the year with	We will achieve higher than the national average for the

group and through education to ensure that the advanced care planning needs of patients needs are understood and addressed. The national audit will be repeated in 2023-24.		varied agenda and action plan. The annual NACEL confirms that the Trust continues to recognise patients in the last days of life. Completion of the 2023-24 NACEL audit is underway.	NACEL quality measures.
The End of Life Care (EOLC) 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.	Achieved	Medical Examiner reviews and SJRs are shared with the End of Life Steering Group for learning and action where this is required.	NA
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.	Achieved	Chaplains contribute to and lead training on pastoral, spiritual and religious care to staff. We have identified and implemented a Spiritual Assessment tool that offers a step-by-step guide to help gather information about a patient's spiritual history and preferences.	We will deliver Spiritual Assessment training to all wards.
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.	Achieved	The Chaplaincy team have continued to respond to the pastoral and spiritual care needs of patients, carers, families and staff through times of personal need.	We will continue to deliver a person-centred service to ensure that religious, pastoral and spiritual support is integral to the holistic response to patient needs.

		During the reporting year the Chaplaincy team have responded to 875 requests from patients for visits and support. A further 191 referrals were made to the Chaplaincy team regarding staff support. The team met 100% of these requests.	
We will continue to identify and support request for any religious ceremony or blessing where appropriate.	Achieved	The Chaplaincy team met 100% of the requests for a religious ceremony of blessing.	We will ensure that information about the Chaplaincy service is communicated in the *"right way, at the right time and in the right place"*.
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.	Achieved	Chaplains acknowledge the complex changing nature of communities in Barnsley. The diversity of religions, beliefs and cultures within the people has grown. The multi-faith Chaplaincy team have responded to requests for support ensuring that they meet the pastoral, religious and spiritual needs of everyone. Chaplains have worked with staff	We will ensure that there are consistent and robust processes in place for the ongoing evaluation of the effectiveness of the Chaplaincy service. This will assess the impact of the service and guide its development.

		to ensure patients are asked of their need and preference for support from the Chaplaincy team on admission.	

Data source: local Trust data source, 2023-24.

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

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will ensure that patient engagement and involvement is considered at the start of any improvement, design and re-design activity within the Trust.	Achieved	Patient engagement has been included in the Trust's business case process. The Service User Engagement toolkit was established to support services to undertake patient/public engagement in improvement, design and re-design workstreams. Patient and Carer Experience Leads have been aligned to CBUs to embed overarching patient experience initiatives and workstreams, including engagement and involvement. This work will be maintained as	As a result of concerns, formal complaints, insight and engagement we will identify local improvement initiatives regarding patient communication.

		part of the ongoing patient experience portfolio.	
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.	Achieved	Public and service user engagement and involvement is now well embedded within the Patient Experience team. Links have been established with a diverse and wide-ranging number of community and voluntary organisations.	We will work in partnership across South Yorkshire to align the ICS and ICB patient and public involvement priorities into the work of the Trust.
We will continue to recruit to the Patient Panel and utilise the diversity panel to ensure that each relevant service is appropriately represented.	Partially achieved	The Patient and Carer Panel terms of reference has been revised and is accompanied by a Patient and Service User representative role outline to support recruitment. The Trust Inclusion and Wellbeing Lead is involved in supporting engagement and diverse panel membership. This work will be maintained as part of the ongoing patient experience portfolio.	As a result of concerns, formal complaints, insight and engagement we will implement new innovations to support improved person-centred care and support CBU improvement initiatives aimed at addressing deconditioning, improved discharge, high quality and sustained nutrition.

Data source: local Trust data source, 2023-24.

