Barnsley Hospital NHS Foundation Trust

Quality Report

2024-25

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Part 1: Statement on quality from the Chief Executive

The Barnsley Hospital NHS Foundation Trust Quality Account outlines the Trust's progress and achievements throughout the 2024–25 reporting period, highlighting our ongoing commitment to delivering the highest standards of care to our patients and service users.

Over the last year, we have celebrated several key milestones in our journey towards excellence. At the same time, we recognise that there remain areas requiring further focus and improvement as we move into 2025–26. The quality indicators we selected for 2024–25 reflect both local and national priorities and align with our long-term aspiration to achieve an 'outstanding' rating.

Part three of this report presents the outcomes of our quality indicators for 2024–25 and sets out our priorities for 2025–26, as we continue to enhance the quality of care provided to the people of Barnsley and beyond, across all stages of life.

Below I have highlighted a selection of our key achievements and areas for improvement from the last year, which I am pleased to share with you:

- The Trust has successfully met all mandated objectives set by the Regional Research Delivery Network for the year 2024-25. I am proud that the Trust has exceeded its overall recruitment target for research participants and feedback from the patient research experience survey has been overwhelmingly positive. This reflects our dedication to ensuring robust participation in our research initiatives.
- In June 2024, the Care Quality Commission (CQC) conducted an inspection to assess the Trust's compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) within our nuclear medicine service. Following this inspection, the Trust developed a comprehensive action plan to ensure ongoing and future compliance with IR(ME)R standards.
- The Trust has observed an improvement in the Summary Hospital-level Mortality Indicator over the last year. There has been a strong focus on learning from deaths throughout 2024-25. As part of this commitment, all relevant in-patient deaths have undergone scrutiny by medical examiners. This rigorous review process supports us to improve our practices and provide the highest standard of care to our patients.
- Throughout the year, we have continued to refine and implement a systematic and consistent methodology for achieving excellence in data quality. This ensures we have access to accurate and reliable data, which is crucial for monitoring and improving the quality of care we provide to our patients.
- In 2024-25 Barnsley Hospital launched 'Our Leadership Way' to outline expectations for line managers and provide development support for new leaders. This initiative includes the 'Proud to Manage People' programme and local leadership development support, aimed at fostering effective leadership in the organisation.
- In response to colleague feedback regarding wellbeing, the Trust has introduced a comprehensive health and wellbeing strategy. This includes the implementation of a new stress policy, the organisation of wellbeing events, and the introduction of a team stress diagnostic tool (Flourish DX). We hope that these measures will support the mental and physical health of our staff, ensuring a positive and supportive work environment in 2025-26.

- The Trust successfully transitioned to the national learn from patient safety events service and embedded the patient safety incident response framework in 2024-25. Following an internal audit, we received an opinion of significant assurance, highlighting our commitment to maintaining high standards of patient safety and continuous improvement.
- Throughout the year, the Trust has maintained dynamic monitoring of safe nursing staffing levels, including the reporting of red flags to ensure patient safety. Additionally, we have made significant investments in our medical staffing. This has enabled us to staff our wards within medical specialties in accordance with the guidance provided by the Royal College of Physicians.
- The Trust has focused on the effective management and prevention of pressure ulcers and in-patient falls, alongside improving the standards of infection prevention and control. Our commitment to these key quality metrics will continue into 2025-26, ensuring ongoing improvements in patient safety and quality of care.
- In 2024-25, the Trust did not meet the NHS England threshold for the number of cases of Clostridioides difficile. To address this, we sought advice from the NHS England Regional Infection Prevention and Control team to ensure our prevention and management strategies were satisfactory. We are pleased to report that we successfully implemented all actions identified in the C. difficile reduction action plan and as a result, we have observed a reduction in the number of C. difficile infections in the last two quarters of the reporting year.
- By the end of the year, the Trust achieved over 90% compliance for completing risk assessments for patients receiving enhanced care assessments across all adult in-patient areas. This demonstrates our commitment to ensuring the safety and well-being of our patients through thorough and consistent risk assessment practices.
- The Trust has continued to identify initiatives to improve patient-reported outcomes data following total hip and total knee replacements with the aim of improving patient care and experience for our patients undergoing elective total knee and total hip replacement surgery.
- The Trust has seen a thirty percent reduction in formal complaints related to person-centred communication, thanks to our targeted improvement projects in this area. These efforts have enhanced the quality of interactions between patients and staff, ensuring that communication remains respectful and responsive to individual needs.
- Throughout 2024-25, the Trust has maintained its commitment to partnership working across South Yorkshire. We have aligned our patient and public involvement priorities with those of the Integrated Care System. This collaborative approach ensures that our initiatives align with regional peers and partners, enhancing the overall effectiveness and impact of our services.
- In 2024-25, the culture of quality improvement has become further embedded across the organisation. This cultural shift has supported the delivery of a comprehensive portfolio of improvement and innovation initiatives, benefiting patients, staff, partners, and the wider community.
- By the end of the year, the Trust achieved over 90% compliance for ensuring that patients with suspected sepsis, identified through screening, received antibiotics within one hour of diagnosis in both the emergency department and acute in-patient settings. This highlights our commitment to timely and effective sepsis management, which is crucial for improving patient outcomes.

- Throughout the year, the Trust has made significant efforts to improve our performance against the national indicators for waiting times. This remains a priority for us, and we are committed to continuing these improvement efforts into 2025-26. Our focus on reducing waiting times is essential for our patients to be able to access timely and effective care.

I would like to take this opportunity to acknowledge the dedication and commitment demonstrated by all our teams and services across the organisation over the last year. Despite the ongoing pressures facing the NHS and the continued demands on hospital services, our collective focus on delivering the highest standards of safe and effective care has remained unwavering.

As Chief Executive of Barnsley Hospital NHS Foundation Trust, I am immensely proud of the progress we have made and of our continued ambition to be the leading provider of care for our local community.

This report has been reviewed and approved by the Board of Directors, who confirm that it offers an accurate and balanced reflection of our performance during 2024–25. I hope it provides assurance to all readers that patient safety, experience, and continuous quality improvement are at the heart of everything we do at Barnsley Hospital.

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Dr Richard Jenkins, Chief Executive
Date: 20 June 2025

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

2.1(i) Quality Goals 2024-25 (cross reference to Section 3.0; other information)

In 2024-25 our priorities for improving quality for our patients fell within four core goal areas:

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

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

Clinical Effectiveness
It is our continued aim to deliver the best clinical outcomes, to establish standards against which we will continuously improve the care we provide. In 2024-25 our focus was around learning from deaths, improving our identification and management of venous thromboembolism, utilising a programme of clinical audit to ensure our care and treatment is in line with best practice and national guidance and benchmarking applicable services against the Further Faster Programme.

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. In 2024-25 our focus was around maintaining safe staffing levels across the organisation, identifying and acting upon abnormal clinical signs and investigation results, timely communication of patient's needs on discharge, effective management and prevention of pressure ulcers and in-patient falls and the maintenance of high standards of infection prevention and control processes.

Person Centred Care
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. In 2024-25 our focus was around understanding the needs of autistic people and those living with a learning disability and caring for patients at end of life including understanding the spiritual, religious and holistic needs of all patients and their loved ones. The Trust has continued to act on the feedback for patients and work in partnership with service users in co-designing service and workstream improvements.

Quality Improvement
We aspire to drive outstanding care, in collaboration with patients, carers and families, by empowering all staff to make changes that matter. In 2024-25 a culture of quality improvement has become embedded across the organisation which has supported the

delivery of a portfolio of improvement and innovation for the benefit of patients, staff, partners and the wider community.

2.1 (ii) 2024-25 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 2025-26 indicators are included in the tables in section 3 of this report.

Measurement, monitoring and reporting

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

2.2 Statements of Assurance from the Board

Information on Review of Services

During 2024-25 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 2024-25 represents 100% of the total income generated from the provision of relevant health services by the Barnsley Hospital NHS Foundation Trust for 2024-25.