3.3.3 Customer Service Mind-Set

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will introduce tools supporting real time patient feedback.	Partially achieved	Electronic methods of collecting NHS Friends and Family test (FFT) data have been introduced to support real-time feedback. SMS text-messaging for the purpose of collecting FFT has been introduced across in-patient, day-case, maternity, ED, children and young people's services. The Patient Experience team is working with the Information and Communication Technology team to develop real-time dashboards to support this work. This work will be maintained as part of the ongoing patient experience portfolio.	We will communicate and document improvements via a portfolio of *"You said, we listened"* as a result of concerns, formal complaints, insight and engagement.
We will continue to demonstrate and broaden the scope of our response to feedback from patients, families and carers through collaborative focussed improvement working and to embed the Always Events identified through	Partially Achieved	Care Partners, welcome packs and 'Three Things about Me' have been implemented across CBUs. The 'Check in – Check out'	We will continue to implement, embed and evaluate patient experience improvement initiatives underpinning the Trust-wide approved Always Events.

service user feedback and engagement. We will implement a local care partner policy and charter.		initiative is in the early stages of development and will continue to be implemented throughout 2024-25. Patient experience is a workstream aligned to the Discharge and Patient Flow Steering group and work is ongoing to support improvements.	We will establish robust qualitative and quantitative analysis to evaluate the impact and effectiveness of the wider patient experience improvement initiatives.
We will ensure that 100% of patients, families and carers are offered feedback on the implementation of the improvements identified in serious incident investigations.	Achieved	One hundred percent of patients, families and carers have been offered feedback on the implementation of the improvements identified in serious incident investigations.	We will ensure that PSIRF is implemented and embedded during 2024-25.
We will ensure that feedback is offered for 100% of high risk, upheld complaints.	Achieved	One hundred percent of complainants aligned to high risk upheld complaints were offered the opportunity to receive feedback on the completion of implemented actions and any related quality improvement (QI) workstreams.	We will conduct an assurance review on all high risk, upheld complaints, and offer feedback on the findings of these to the original complainant.

Data source: local Trust data source, 2023-24.

Goal 4

3.4 We will have a culture of improvement

3.4.1 We Will Build Improvement Capability Across the Trust

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will have delivered the Proud to Improve Introduction to QI training module to 75% of all staff by April 2024.	Achieved	We have delivered the Proud to Improve Introduction to QI training module to 77.62% of all staff.	We will have delivered the Proud to Improve Introduction to QI training module to 80% of all staff by April 2025.
We will keep an inventory of improvement work, make it accessible across the organisation and link the projects to the Trust objectives.	Achieved	An inventory of all proposed, ongoing and closed QI project work is available on the QI intranet page. Each QI project highlights which Trust objective(s) it links to. Monthly QI reports are compiled and available via the Trust governance processes.	We will continue to maintain an inventory of all proposed, ongoing and closed QI project work to facilitate spread.
			We will ensure that 5% of staff are trained in QI Foundations.
			We will continue to work to transition from a quality improvement trained organisation to a fully demonstrable QI ethos and act on the results of the QI culture survey to inform change.

Data source: local Trust data source, 2023-24

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

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will continue to build patient engagement into all patient pathway improvement projects.	Partially achieved	Patient engagement and involvement is covered as part of QI training.	We will continue to promote the use of patient engagement into all patient pathway improvement projects.
We will provide service user quality improvement training from 2024.	Achieved	Training is available that is bespoke for the service user dependent on the project they are involved in. Review of existing training has been undertaken and it is clear which sections would be appropriate.	We will deliver quality improvement training for service users who are involved in improvement projects.

Data source: local Trust data source, 2023-24.

3.4.3 Innovation

Indicator	2023-24 achievement	Highlights and exceptions	Proposed 2024-25 indicator
We will repeat the unmet needs exercise and continue to increase the number of innovations implemented by the Trust.	Partially achieved	Throughout 2023-24 we have: • Shared the unmet needs work regionally • Successfully implemented pre-eclampsia testing as part of MedTech arrangements • Trialled 'Express' within the Ear, Nose and Throat (ENT)	We will work with the CBUs to facilitate new innovations within specialties across the Trust. We will continue to develop work in conjunction with the

		service • Implemented a task and finish group focussed on safe and effective chest drain management • Planned the development of Thopaz+ equipment in 2024 • Commenced the delivery of the CytoSponge service in collaboration with the Gastroenterology team.	Research and Development team focussing on opportunities within the artificial intelligence (AI) and digital agenda.
We will seek to ensure continued engagement and implementation with the annual MedTech funded developments through the Academic Health Science Network (AHSN).	Achieved	We have maintained regular updates with AHSN (now HIN) part of which has supported assessment of the MedTech funding.	We will continue to assess the impact of Health Technology Evaluations (HTE's) to support delivery of innovation within the Trust.
We will report on findings where we have implemented change as a result of research development.	Achieved	As a result of undertaking research within the organisation participants have been provided access to treatments that they would not have received in routine clinical care.	We will report on findings where we have implemented change as a result of research development.

Data source: local Trust data source, 2023-24.

If you would like to read more about this work please read our Research and Development Annual Report, 2023-24 (RD Annual Report 23_24.pdf (barnsleyhospital.nhs.uk))

Performance against national indicators 2023-24

Barnsley Hospital NHSFT 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 2021-22	BHNFT 2022-23	BHNFT 2023-24	National Target 2023-24
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	71.2%	64.30%	62.54%	-
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	93.4%	83.14%	73.13%	-
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	85.8%	79.70%	70.44%	--
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	68.7%	61.80%	66.3%	76%
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	74.6%	67.1%	72.6%	85%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	83.7%	82.0%	77.5%	90%
All cancers: 31-day wait from diagnosis to first treatment	95.7%	93.7%	95.6%	96%
Cancer: two week wait from referral to date first seen, comprising all urgent referrals (cancer suspected)	90.7%	92.6%	94.3%	93%
Cancer: two week wait from referral to date first seen, comprising for symptomatic breast patients (cancer not initially suspected)	79.8%	91.0%	89.2%	93%
Maximum 6-week wait for diagnostic procedures	26.4%	11.1%	4.7%	1%
Clostridium (C.) difficile – variance from plan	32	42	54	-

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

Barnsley Healthwatch comments on BHNFT Quality Report 2023-24

Barnsley Hospital NHS Foundation Trust Quality Report 2023-24
Thank you for giving us the opportunity to comment on your draft Quality Report for 2023-24. There is nothing within this report that is contradicted by the intelligence we have received.

It is pleasing to see the work being done to ensure that BHNFT provides patient centred services, and we would like to commend the work that has been done to ensure that links have been made with a diverse range of communities within Barnsley. It is important that we listen to our communities and provide feedback on what we have heard and how this has been used this to influence change and the "You said, we did" portfolio is a great way to capture this.

We welcome the work that has been done with Care Partners and it is great to see the Welcome Packs and Three Things About Me now being implemented across all CBUs. We look forward to following the progress of the "Check in – Check out" initiative during 2024-25.

Healthwatch Barnsley will continue to support the Trust and look forward to seeing continuing improvement in the quality of the services it provides.

Barnsley Integrated Care Board comments on BHNFT Quality Account 2023-24

South Yorkshire 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 2023/24. 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.

The ICB note and welcome the improvement plans for healthcare associated infections (HAIs), in particular for Clostridium difficile (C. diff). It has been positive to note that most of the agreed priorities set for 2023/24 have been achieved and there are improvement plans for those that have not. The ICB would welcome improvement plans to address cancer diagnostics waits.

BHNFT Council of Governors comments on BHNFT Quality Account 2023-24

This information was unavailable at the time of completing the report.

Overview and Scrutiny Committee comments on BHNFT Quality Account 2023-24

The Committee would like to thank Barnsley Hospital NHS Foundation Trust for the services they continue to provide to the residents of Barnsley, and for the opportunity to contribute to the Quality Account for 2023-24.

Quality Goals 2023-24

The Committee is satisfied that the priorities to deliver the best clinical outcomes; provide harm free care; provide patient centred services; and empowering staff to make changes that matter, align with those of the public.

The Committee note that although performance has improved from the previous year, the national indicator relating to A&E wait times has not been achieved and we will continue to keep a watching brief in this area during 2024-25.

It has also been noted that national targets relating to 62 day waits for first treatment for Cancer have not been achieved and we will also continue to keep a watching brief on Oncology services, both locally and regionally during 2024-25.

We are aware of the outcome of the Care Quality Commission's (CQC's) inspection of maternity services and, by working with the Trust, we are also aware of the work planned to address the areas for improvement.

Following our comments in the Quality Account for 2022-23, we are pleased to see that significant improvements have been made against the Oxford hip score, although the Trust remains below the national benchmark. We are also pleased to see that the Trust continues to be above the national benchmark for the Oxford knee scores. During 2023-24, Barnsley Council, as part of the South Yorkshire, Nottinghamshire & Derbyshire Joint Health Overview and Scrutiny Committee (JHOSC), has scrutinised the implementation of the Mexborough Elective Orthopaedic Centre of Excellence and will continue to scrutinise the impact on residents during 2024-25.