Information on Participation in Clinical Audits

During 2024-25, 34 national clinical audits and seven national confidential enquiries covered relevant health services that Barnsley Hospital NHS Foundation Trust provides.

During that period Barnsley Hospital NHS Foundation Trust participated in 88% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Please see table 1.0 for the national clinical audits and national confidential enquiries that Barnsley Hospital NHS Foundation Trust was eligible to participate in during 2024-25.

The national clinical audits and national confidential enquires that Barnsley Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2024-25, 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 the national clinical audits which the Trust participated in were reviewed by the provider in 2024-25 and Barnsley Hospital NHS Foundation Trust intends to take the actions detailed in appendix A to improve the quality of healthcare provided.

The reports of all local clinical audits were reviewed by the provider in 2024-25 and Barnsley Hospital NHS Foundation Trust intends to take the actions detailed in appendix B to improve the quality of healthcare provided.

Table 1.0: All national clinical audits, national confidential enquiries and audits included on the quality account programme for 2024-25.

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 NHSE
A1	Indicates if the project is applicable to Barnsley Hospital
P1	Indicates if Barnsley hospital participated in the project and submitted (or is currently submitting) data.
% cases submitted	Where data collection was completed during 2024/25 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.

WSN*	Workstream name *Workstream number from the QA list*	Provider organisation	NCA	QA	A1	P1	% cases submitted	Data collection complete?
Clinical Business Unit 1: Medicine								
Emergency Medicine QIPs:								
9	a) Mental Health	Royal College of Emergency Medicine	×	✓	✓	✓	74%	Yes
10	b) Care of Older People		×	✓	✓	✓	65%	Yes
11	c) Time Critical Medications		×	✓	✓	✓	12%	Yes
18	Medical and Surgical Clinical Outcome Review Programme – Acute Limb Ischaemia.	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	✓	✓	100%	Yes

61	National Major Trauma Registry Note: previously TARN	NHS England	×	✓	✓	✓	84%	Ongoing
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
National Adult Diabetes Audit (NDA)								
20	a) National Diabetes Core Audit includes: - Care Processes and Treatment Targets - Complications and Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	NHS England (formerly NHS Digital)	✓	✓	✓	✓	35%	Deadline 23 May 2025
21	b) Diabetes Prevention Programme (DPP) Audit		✓	✓	×	×	×	Community based
22	c) National Diabetes Footcare Audit (NDFA)		✓	✓	✓	✓	100%	Deadline 23 May 2025
23	d) National Diabetes Inpatient Safety Audit (NDISA)		✓	✓	✓	✓	100%	Deadline 23 May 2025
25	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit		✓	✓	✓	✓	100%	Yes
27	National Audit of Cardiac Rehabilitation	University of York	×	✓	×	×	-	-

28	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	NHS Benchmarking Network	✓	✓	×	×	-	-
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
National Cardiac Audit Programme (NCAP)								
43	a) National Adult Cardiac Surgery Audit (NACSA)	National Institute for Cardiovascular Outcomes Research (NICOR)	×	✓	×	×	-	-
44	b) National Congenital Heart Disease Audit (NCHDA)		×	✓	×	×	-	-
45	c) National Heart Failure Audit (NHFA)		×	✓	✓	✓	100%	Deadline 31 May 2025
46	d) National Audit of Cardiac Rhythm Management (CRM)		×	✓	✓	✓	100%	Deadline 31 May 2025
47	e) Myocardial Ischaemia National Audit Project (MINAP)		×	✓	✓	✓	100%	Deadline 31 May 2025
48	f) National Audit of Percutaneous Coronary Intervention (NAPCI)		×	✓	×	×	-	-
49	g) National Audit of Mitral Valve Leaflet Repairs (MVLR)		×	✓	×	×	-	-

50	h) UK Transcatheter Aortic Valve Implantation (TAVI) Registry		×	✓	×	×	-	-
51	i) Left Atrial Appendage Occlusion (LAAO) Registry		×	✓	×	×	-	-
52	j) Patent Foramen Ovale Closure (PFOC) Registry		×	✓	×	×	-	-
53	k) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry		×	✓	×	×	-	-
58	National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology	✓	✓	✓	✓	100%	Yes
69	National Pulmonary Hypertension Audit	NHS England (formerly NHS Digital)	×	✓	×	×	-	-
National Respiratory Audit Programme (NRAP) **Note: previously named National Asthma and COPD Audit Programme (NACAP)**								
70	a) COPD Secondary Care	Royal College of Physicians	✓	✓	✓	✓	96%	Deadline 16 May 2025
71	b) Pulmonary Rehabilitation		✓	✓	×	×	-	-
72	c) Adult Asthma Secondary Care		✓	✓	✓	✓	100%	Yes
86	Sentinel Stroke National Audit Programme (SSNAP)	King's College London	✓	✓	✓	✓	100%	Yes
18	Medical and Surgical Clinical	National Confidential Enquiry into	✓	✓	✓	✓	100%	Yes

	Outcome Review Programme – Juvenile Idiopathic Arthritis	Patient Outcome and Death (NCEPOD)						
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
88	Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine	×	✓	✓	✓	-	Yes
Clinical Business Unit 2: Surgery								
BAUS Data & Audit Programme								
1	a) Penile Fracture Audit	The British Association of Urological Surgeons (BAUS)	×	✓	×	×	-	-
2	b) Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices) (I-DUNC)		×	✓	×	×	-	-
3	c) Environmental Lessons Learned and Applied to the Bladder Cancer Care Pathway Audit (ELLA)		×	✓	×	×	-	-
4	Breast and Cosmetic Implant Registry	NHS England (formerly NHS Digital)	×	✓	✓	✓	100%	Yes
5	British Hernia Society Registry	British Hernia Society	×	✓	✓	×	-	Launch of registry delayed nationally
6	CASE Mix Programme	Intensive Care National Audit & Research Centre (ICNARC)	×	✓	✓	✓	100%	Yes

18	Medical and Surgical Clinical Outcome Review Programme – Rehabilitation Following Critical Illness	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	✓	✓	100%	Yes
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
31	National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society	×	✓	×	×	-	-
59	National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	✓	✓	✓	93%	31 May 2025
60	National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)	✓	✓	✓	✓	100%	Yes
7	Child Health Clinical Outcome Review Programme Emergency Paediatric Surgery	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	✓	✓	100%	Yes
15	Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Royal College of Physicians	✓	✓	✓	✓	100%	Yes
National Ophthalmology Database (NOD)								
65	a) Age-Related Macular Degeneration Audit	The Royal College of Ophthalmologists (RCOphth)	×	✓	✓	×	-	Service decision not to participate and to undertake local audits to provide assurance

66	b) Cataract Audit		×	✓	✓	✓	79%	16 June 2025
74	National Vascular Registry (NVR)	Royal College of Surgeons of England (RCS)	✓	✓	×	×	-	-
77	Perioperative Quality Improvement Programme	Royal College of Anaesthetists	×	✓	×	×	-	-
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)								
81	a) Oncology & Reconstruction	British Association of Oral and Maxillofacial Surgeons (BAOMS)	×	✓	×	×	-	-
82	b) Trauma		×	✓	×	×	-	-
83	c) Orthognathic Surgery		×	✓	×	×	-	-
84	d) Non-Melanoma Skin Cancers		×	✓	✓	×	-	The service chose not to participate due to clinical priorities and lack of capacity
85	e) Oral and Dentoalveolar Surgery		×	✓	✓	×	-	
Other related workstreams								
90	UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	×	✓	×	×	-	-