Important Omissions

The Committee is satisfied that there does not appear to be any important omissions.

Patient & Public Engagement

It is clear from the Quality Account that the trust engages with patients and the public, through participation in clinical research; establishing links with a diverse and wide-ranging number of community and voluntary organisations; and embedding the work into business cases and work streams; and that there are ambitions to progress this further. The Committee is pleased to see that the Trust will work in partnership across South Yorkshire to align the Integrated Care System and the Integrated Care Board (ICB) patient and public involvement priorities into the work of the Trust, as the JHOSC has been involved in the work of the ICB 'Start With People Strategy refresh as part of their work programme for 2023-24. As with regional partners, we would expect the Trust to be mindful that patient engagement must be of sufficient quality and quantity to ensure that is fully represents the diverse communities that it serves.

Work of the Overview & Scrutiny Committee (OSC) in 2023-24

During 2023-24, the Trust has supported the Overview & Scrutiny Committee to scrutinise the following topics: -

- Children & Young People's Mental Health Services (CYPMHS)
- Special Education Needs and/or Disability (SEND) Provision in Barnsley
- Safeguarding Adults Board Annual Report 2022-23
- Safeguarding Children's Partnership Annual Report 2022-23
- Healthy Life Expectancy & Health Inequalities Strategy
- Barnsley Health & Care Plan 2023-25
- Vaping (Task & Finish Group)
- Adult Health & Care Workforce (Task & Finish Group)

We look forward to working in partnership with the Trust throughout 2024-25.

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.
CareFlow Vitals	An electronic system used in the Trust to record a variety of patient observations and assessments.
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.
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
EQ-5D Index	Collates responses in five broad areas; mobility, self-care, usual activities, pain/discomfort and anxiety/depression.
EQ VAS	A simple and easily understood 'thermometer'-style measure based on a patient's self-scored general health on the day that they completed the questionnaire.
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	The HSMR measures whether or not the mortality

Mortality Ratios (HSMR)	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.
INR	The international normalised ratio (INR) blood test that measures how long it takes for blood to form a clot.
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.
Level 2 care or above	Critical care where patients require increased levels of observations or interventions including basic support for two or more organ systems.
LUNA	NHS England's national data quality programme.
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 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.
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.
Patient Safety Incident Investigation (PSII)	Undertaken when an incident or a near-miss indicates significant patient safety risks and potential for new learning.
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'.
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.
Small Bowel Capsule Endoscopy	A test that involves swallowing a capsule which looks for abnormalities in the small bowel.
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.
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.
Tendable	A smartphone application for healthcare inspections which assists nursing teams to monitor the quality of care.
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: ID2798: The Sentinel Stroke National Audit Programme (SSNAP) Annual Report	
Purpose	The SSNAP is a major national healthcare quality improvement programme. The audit measures stroke care across the NHS in England, Wales and Northern Ireland. The project produces timely information to clinicians, ICBs, patients and the public for the purpose of improving the quality of care provided.
Performance	Good progress across the SSNAP domains has been made, reflected in the Trust's SSNAP results. Improvement is noted across most domains pertinent to an Acute Stroke Unit (ASU) however, due to the shortage of Speech and Language Therapists (SALT) it is likely that the SALT domain score will remain in the lower SSNAP performance banding for the foreseeable future. This concern has been added onto the Trust's risk register and a programme of work is underway to ensure patients are receiving timely SALT input.
Reviewed by	• Care of the Elderly governance meeting, 16 January 2024 • Clinical Effectiveness group, 17 January 2024 • CBU1 business and governance meeting, 7 February 2024.
Actions	• Relaunch of the new stroke pathway documentation. • Forging good relationships across the Integrated Stroke Delivery Network (ISDN) and Yorkshire Ambulance Service (YAS) to ensure patients are taken to the most appropriate care setting for their care. • Awareness campaign in collaboration with Public Health England and Barnsley Metropolitan Borough Council to raise awareness of the importance of presenting early to hospital when experiencing symptoms of stroke.

Project title: ID2404 and ID2405 Round 4 National Audit of Care at the End of Life (NACEL)

Purpose	To improve the quality of care for people at the end of their life in acute hospitals. The audit comprises of four elements: an organisational questionnaire, patient record review, a staff survey and a quality survey. The quality survey is designed to allow relatives, carers and those close to the person who died to feedback on their experiences of the care and support received.
Performance	The Trust achieved above the national summary score in nine out of the eleven measures. The Trust achieved 82% against the national standard of 87% in relation to the recognition of possible imminent death. This is an improvement against our compliance in comparison to round three. A programme of ongoing work is in progress to improve performance against this standard.
Reviewed by	• End of Life Care steering group, 15 August 2023 • Clinical Effectiveness group, 18 October 2023.
Actions	Education and training will be provided to all appropriate staff 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.

Project title: ID2174 and ID2204 National Audit of Inpatient Falls (NAIF) Annual Report	
Purpose	To improve practice in the measures taken to prevent inpatient falls and improve care following a fall.
Performance	The Trust's results are in line with, or above, national results. However, on review of our position against the national results the areas for consideration, at a local level, are as follows;
Reviewed by	• Falls Prevention group, 9 June 2023 • Clinical Effectiveness group, 16 August 2023.

Actions	• Undertake a local audit to provide assurance that continence and delirium assessments are being completed as part of the multifactorial risk assessment (MFRA). • A mandated field has been added to the incident reporting system to ensure it is reported how a patient is moved from the floor following a fall. • Extend training to include the use of flat lifting equipment.

Project title: ID2152 National Hip Fracture Database (NHFD)	
Purpose	To monitor compliance against NICE standards for hip fractures.
Performance	The latest available NHFD audit results (2021) demonstrate that the Trust is in the top quartile for six out of the 22 standards.
Reviewed by	• Hip Fracture meeting, 8 March 2023 • Trauma and Orthopaedics business and governance meeting, 17 April 2023 • CBU2 business and governance meeting, 26 April 2023 • Clinical Effectiveness group, 22 June 2023.
Actions	• Ensure improvements in compliance with the standard for ‘eligible displaced intracapsular fractures treated with total hip replacement’. The NHFD Clinical Lead will monitor compliance with this. • Ensure that the data collected from the 120 day follow up and bone health recommendations are reviewed. • Continue to drive improvement with nutritional screening.

Project title: ID2183 National Ophthalmology Database (NOD)	
Purpose	To drive improvement in the quality of care for patients undergoing cataract surgery.

Performance	All cases included in the audit were recorded as being carried out by a consultant and or by an experienced trainee surgeon. The Trust's compliance with recording post-operative visual acuity (VA) data has improved significantly from the previous year's data. There has been a significant improvement in the compliance of recording post-operative VA data from 9% in 2017-18, 76% in 2018-19 to the current performance of 97.7% during 2021-22. Posterior capsular rupture (PCR) is the most common complication during cataract surgery, leading to an increased risk of post-operative complications. The audit findings are favourable, indicating no cases of PCR complications.
Reviewed by	• Ophthalmology Business and Governance meeting, 27 November 2023 • CBU2 Business and Governance meeting, 29 November 2023 • Clinical Effectiveness group, 17 January 2024.
Actions	• A review of patient waiting times is required to ensure all patients meet the 90 day criteria.
Project title: ID2126 National Emergency Laparotomy Audit (NELA) Year 8	
Purpose	To improve the quality of care for patients undergoing emergency laparotomy. NELA is a collaboration between anaesthetics, surgical and other key stakeholders.
Performance	The Trust continues to perform well against the NELA standards achieving in excess of 90% compliance in five out of the thirteen measurable standards and above the national average for a further six. Compliance locally has improved and is above national average for the standard assessment by elderly medicine specialist in patients > 65 years and frail or > 80 years. The Trust did not achieve 85% compliance for the standard CT reported before surgery. Compliance has increased from the previous year and is above the national average. Compliance will continue to be lower than 85% until NELA changes the definition of the standard.
Reviewed by	• Anaesthetics and Critical Care Business and Governance meeting, 18 August 2023 • General Surgery Business and Governance meeting, 18 August 2023

	• CBU2 Business and Governance meeting, 23 August 2023 • Clinical Effectiveness group, 18 October 2023.
Actions	• Improve recording of the anaesthetist's name on the anaesthetic record/chart. • Identify an anaesthetic lead for NELA. • Improve timely (one hour) antibiotic prescribing. • Undertake a local audit of compliance in use of the new laparotomy bundle form.