91	UK Renal Registry National Acute Kidney Injury Audit		×	✓	✓	✓	100%	Yes
Clinical Business Unit 3: Women's and Children's services								
8	Cleft Registry and Audit NEtwork (CRANE) Database	Royal College of Surgeons of England (RCS)	×	✓	✓	✓	100%	Continuous data collection
12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Yes
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
17	Maternal, Newborn and Infant Clinical Outcome Review Programme Saving Lives: Improving Mothers' Care	University of Oxford / MBRRACEUK Collaborative	✓	✓	✓	✓	100%	Yes
17	Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance	University of Oxford / MBRRACEUK Collaborative	✓	✓	✓	✓	100%	Yes
24	National Adult Diabetes Audit (NDA) e) National Pregnancy in Diabetes Audit (NPID)	NHS England (formerly NHS Digital	✓	✓	✓	✓	100%	Yes
26	National Adult Diabetes Audit (NDA) g) Gestational Diabetes Audit		✓	✓	✓	✓	100%	Yes

62	National Maternity and Perinatal Audit (NMPA)1	Royal College of Obstetricians and Gynaecologists	✓	✓	✓	✓	100%	Yes
63	National Neonatal Audit Programme (NNAP)1	Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Yes
67	National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	✓	✓	✓	✓	100%	Yes
68	National Perinatal Mortality Review Tool	University of Oxford / MBRRACEUK Collaborative	×	✓	✓	✓	100%	Yes
73	National Respiratory Audit Programme (NRAP): note: previously named National Asthma and COPD Audit Programme (NACAP) d) Children and Young People's Asthma Secondary Care	Royal College of Physicians	✓	✓	✓	✓	91%	Deadline 16 May 2025
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
76	Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	✓	✓	×	×	-	-
89	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	×	✓	×	×	-	-
Nurse-led								
Falls and Fragility Fracture Audit programme (FFFAP)								

13	a) Fracture Liaison Service Database	Royal College of Physicians	✓	✓	×	×	We do not provide this service	
14	b) National Audit of Inpatient Falls		✓	✓	✓	✓	100%	Yes
16	Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)	NHS England	×	✓	✓	✓	100%	Yes
18	Medical and Surgical Clinical Outcome Review Programme – End of Life Care	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	✓	✓	100%	Yes
19	Mental Health Clinical Outcome Review Programme	The University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health	✓	✓	×	×	-	-
29	National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	✓	✓	✓	✓	100%	Continuous data collection
30	National Audit of Dementia (NAD)	Royal College of Psychiatrists	✓	✓	✓	✓	100%	Yes
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
42	National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	×	✓	✓	✓	100%	Continuous data collection
54	National Child Mortality Database (NCMD)	University of Bristol	✓	✓	✓	✓	100%	Yes
18	Medical and Surgical Clinical Outcome Review Programme – Acute Illness in People with a	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	✓	✓	To be confirmed	Data collection on-going

	Learning Disability							
Corporate								
18	Medical and Surgical Clinical Outcome Review Programme – Blood Sodium	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	✓	✓	100%	Yes
National Cancer Audit Collaborating Centre (NATCAN)								
32	National Audit of Metastatic Breast Cancer (NAoMe)	Royal College of Surgeons of England (RCS)	✓	✓	✓	✓	100%*	No *100% of data has been collected however, submission delayed
33	National Audit of Primary Breast Cancer (NAoPri)		✓	✓	✓	✓		
34	National Bowel Cancer Audit (NBOCA)		✓	✓	✓	✓		
35	National Kidney Cancer Audit (NKCA)		✓	✓	✓	✓		
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**
36	National Lung Cancer Audit (NLCA)		✓	✓	✓	✓	100%*	No *100% of data has been collected however,
37	National Non-Hodgkin Lymphoma Audit (NNHLA)		✓	✓	✓	✓		

38	National Oesophago-Gastric Cancer Audit (NOGCA)		✓	✓	✓	✓		submission delayed
39	National Ovarian Cancer Audit (NOCA)		✓	✓	✓	✓		
40	National Pancreatic Cancer Audit (NPaCA)		✓	✓	✓	✓		
41	National Prostate Cancer Audit (NPCA)		✓	✓	✓	✓		
55	National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists	✓	✓	×	×	-	-
75	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	University of Warwick	×	✓	×	×	-	-
National Comparative Audit of Blood Transfusion								
56	a) National Comparative Audit of NICE Quality Standard QS138	NHS Blood and Transplant	×	✓	✓	×	-	Service chose not to participate due to service priorities and lack of capacity
WSN*	**Workstream name** **Workstream number from the QA list*	**Provider organisation**	**NCA**	**QA**	**A1**	**P1**	**% cases submitted**	**Data collection complete?**

57	b) National Comparative Audit of Bedside Transfusion Practice		×	✓	✓	✓	100%	Yes
64	National Obesity Audit (NOA)	NHS England (formerly NHS Digital)	✓	✓	×	×	-	-
87	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	×	✓	✓	✓	100%	Continuous data collection
Mental Health								
Prescribing Observatory for Mental Health (POMH)								
78	a) Rapid Tranquillisation in the Context of the Pharmacological Management of Acutely Disturbed Behaviour	Royal College of Psychiatrists	×	✓	×	×	-	-
79	b) The Use of Melatonin		×	✓	×	×	-	-
80	c) The Use of Opioids in Mental Health Services		×	✓	×	×	-	-

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Barnsley Hospital NHS Foundation Trust in 2024-25 that were recruited during that period to participate in research approved by a Research Ethics Committee was 654.

The Trust's performance has been exceptional, achieving all of the Regional Research Delivery Network's (RRDN) mandated objectives for 2024-25 including:

- Exceeding the Trust's overall recruitment target
- Ninety two percent of studies have recruited to time and target
- Patients have reported a positive research experience in the patient research experience survey

The Trust has seen significant improvements in all aspects of the Research and Development portfolio:

- 88 staff delivering research across all CBUs
- 41 health care professionals appointed as Principal Investigators
- 151 staff trained in good clinical practice (GCP)
- 98% compliance with GCP training
- 35 studies in 17 specialties across all CBUs were open to recruitment in the reporting year

The Research and Development team have faced some challenges throughout the reporting year:

- The RRDN funding has remained static for 2024-25 despite the team's continued good performance. This somewhat limits the Trust's ability to grow the Research and Development team any further
- The Trust has been unsuccessful in selection for a number of commercial studies
- A number of commercial studies have not progressed in the United Kingdom
- A large number of studies within the Research and Development team's portfolio have closed. The Trust relied on these studies to maintain participant recruitment numbers.
- The Trust needs to identify and secure more larger recruiting studies to ensure the mandated recruitment target is met
- The Trust has been unable to secure plans for, and commitment to progress a dedicated research facility

The Research and Development team are proud to have diversified the research portfolio by participating in more complex studies. This can be further improved by focussing on growing commercial research in order to support new treatments for patients whilst also generating income for the Trust. This is challenging for smaller organisations who have less resource and infrastructure compared to teaching hospitals who are the Trust's competitors in this process.

The Research and Development team have ambitious plans for 2025-26 and have developed a new three year research and development strategy that will focus work in line with national and Trust priorities. The team are confident in their ability to continue the success achieved so far in their research endeavours.

Commissioning for Quality and Innovation (CQUIN) Framework

The Commissioning for Quality and Innovation (CQUIN) framework enables BHNFT's commissioners to reward excellence, by linking a proportion of our income to the achievement of local quality improvement goals. NHS England paused the nationally mandated CQUIN quality incentive scheme for 2024-25.

Regulation and Compliance

Barnsley Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against the Trust during 2024-25.

In June 2024 the CQC undertook an inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the nuclear medicine service at Barnsley Hospital.

The inspection identified a number of recommendations. Following the submission of the Trust's detailed action plan the CQC were assured that the measures taken or planned addressed the recommendations made and would demonstrate compliance with IR(ME)R in the future.

Quality of Data

Barnsley Hospital NHS Foundation Trust submitted records during 2024-25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

99.9% for admitted patient care
100% for out-patient care and
99.7% for accident and emergency care

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

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

Information Governance

Barnsley Hospital NHS Foundation Trust Information Governance Assessment Report for 2023-24 was graded as overall risk assurance across all 10 standards – moderate and confidence level in the veracity of the self-assessment – high.