Project title: ID2203 Myocardial Ischaemia National Audit Project (MINAP)	
Purpose	To collect information about the care provided to patients who are admitted to hospital with acute coronary syndromes.
Performance	The Trust's results are in keeping with national compliance when compared with other hospitals.
Reviewed by	Cardiology Governance meeting, 23 January 2024
Actions	A Standard Operating Procedure (SOP) will be developed for data collection and data validation.

Project title: ID2636: National Audit of Cardiac Rhythm Management (NACRM)	
Purpose	To review the care of patients with implanted devices for the treatment of abnormal heart rhythms.
Performance	The Trust performance has improved on previous year and is comparable with other Trusts in the South Yorkshire Integrated Care Board (ICB).
Reviewed by	Cardiology Governance meeting, 23 January 2024
Actions	The results demonstrated an excellent level of care being provided to these patients and therefore, no further action was required. Standards will continue to be monitored through the national audit.

Project title: ID2223 National Neonatal Audit Programme (NNAP)	
Purpose	To measure the standards of care for babies admitted to neonatal units (NNU) in an aim to drive improvements against the NNAP audit standards.
Performance	The Trust performance is above national level in ten standards and below national level in seven standards. Nationally, there is lower compliance against the standards for early breastmilk feeding and breastmilk on discharge. The NNU team continues to work towards the Neonatal Baby Friendly Initiative (BFI) accreditation and has achieved stage 1. Compliance with delayed cord clamping has improved and there has also been an improvement in parents attending at least one consultant ward round. Compliance against the NNAP standards of care reflect a service which delivers safe and effective care and a service which are keen to continue to make improvements.
Reviewed by	• Paediatric Business and Governance meeting, 9 February 2024 • CBU3 Business and Governance meeting, 28 February 2024.
Actions	• Utilise safety huddles and ward meetings to escalate any learning from new admissions. • Improve the use of the peri-prem passport.

Appendix B

Examples of actions agreed following the review of local audit results at BHNFT

Project title: ID2619 Protocol for the Management of Suspected Bruising in a Non-Mobile Infant or Child	
Purpose	To provide assurance that practice relating to bruising, marking or injury in non-mobile children across all services is working effectively to safeguard infants and children.
Performance	Good practice was found in several aspects of the pathway to ensure the appropriate assessment of this vulnerable patient group and any potential risks to them. This included very good use of using the Child Protection Information Sharing system (CPIS) to establish if the patient already had any safeguarding concerns and patients being reviewed by the paediatrics team. Some aspects of the pathway were completed less regularly which may result in insufficient action being taken to appropriately assess the potential for actual (or likely) harm occurring to the presenting infant/child.
Reviewed by	• Safeguarding Steering group, 11 September 2023 • ED Governance meeting, 27 November 2023 • Clinical Effectiveness group, 17 January 2024
Actions	• Training on record keeping in line with safeguarding recommendations for ED staff with input from the Trust's Solicitor • Implementation of an auto-populated social care referral on CareFlow.

Project title: ID2623 Anticoagulation Clinic Review	
Purpose	To provide assurance that the Trust's anticoagulant practices are in line with the British Society for Haematology (BSH) standards and are maintaining patient safety.

Performance	The results demonstrate that the Trust's Anticoagulant Clinic performs well against the standards set out by the BSH and the national patient safety alert.
Reviewed by	• Pharmacy Business and Governance meeting, 19 September 2023 • CBU3 Business and Governance meeting, 27 September 2023 • Clinical Effectiveness group, 15 November 2023
Actions	• Highlight any patients that have an international normalised ratio (INR) of >8 and >5 to consider referral back to the responsible clinician for other treatment. • Continue to educate patients during their regular dosing phone calls regarding the effects of factors e.g. alcohol, antibiotics and dietary changes on their INR.

Project title: ID2239 Audiology Rehabilitation Pathway	
Purpose	To review the care provided to patients through the treatment pathway.
Performance	The service performed well, ensuring patients follow the pathway to receive all relevant aspects of care.
Reviewed by	• ENT Business and Governance meeting, 16 June 2023 • CBU2 Business and Governance meeting, 28 June 2023 • Clinical Effectiveness group, 16 August 2023
Actions	• Develop a new pure tone audiometry (PTA) policy to include clarity on when a bone conduction can be performed. • Provide an audiology department guide and a hearing aid instruction leaflet to all patients. • Develop patient information packs for fitting or reassessment appointments. • Provide patients with the choice of either a face to face or telephone follow up appointment. • Ensure dedicated, appropriate rooms are available to undertake bone conduction.

Project title: ID2684 Joint Advisory Group (JAG): Small Bowel Capsule Endoscopy (SBCE)	
Purpose	It is mandated for the JAG accreditation that the service audit the outcomes of all SBCE procedures.
Performance	All aspirational standards required by JAG were achieved. No risks to patients were identified. Caecal visualisation and thus a complete small bowel examination was achieved for 99% (149/151) of patients, an increase from the previous year (94%). All patients that had a procedure, which was not completed due to poor caecal visualisation, were offered a repeat procedure if deemed appropriate. Capsule retention is a known risk which occurs nationally in 1.7% of all patients. There were no capsules retained for any patients.
Reviewed by	• Endoscopy User group, 9 June 2023 • Endoscopy Governance meeting, 11 July 2023 • CBU1 Business and Governance meeting, 25 August 2023 • Clinical Effectiveness group, 11 October 2023
Actions	• Introduce additional capsule clinics and consultant reporting sessions to provide a quick turnaround for patients. • Accept referrals from neighbouring Trusts. • Continue annual monitoring to support the JAG accreditation.

Project title: ID2642 Joint Advisory Group (JAG) Standards for Endoscopy: Gastric Ulcer	
Purpose	To audit 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 to ensure that there are no unexpected or poor outcomes for patients.

Performance	Compliance with the standard improved from 80% in the previous audit period to 91% in this audit period. Three of the four patients did not have their appointment within the 12 weeks required chose to delay their appointments.
Reviewed by	• Endoscopy User group, 9 May 2023 • Endoscopy Governance meeting, 11 July 2023 • CBU1 Business and Governance meeting, 25 August 2023 • Clinical Effectiveness group, 11 October 2023
Actions	• Display a poster of the results on the endoscopy noticeboard.

Project title: ID2428 Cirrhosis and Fibrosis Tests for Alcohol Dependent Patients (CQUIN 2022-23 CCG9)	
Purpose	To encourage continuous quality improvement and to deliver better outcomes for patients.
Performance	The target of 35% was achieved.
Reviewed by	• Gastroenterology Governance meeting, 24 May 2023 • CBU 1 Business and Governance meeting, 24 May 2023 • Clinical Effectiveness group, 17 May 2023 • Executive Team meeting, 19 April 2023
Actions	• Develop a business case to expand the service.

Project title: ID2577 Re-audit of Fetal Monitoring (Fresh Eyes)			
Purpose	An initial audit was undertaken in 2021 to ensure compliance with Saving Babies Lives Care Bundle Version 2 (SBLv2). This re-audit was undertaken 12 months later.		
Performance	**Results:**	**Initial audit:**	**Re-audit:**
	Appropriate risk assessment performed	97%	100%
	Hourly Fresh Eyes approach undertaken	76%	89%

	Appropriate classification documented	83%	90%
	Patients appropriately escalated	93%	97%
Reviewed by	• Women's Clinical Audit Presentation meeting, 20 January 2023 • Women's Business and Governance meeting, 15 December 2023 • CBU3 Business and Governance meeting, 24 January 2024 • Clinical Effectiveness group, 20 March 2024.		
Actions	• All CTG stickers to be fully completed including appropriate categorisation by all staff when reviewing CTG. • Update the fetal monitoring policy in line with new NICE guidance (NG229). • To implement Teach or Treat and 'Advice, Inform, Do' (AID) to assist with discussions around non-agreement of CTG categorisation. • Train all midwives band 5 and above to perform Fresh Eyes. • Update the Fetal Auscultation guideline • Add the time Fresh Eyes is due onto the Birthing centre board.		