Clinical Coding

Barnsley Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024-25 but was subject to a Data Security and Protection Toolkit audit in February 2025.

Coding Field	Percentage
Primary Diagnosis	83%
Secondary Diagnosis	93%

Primary Procedure	89%
Secondary Procedure	91%

Data Quality

Ensuring high standards of data quality is vital to the effective operation, planning, and service delivery within acute hospitals. The Trust's action plan adheres to operational planning guidance and provides a structured approach to achieving excellence in data quality across all relevant areas. Barnsley Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Guarantee the accuracy, completeness, and timeliness of data to support operational planning, informed decision-making, and patient care delivery
- Strengthen compliance with national reporting standards and regulatory requirements
- Enhance data governance frameworks and ensure staff accountability for data management practices
- Promote a culture of continuous improvement and heightened awareness of the importance of data quality
- Regularly review the data quality dashboard during monthly data quality meetings to monitor progress, identify trends, resolve issues, and provide updates on resolution statuses
- Support validation sprint exercises across the Trust, offering monitoring and guidance as needed
- Collaborate with teams to utilise the Federated Data Platform, starting with outpatient services, to address validation challenges
- Identify areas where discharge-ready data is incomplete or incorrect and implement processes to rectify errors
- Review and update the Trust's existing data quality policy to reinforce ongoing improvements in data management
- Conduct quarterly validations of clock stops to maintain high standards of patient safety and care
- Enhance the LUNA report by identifying duplicate pathways and providing services with targeted training based on identified needs
- Monitor outpatient consultation records to ensure proper documentation for every appointment
- Verify that outpatient procedure codes are consistently and accurately entered where applicable
- Participate in annual audits to uncover discrepancies, gaps, and inaccuracies, utilising feedback to support continuous learning and improvement
- Maintain daily oversight of referral to treatment (RTT) data quality issues, with a focus on long wait times and status errors. This includes:
    - Reviewing approximately 50 items daily
    - Supporting an average of 150 patient record amendments
- Review and adapt to new RTT guidelines, implementing necessary changes to recording procedures and patient systems
- Ensure robust escalation processes for addressing long wait times and discrepancies, providing visibility to the Data Quality group (DQG).
- Leverage the Data Quality Maturity Index (DQMI) to identify and address data errors, implementing procedures to enhance accuracy
- Continuously monitor maternity data quality to address income-related inaccuracies, with updates reported on a central dashboard

- Support the rollout of the new tele-tracking patient flow system to improve discharge processing accuracy, including discharge times
- Conduct audits of discharge times to address inaccurate entries
- Identify and resolve issues related to discharge-ready dates to optimise trustwide patient flow.
- Escalate high-impact data quality issues to Executive Team meetings for timely resolution
- Ensure relevant updates from the Information Governance group are communicated to the Clinical Effectiveness group.
- The Business Intelligence team will continue to develop advanced reporting mechanisms to ensure accurate and timely data submissions. These reports will facilitate comparisons with local Trusts, fostering shared learning and improvement

The data quality action plan establishes a comprehensive framework for improving data quality within the Trust, ensuring alignment with operational planning objectives. Its success relies on collective accountability, continuous monitoring, and a commitment to excellence across all departments.

Learning from Deaths

(27.1) During 2024-25 1115 of Barnsley Hospital NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
285 in the first quarter
243 in the second quarter
303 in the third quarter
284 in the fourth quarter.

(27.2) By 31 March 2025, 72 case record reviews and four investigations have been carried out in relation to 1115 of the deaths included in item 27.1.

In four cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
21 structured judgement reviews (SJRs)/one patient safety incident investigation (PSII) in the first quarter;
19 SJRs/one PSII in the second quarter;
17 SJRs/one PSII in the third quarter;
15 SJRs/one PSII in the fourth quarter.

(27.3) Four representing 0.36% 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:
One representing 0.35% for the first quarter;
One representing 0.41% for the second quarter;
One representing 0.33% for the third quarter;
One representing 0.35% for the fourth quarter.
These numbers have been estimated using the records held in the Trust's incident reporting system.

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

Learning from the completed PSIIs includes:

- Systems to support clinicians with VTE assessment and anticoagulation management are required.
- Post-operative instructions should be communicated and implemented effectively.
- Consistency is required in relation to the senior medical review of trauma and orthopaedic patients.
- Systems for junior staff support in trauma and orthopaedics are required.
- When junior doctors change over there is an increased risk of patient safety incidents occurring, as these staff will not be familiar with the detailed working relationships and routines within a ward environment.

Learning from the SJRs includes:

- Recognising when it is appropriate to begin honest conversations about treatment when some medical problems cannot be reversed or when treatments will not help.
- Recognising a patient is entering the last days to hours of life and the communication with the patient (if appropriate) and those close to them is important. The focus at this stage should be on symptom control, stopping unnecessary interventions and tests.
- Precipitating factors for delirium can be frequently overlooked. The management of some of the common causes of the iatrogenic illness; treating constipation, monitoring fluid balance in the confused and developing policies such as the management of hypernatremia has been shared with clinical teams.
- Learning has also been shared from good care; the importance of regular consultant review and seeking input from the wider multidisciplinary team.
- The excellent care of a patient with a learning disability was shared to highlight the importance of considering the expert knowledge of the family and carers when discussing care plans and management.
- The use of a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) plan makes discussion about prognosis and management options easier to manage in an emergency situation. The ReSPECT process creates a personalised recommendation for clinical care in emergency situations, where the patient is not able to make decisions or express their wishes.

(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 PSIIs include:

- The electronic prescription and medicines administration (EPMA) team should explore the possibility of alerts being added to the EPMA system when a medication has been suspended or the team should consider an alternative visual colour prompt that is designated to drugs that have been temporarily suspended.
- Venous thromboembolism (VTE) risk assessment and thromboprophylaxis should be routinely reviewed on consultant and specialist registrar ward rounds and discussed and documented at the trauma meeting.

- Nursing and medical staff require training and education on the Trust's bridging anticoagulation guidelines.
- A written standard is required in relation to the completion of and communication of post-operative instructions in and out of hours across the trauma and orthopaedic service.
- Where new or additional medications are recommended at the end of a surgical procedure these should be prescribed on the EPMA system in theatre by the clinician requesting the treatment.
- The trauma and orthopaedic service should consider how information from the post-operative instruction note made in theatre could be added to the electronic handover record before the patient leaves theatre.
- A standard operating procedure is needed to detail the requirement for the consultant ward round and post-operative review of patients by the consultant.
- The trauma and orthopaedic service management team require assurance that all patients receive a daily senior medical review at the bedside and a post-operative consultant review in line with National Institute for Health and Care Excellent (NICE) Quality Standard QS174.
- A standard operating procedure is required for safety board rounds. VTE assessment, thromboprophylaxis and completion of post-operative instructions should be routinely covered by this guidance.
- The trauma and orthopaedic service management should ensure active support systems are in place in the first two weeks following junior doctor change over for all levels of trainee. The support systems must include direct training on use and access to the EPMA system and ensure direct support from senior doctors is available on the ward.
- The trauma and orthopaedic service should continue to monitor and act upon junior doctor exception reports and this information should be shared on a monthly basis through the trauma and orthopaedic governance meeting.
- VTE assessment, thromboprophylaxis and completion of post-operative instructions should be routinely included in the nursing handover information.

Learning from SJRs that do not go on for further in-depth review is shared via learning from deaths bulletins, which also include learning from good care as described in section 27.4.

(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 serious incident (SI) 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 limited assurance 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.

(27.7) Zero case record reviews and zero investigations completed after the last reporting period which related to deaths which took place before the start of the reporting period. *(The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous 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 records in the Trust's incident reporting system (Datix).

(27.9) Zero representing 0% of the patient deaths during the previous 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 2.0 Barnsley Hospital NHS Foundation trust performance against the NHS Outcomes Framework 2024-25 Indicators

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
SHMI value and banding November 2024 (latest available data)	98.15	100.36	N/A	N/A	96.60	102.29	101.89

The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI, (NHS England)

Trust Assurance Statement:

The 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

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

- Reviewing the statistic at the Mortality Overview group (MOG) and the Learning from Deaths group
- Ensure delivery of the statutory Medical Examiner (ME) service
- Continue to apply learning from SJRs and PSIIs
- Work with the Coding team to ensure all available coding sources are utilised for accuracy in the SHMI
- Work with the external informatics company to ensure all avenues of potential improvements are identified

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
% of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	60.06%	45.77	69.56	13.52	36.65%	18.80%	18.79%

Trust Assurance Statement:

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

- Significant work has continued through 2024-25 to ensure there is a systematic and consistent methodology for the coding of patient deaths with the palliative care code

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

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

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
The Trust's responsiveness to the personal needs of its patients during 2024-25.	Data not available (awaiting CQC publication)	No comparable data available at time of reporting			66%	83%	78%

Trust Assurance Statement:

The 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 from the CQC adult inpatient survey, to monitor its responsiveness to the personal needs of patients. Whilst the majority of results were predominantly positive, the question pertaining to patients being given information about their medicine at discharge needs significant improvement. Data for the adult inpatient survey 2024 will be published via the CQC website later this year
- Intelligence gained from the adult inpatient survey is used to inform service level action plans and local surveys to monitor service improvements across the Trust

The 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 (MDT) approach to proactively establish improvement workstreams across the Trust. These include; person-centered communication, nutrition and hydration and person-centered care (including end of life care)
- Assigning Patient and Carer Experience Leads to CBUs to support service improvement workstreams and responding to information obtained through patient, family and carer feedback, insight and engagement
- Developing a MDT task and finish group, consisting of nursing, medical and pharmacy colleagues, to review the self-administration of medications (SAM). The task and finish group will review the SAMs policy and develop a supporting information leaflet. Once the draft is complete, the project will be piloted in one key area of the Trust before being rolled out further as appropriate

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 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.	68.66%	61.54%	89.59%	39.72%	67.23%	64.4%	66.9%

Trust Assurance Statement:

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

- The Trust aspires to be a compassionate and inclusive place to work in an environment of psychological safety where people can raise concerns
- The Trust provides excellent care delivered by experienced and highly skilled people in an environment of engagement, continuous learning and support for colleague wellbeing
- Retention and attraction are strong in comparison to some organisations resulting in a well-resourced organisation
- Regular colleague communications and recognition of staff for excellence continually reinforces the focus on care of patients/service users

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

- Acting in response to the staff survey and continuing to improve staff experience; for example, in the development of teams, staff health and wellbeing, leadership, development opportunities and listening
- Trustwide and local action plans have been developed. In response to feedback about colleague wellbeing, a Health and Wellbeing strategy, a new Stress policy, wellbeing events and a team stress diagnostic (Flourish DX) have been introduced
- A wide range of recognition initiatives including a new weekly Proud News publication, Shout Outs, monthly Brilliant Awards and annual Heart Awards
- The launch of ‘Our Leadership Way’ and line manager expectations, together with development support aimed at new leaders in the form of the ‘Proud to Manage People’ programme and local leadership development support
- Implementing additional guidance and oversight to support CBUs with sharing results of the staff survey and involving their teams in identifying actions appropriate to them. CBUs are expected to share updates on their action plans at the People Engagement group, chaired by the Director of People
- Introducing cultural development programmes and interventions such as ‘Even Better Together’ (a colleague-led initiative in maternity designed to increase staff voice)
- The Trust shares high level Trust performance in the monthly Team Brief which also provides staff with the opportunity to raise questions and concerns

Indicator	2023-24 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
28-day readmission rates for patients aged 0 to 14 during 2024-25.	16.14%	Data unavailable. Benchmarking for readmissions is several months behind real time so no comparable data available at time of reporting.			15.82%	17.92%	16.59%
28-day readmission rates for patients aged 15 or over during 2024-25.	9.93%	Data unavailable. Benchmarking for readmissions is several months behind real time so no comparable data available at time of reporting.			9.33%	9.53%	16.5%

Trust Assurance Statement:

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

- Patients attending the Same Day Emergency Care Medical and Surgical units are recorded as non-elective admissions with a zero length of stay, this allows ambulant patients to be care for and managed without having to remain in hospital

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

- The Trust has developed a Virtual Ward that supports frailty and respiratory patients in their own home.
- The Trust works closely with partners reviewing high intensity users
- 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 safety nets 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	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
% of admitted patients who were admitted to hospital and who were risk assessed for venous thromboembolism during 2024-25 ***latest available published data December 2024**	98.9%	89.1%	100%	12.7%	98.1%	97.1%	98.2%

Trust Assurance Statement:

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

- The data is taken from the electronic patient record where questions about VTE risk assessment are recorded

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

- Continuing to review any contributory factors in the VTE assessment process and take appropriate actions where necessary
- Continuing to deliver training on the importance of VTE assessment
- The Thromboprophylaxis and Thrombosis committee will continue to meet monthly oversight and sustainability of compliance VTE assessment and management

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
Number cases of C.difficile infection amongst patients aged 2 or over during 2024-25.	73 cases	Data unavailable from national source at the time of completing this report.			54 cases	43 cases	32 cases

Trust Assurance Statement:

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

- Data collated through surveillance programmes and national reporting requirements in conjunction with local review supports the accuracy of the data

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

- Reviewing and auditing practice, surveillance and education, thorough systems- based investigations
- The Trust has sought advice from NHS England North East and Yorkshire Regional Infection Prevention and Control team to ensure that the Trust's current prevention and management strategies are satisfactory
- Participating in benchmarking with other Trusts to identify any shared learning and improvements

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24 BHNFT	2022-23 BHNFT	2021-22 BHNFT
Number of patient safety incidents reported during 2024-25.	13,449	National data no longer provided			14,419	14,322	11,859

Trust Assurance Statement:

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

- NHS England paused the publication of the monthly and annual data of the number of patient safety incidents reported to the National Reporting and Learning System (NRLS)
- Due to its aging infrastructure the NRLS was withdrawn on the 30 June 2024 and replaced by the Learn from Patient Safety Events (LFPSE) service. The Trust began reporting to the LFPSE on the 17 June 2024
- 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

The 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
- The number of incidents reported, themes and trends, the number of open incidents and the learning and action taken following incidents is summarised in clinical governance reports and presented by the Clinical Governance team at relevant corporate groups; e.g. Infection Prevention and Control group, Medicines Management Operational group and Nutrition and Hydration Operational group
- Training is provided to staff on incident reporting and investigating incidents at study days, team meetings and one-to-one training is provided at individuals' request

Indicator	2024-25 BHNFT	National Average	Best Performer (if applicable)	Worst Performer (if applicable)	2023-24	2022-23 BHNFT	2021-22 BHNFT
Number of patient safety incidents reported during 2024-25 that resulted in severe physical harm, severe psychological harm or a fatal outcome	Severe physical harm 22 (0.16%) Severe psychological harm 1 (0.01%) Fatal outcome 10 (0.07%)	National data no longer provided			Severe harm 24 (0.17%) Death 13 (0.09%)	Severe harm 24 (0.2%) Death 17 (0.1%)	Severe harm 32 (0.2%) Death 18 (0.1%)

Trust Assurance Statement:

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

- NHS England paused the publication of the monthly and annual data of the number of patient safety incidents reported to the National Reporting and Learning System (NRLS)
- Due to its aging infrastructure NRLS was withdrawn on the 30 June 2024 and replaced by the Learn from Patient Safety Events (LFPSE) service. The Trust began reporting to the LFPSE on the 17 June 2024
- Following feedback from staff, patients and families the LFPSE service introduced a new addition in relation to patient safety incident data. Physical harm and psychological harm are graded separately in LFPSE
- The number of patient safety incidents reported that have resulted in severe physical harm, severe psychological harm or a fatal outcome has been taken from the Trust's incident reporting system, Datix

The 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 NHS England Patient Safety Specialist meetings to ensure that the Trust meets the requirements of the national Patient Safety strategy
- The Trust has embedded the Patient Safety Incident Response Framework (PSIRF) throughout 2024-25. An external review of the Trust's implementation of PSIRF undertaken by 360 Assurance provided significant assurance
- Incidents that require escalation and confirmation of an appropriate learning response 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 all learning responses is shared with the staff and the service directly involved in the incident, trustwide through a sharing the learning bulletin and through the Trust's governance framework
- Triangulation of complaints, litigation, incidents and HM Coroners inquests is undertaken at the weekly MDT huddle
- 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. During 2024-25 assurance reviews were introduced to the Perinatal Mortality Review Tool (PMRT) process

Table 3.0: Patient Reported Outcome Measures (PROMs) reporting period: April 2023 to March 2024 (*latest data available*)

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

For total hip replacement (THR) surgery:

- In 2023-24 the Trust fell below the national benchmark in four out of five of the EQ5D general health questions.
- In 2023-24 the Trust remained above the national benchmark for the EQVAS (visual analogue) scale.
- In 2023-24 the Trust improved to meet the national benchmark for the Oxford hip score however, is still below the national benchmark in four out the eleven questions.

For total knee replacement (TKR) surgery:

- In 2023-24 the Trust met the national benchmark with the EQ5D general health questions.
- In 2023-24 the Trust has significantly improved and is now above the national benchmark for the EQVAS (visual analogue) scale.
- In 2023-24 the Trust remained below the national benchmark for the Oxford knee scores.

Since 2022-23 there has been an overall deterioration across the EQ5D general health questions for THR and TKR, and for the Oxford hip and knee scores.

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

- Participation in the PROMS was below the 60-70% target in 2023-24.
- The general health of the population has deteriorated and patients are waiting longer to undergo their surgery.

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

- Further improve the collaborative MDT leadership across the elective orthopaedic pathway.
- Implement a MDT Steering group to review and understand the detail in the question specific responses.
- Consider approaches to offering patients pre-operative support; for example an active wait programme.
- Recommence the collection of data pre-operatively and at eight weeks post-operatively.
- Explore opportunities to improve participation in the PROMS.

Part 3: Other information

Trust performance against agreed 2024-25 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 2024-25. The final column in each table confirms the indicators we have agreed against the quality priorities for 2025-26.

Goal 1

3.1 We will deliver the best possible clinical outcomes

3.1.1 Mortality

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
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.	Achieved	All relevant in-patient hospital deaths have received a ME scrutiny. Feedback has been sought by the ME officer from the designated next of kin.	We will ensure the statutory requirements and the NHS contract service conditions for the ME service are met. This will include ensuring that 100% of non-coronial in-patient deaths are reviewed by a ME.
We will continue to maintain SJRs for all relevant deaths and will implement learning to improve care for future patients.	Achieved	SJRs have been completed for all relevant deaths and either escalated for further investigation or learning shared via bulletins.	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.		The SJR library has been established and anonymised SJRs are available for learning.	We will address health inequalities by ensuring a 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 mortality statistics remain within confidence limits.	Achieved	As at 31 March 2025 mortality statistics were within confidence limits.	We will ensure mortality statistics remain within confidence limits.

Data source: local Trust data source, 2024-25.

3.1.2 Improvements in clinical services

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
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 Getting It Right First Time (GIRFT) Oversight group meetings.	Achieved	Services have been benchmarked against the FFP improvement checklists and action plans have been developed to support the services to make improvements where applicable.	We will continue to monitor and report progress via the Clinical Effectiveness group and GIRFT Oversight group meetings. We will review the FFP action plans will take place quarterly throughout the reporting year.
We will continue to learn from other Trusts and utilise benchmarking data to identify improvements and embed best practice.	Achieved	This is an on-going indicator with the benchmarking data changing frequently each month. The Model Health System (MHS) data and GIRFT best practices are shared with the services and	We will continue to learn from other Trusts and utilise benchmarking data to identify improvements and embed best practice.

		incorporated into the GIRFT Oversight group for the services to be able to identify improvement and embed best practice.	
We will respond to increased frequency from the national clinical audits. We will ensure that there are processes in place to identify and agree improvements plans where required.	Achieved	Changes have been made to the internal reporting process in response to the increased reporting frequency of the national clinical audits. Quarterly data is reviewed and discussed at an appropriate forum. Where data shows that improvement may be required, actions are agreed to address these in a timely manner. Annual reports are produced for full oversight and reporting through the appropriate governance route and through to the Clinical Effectiveness group for oversight.	We will review and improve the internal process for the monitoring of NICE guidance including the development and approval of key performance indicators.

Data source: local Trust data source, 2024-25.

3.1.3 Implementation of systems to prevent avoidable harm

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
Eighty percent or above of key staff identified through appropriate role profile will receive training in human factors (HF).	Achieved	As at 31 March 2025 HF training compliance was 86%.	We will maintain 85% or above compliance for HF training for key staff identified through appropriate role profile.
We will maintain 95% or above compliance with VTE risk assessment in all adult in-patient areas.	Achieved	As at 31 March 2025 compliance with VTE risk assessment was 99.74% 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 incidents of hospital acquired VTE where the patient has died or required level two or above care (as a result of VTE), as well as a sample of other patients to inform on any improvements needed.	Achieved	All hospital acquired VTE cases have been discussed at the Trust's Thromboprophylaxis and Thrombosis committee and actions are monitored via this group.	We will investigate incidents of hospital acquired VTE where the patient has died or required level two 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, 2024-25.

Goal 2

3.2 We will deliver safe care

3.2.1 Safe staffing

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
We will have established safe staffing levels (medical and nursing) which are monitored for compliance.	Nursing – achieved	Throughout the reporting year we have maintained dynamic monitoring of safe nursing staffing levels with the reporting of red flags. Where risks have been identified appropriate mitigating actions have been put in place.	We will deliver a safer staffing masterclass for Matrons and Lead Nurses.
The updated safer nursing care tool will be utilised for nursing establishment reviews; this will include the Emergency Department.		Bi-annual nursing establishment reviews have been completed in the reporting year. This included the Emergency Department.	We will continue to complete bi-annual nursing establishment reviews.

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 the Royal College of Physicians (RCP) guidance.	Medical - achieved	A medical staff investment case has allowed us to improve safe staffing of doctors across wards within medical specialties in line with the RCP guidance.	We will maintain optimum medical staffing levels across all specialities and CBUs with minimal use of agency staff in line with our target trajectory.
We will maintain a high level of performance with less than one exception report per day.	Achieved	In the reporting period 347 exception reports were submitted.	We will maintain a high level of performance with less than one exception report per day.

Data source: local Trust data source, 2024-25.

3.2.2 Proactively implement improvements to keep our patients safe

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 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.	Partially achieved	Work is ongoing across all CBUs to improve ICE filing performance and compliance. This year has seen a number of ICT related issues caused by the supplier of the system. Performance against all abnormal results reported through the ICE system being viewed and acted on within 14 working days has been impacted by	

		this issue. The known system issues are now resolved, and performance is expected to improve.	
We will ensure 90% completion of hospital discharge summaries (D1) within 24 hours of discharge.	Achieved	As at 31 March 2025 over 95% of D1s were completed within 24 hours of discharge.	We maintain over 95% 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	As at 31 March 2025 the 90% trust wide target was achieved in five out of the twelve months. For three months compliance was 89%. The remaining four months compliance was between 83% and 89%.	Quality information regarding pressure ulcers will be monitored through the Trust's 2025-26 objectives around person-centred care.
We will achieve and sustain 90% trust wide compliance on patient's risk level to pressure ulcers being reassessed on transfer to the ward.	Achieved	As at 31 March 2025 the 90% trust wide target was achieved in eleven out of the twelve months. In December 2024 87% compliance was achieved. Review of bed occupancy identified that during December 2024 there was a significant increase in the number of additional occupied in-patient beds.	Quality information regarding pressure ulcers will be monitored through the Trust's 2025-26 objectives around person-centred care.
We will ensure that 90% of patients receiving enhanced care will have enhanced care risk assessments completed.	Achieved	As at 31 March 2025 over 94% compliance was achieved for patients receiving enhanced care had enhanced care risk assessments completed.	Quality information regarding enhanced care will be monitored through the Trust's 2025-26 objectives around person-centred care.
We will achieve 90% trust wide compliance on Tendable falls prevention intervention audits.	Achieved	As at 31 March 2025 over 94% compliance was achieved on Tendable falls prevention audits.	Quality information regarding falls will be monitored through the Trust's 2025-26 objectives around person-centred care.
We will ensure that 90% of patients over	Not achieved	The 90% target was not achieved.	We will ensure that 90% of

65 years have a lying and standing blood pressure (BP) recorded within 24 hours of admission.		Compliance month to month ranged between 77% to 89%. For ten out of the twelve months the compliance ranged between 84% and 89%.	patients over 65 years have a lying and standing BP completed on admission.
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.	C. difficile – not achieved	The numbers of C. difficile infections reduced in quarters three and four of the reporting year. All of the actions in the C. difficile reduction action plan have been achieved.	We will achieve the NHS England reduction thresholds relating to C. difficile infections.
The reduction of MRSA bacteraemia will form part the Trust's 2024-25 IPC action plan.	Achieved	Zero cases of MRSA bacteraemia identified in 2024-25	We will achieve and sustain the NHS England reduction thresholds for MRSA bacteraemia.

Data source: local Trust data source, 2024-25.

3.2.3 Prevent avoidable patient deterioration

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 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	100% of patients with AKI had their AKI status documented on CareFlow Vitals.	We will improve the knowledge and awareness of AKI amongst by ensuring 70% of relevant clinical staff complete the AKI e-learning.
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	Achieved	As at 31 March 2025 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	We will continue to reduce the physical and emotional side effects of sepsis by ensuring we meet the national standards for sepsis screening and

diagnosis in the ED and acute in-patient settings.		acute in-patient settings was • Trustwide 94.60% • In-patients 97.36% • Emergency Department 91.71%	management.
			We will embed Martha's Rule in line with the NHS England plan.

Data source: local Trust data source, 2024-25.

Goal 3

3.3 We will provide person centred services

3.3.1 Compassionate, dignified and respectful care

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
We will support the development of a patient passport for people with autism and learning disabilities.	Partially achieved	The 'Universal Passport' has been co-produced by the Public Health Principle and experts by experience. The South Yorkshire Integrated Care Board (ICB) Communications team are finalising the passport design prior to printing and implementation. The Trust continues to use the current hospital passport 'All About Me' to support person-centred care.	We will support the launch and implementation of the 'Universal Passport' for people with autism and learning disabilities.
We will achieve higher than the national	Partially achieved	The NACEL audit identifies ten key	We will improve our compliance

average for the NACEL quality measures.		indicators and highlights an 'above' national average position within eight of these indicators, scoring 75% or over. A quarterly update is presented at the End of Life Steering group. The two key indicators for improving end of life care achieved the following in the NACEL audit: • Evidence of conversations about hydration with the person(s) important to the dying patient 47.3% compliance • Assessment of the patients emotional and psychological needs 57.4% compliance	with the following two key indicators in the NACEL audit: • Evidence of conversations about hydration with the person(s) important to the dying patient • Assessment of the patients emotional and psychological needs
We will deliver spiritual assessment training to all wards.	Partially achieved	As at 31 March 2025 seven wards received training in spiritual assessment. The Chaplaincy team proactively advocate and support patient's holistic and spiritual welfare.	We will continue to roll out spiritual assessment training to all in-patient areas. We will implement a process for monitoring the effectiveness and impact of training sessions of the spiritual assessment training.
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.	Achieved	The Chaplaincy team provides a multi-faith service enabling the religious, pastoral and spiritual needs of patients, their loved ones and staff to be met.	We will continue to achieve and sustain the 100% target standard to visit a patient within the first 72 hours after admission. We will support staff to ensure that the spiritual needs of patients are assessed and recorded on each admission.

We will ensure that information about the chaplaincy service is communicated in the *"right way, at the right time and in the right place"*.	Achieved	The Chaplaincy team have ensured that information about, and how to access the service is available to all patients, their loved ones and staff.	We will ensure that all information about, and how to access the chaplaincy service is accessible for the population of Barnsley.
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.	Achieved	The accessibility and effectiveness of the chaplaincy service is reported on a quarterly and annual basis through the Patient Experience, Engagement and Insight group.	We will ensure that the work and values of the chaplaincy service clearly communicated through the use of accessible information.

Data source: local Trust data source, 2024-25.

3.3.2 Engagement in the delivery of care, design and re-design

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
As a result of concerns, formal complaints, insight and engagement we will identify local improvement initiatives regarding patient communication.	Achieved	The Patient Experience team continue to work with CBUs to embed initiatives aimed at enhancing communication and providing appropriate information including: • Three things about me • Care Partners • Welcome Packs CBUs have been encouraged to respond to feedback, including complaints and concerns related to	We will identify and implement new local improvement initiatives regarding person-centred communication.

		communication with the identification of actions and improvement initiatives. During 2024-25 there has been a significant reduction in the number of formal complaints as a result of person-centred communication concerns.	
We will work in partnership across South Yorkshire to align the Integrated Care System (ICS) and the ICB patient and public involvement priorities into the work of the Trust.	Achieved	The Patient and Carer Experience Manager and the Head of Quality and Clinical Governance are attendees of the Barnsley Involvement and Inclusion Leads group. The three key priorities of the group include: • Health on the High Street • Dementia: Hearing the Voice • Move Well programme Throughout the reporting year the Trust has supported these priorities.	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 identify and implement patient experience initiatives and improvements to enhance person-centred care and communication, especially for those in the last year of life.
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.	Achieved	The Patient Experience team have supported a number of initiatives throughout the Trust in in relation to improved nutrition and hydration. The team have a coordinated approach to Enhanced Support Volunteers who offer support to in-patients at mealtimes. The Care Partner initiative has been implemented and embedded supporting the nutritional needs of	We will focus on identifying and understanding the barriers for the trustwide sustained implementation of 'Three things about me' and 'Care Partners.'

		patients who require physical and/or emotional support. Processes for collecting patient feedback on the effectiveness of these initiatives have been established and implemented. During 2024-25 there has been a significant reduction in the number of formal complaints as a result of nutrition and hydration concerns.	

Data source: local Trust data source, 2024-25.

3.3.3 Customer service mind-set

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
We will communicate and document improvements via a portfolio of 'you said, we listened' as a result of concerns, formal complaints, insight and engagement.	Achieved	There is an accessible 'you said, we listened' page on the public facing Trust website that shares learning from formal complaints. As at 31 March 2025 the Trust has designed and is in the process of implementing patient experience boards in all clinical areas.	We will continue to roll out the key principles of the Patient Experience Navigator concept: • We will communicate with patients, carers, families and advocates to collect real-time feedback • We will support patients, carers, families and advocates to share their experiences • We will ensure patients and visitors are provided with

			welcome packs and other relevant information on their admission into hospital, to support their inpatient stay experience • We will support high quality patient experience
We will continue to implement, embed and evaluate patient experience improvement initiatives underpinning the Trust-wide approved 'Always Events.' We will establish robust qualitative and quantitative analysis to evaluate the impact and effectiveness of the wider patient experience improvement initiatives.	Achieved	Throughout the reporting year 'Always Events' have continued to be launched and implemented across the Trust. The Trust has developed an effective method of evaluating patient experience improvement initiatives. Improvement indicators have been established to use the start of any new service design or redesign.	We will establish a combined qualitative and quantitative approach to patient, family and carer feedback: • We will maintain the collection of feedback and insight via ongoing patient/service user engagement • We will ensure sustained FFT recommendation rates >=95% for all areas • We will ensure processes are in place to recognise, understand and act on inpatient feedback in real-time
We will ensure that PSIRF is implemented and embedded during 2024-25.	Achieved	PSIRF has been successfully implemented and embedded in 2024-25. The Trust received significant assurance in a review of the implementation of PSIRF undertaken by 360 Assurance.	We will review and improve the action plans developed from our PSIRF learning responses.
We will conduct an assurance review on all high risk, upheld complaints, and offer feedback on the findings of these to the original complainant.	Partially achieved	The assurance review process has been developed and approved. This will be implemented from the beginning of 2025-26.	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, 2024-25.

Goal 4

3.4 We will have a culture of improvement

3.4.1 We will build improvement capability across the Trust

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
We will have delivered the Proud to Improve Introduction to QI training module to 80% of all staff by April 2025.	Achieved	As at 31 March 2025 compliance with the Proud to Improve Introduction to QI training module was 83.90%.	We will have delivered the Proud to Improve Introduction to QI training module to 85% of all staff by April 2026.
We will continue to maintain an inventory of all proposed, ongoing and closed QI project work to facilitate spread.	Achieved	All QI project information is available on the Trust's intranet with detailed project posters for all completed business as usual projects.	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.	Achieved	As at 31 March 2025 compliance with QI Foundations training was 7.44%.	We will continue to ensure that at least 7% of active staff members are trained in QI Foundations.
			We will use QI methodology to progress opportunities for

			improving patient care

Data source: local Trust data source, 2024-25

3.4.2 We will ensure staff recognise the importance of patient and public representation in our improvement endeavours

Indicator	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
We will continue to promote the use of patient engagement into all patient pathway improvement projects.	Achieved	Patient engagement is promoted in the Foundations and Practitioner QI training.	We will continue to promote the use of patient engagement into all patient pathway improvement projects.
We will deliver quality improvement training for service users who are involved in improvement projects.	Achieved	Bespoke training for service users who are involved in improvement projects is available.	We will continue to 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	2024-25 achievement	Highlights and exceptions	Proposed 2025-26 indicator
We will work with the CBUs to facilitate new innovations within specialties across the Trust.	Achieved	During 2024-25 the Innovation team have presented at CBU 1, 2 and 3 business and governance meetings. There have been innovation projects	We will continue to raise awareness of innovation and unmet needs within the Trust across all specialties. We will develop a log of

		in all CBUs.	innovations being explored within the Trust and aim to have new innovation projects from each CBU in 2025-26 where relevant.
We will continue to develop work in conjunction with the Research and Development team focussing on opportunities within the artificial intelligence (AI) and digital agenda.	Partially achieved	A member of the Innovation team is currently based in the Research and Development team. The Cytosponge (capsule endoscopy) project began in the Innovation team before moving to the Research and Development team. It will return to the Innovation for the adoption phase.	We will link with Chief Clinical Information Officer and ICT around innovation opportunities within the artificial intelligence (AI) and digital agenda.
We will continue to assess the impact of Health Technology Evaluations (HTEs) to support delivery of innovation within the Trust.	Achieved	The Innovation team review the NICE website on a monthly basis, disseminate the information to relevant specialties.	We will continue to review the NICE website for new and updated HTEs, and will share all applicable guidance with relevant specialities.
We will report on findings where we have implemented change as a result of research development.	Achieved	As a result of research in the Trust participants have received access to treatments that they would not have received in routine care. Case studies of completed innovation projects have been published on the updated innovation website.	We will report on findings where we have implemented change as a result of research development.

Data source: local Trust data source, 2024-25.

Performance against national indicators 2024-25

Barnsley Hospital NHS FT 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 2022-23	BHNFT 2023-24	BHNFT 2024-25	National Target 2024-25
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	64.30%	62.54%	60.27%	92%
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	83.14%	73.13%	70.84%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	79.70%	70.44%	73.1%	92%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	61.80%	66.3%	67.5%	95%
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	67.1%	72.6%	75.8%	70%*
All cancers: 31-day wait from diagnosis to first treatment	93.7%	95.6%	92.8%	96%
Cancer: suspected cancer pathway from referral to date first seen, comprising all urgent referrals (cancer suspected)	92.6%	94.3%	89.1%	93.0%
Cancer: 28 day faster diagnosis standard	N/A	N/A	81.6%	75%
Maximum 6-week wait for diagnostic procedures	11.1%	4.7%	3%	1.8%
Clostridium (C.) difficile – variance from plan	43	54	73	10

*interim target

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

Barnsley Healthwatch comments on BHNFT Quality Report 2024-25

Thank you for sharing this year's draft Quality Report with us. The Quality Report explains issues and achievements presenting information in a clear and concise format. It is good to see how Barnsley is performing against the NHS Outcomes Framework 2024-25 Indicators and to see what actions have been taken and also where work is ongoing.

We would have like to have seen an improvement in cancer wait times especially the 62-day wait for first treatment from NHS Cancer Screening Service. We would have welcomed more detail on how this compares with other Trusts in South Yorkshire and what plans are in place to address this.

The draft Quality Report outlines the Trust's commitment to engaging with patients and the public also ensuring that our more diverse and hard to reach communities are involved and encouraged to share their experiences. The success of this is shown in the reduction of formal complaints and improved communication with patients, carers and their families.

We appreciate the Trust involving us with their patient engagement events regarding Health on the High Street initiative and working being undertaken on the Urgent and Emergency Care projects, we will continue to provide feedback as these projects progress.

Healthwatch Barnsley will continue to support the Trust throughout the coming year in increasingly challenging times.

Barnsley Integrated Care Board comments on BHNFT Quality Account 2024-25

The Integrated Care Board reviewed the Trust's draft Quality Account and did not have any comments to make.

BHNFT Council of Governors comments on BHNFT Quality Account 2024-25

The Council of Governors welcomes the production of the Trust's 2024-25 Quality Accounts and the priorities identified, with a view to strengthening service delivery and improving patient care.

The ongoing commitment of the Trust in recognising and ensuring that colleagues, partners and carers are collaborative co-production partners in driving forward quality improvements is once again to be applauded. It is pleasing to see the number of quality improvement initiatives which had been identified along with the investment in training colleagues and volunteers.

As the Lead Governor of Barnsley NHS Foundation Trust and on behalf of Governors, I am proud to reflect on the achievements and progress we have made over the past year. Our Trust has continued to prioritise patient care, safety, and innovation, ensuring that we provide the highest quality of service to our community.

We are pleased to note that the Trust met all the mandatory objectives set by the Regional Research Delivery Network. In future Quality account reports, It will be exciting to see some feedback on how the research is impacting on patient care for residents of Barnsley and beyond

- **Health and safety:** we are pleased to note that the Trust acted to address issues raised by CQC in the June 2024 inspection.
- **Mortality:** we note that the trust's focus on learning from deaths has had a positive impact in reducing the mortality rate.
- **Data quality:** the initiatives in improving data quality are excellent. In future it would be good to see how advancement in technology can support in developing this initiative.
- **C. difficile:** it is good to see that the number of infections is going down following implementation of various actions.
- **Partnership:** it is pleasing to note our partnership commitment in engaging with partners across the South Yorkshire region and beyond.

Barnsley Hospital is planning to move some of its outpatient services out of the hospital into the new hub at the Alhambra. This will help reduce missed appointments and help improve health outcomes for people who will be more able to access vital services in a place familiar to them rather than having to go to hospital. It will be great to include feedback on impact of this move in future quality accounts reports, when the services are fully operational.

I would like to express the Council of Governors' gratitude for the dedication and hard work of our staff, volunteers, and partners. Together, we will continue to strive for excellence and make a positive impact on the lives of those we serve.

Overview and Scrutiny Committee comments on BHNFT Quality Account 2024-25

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 2024-25.

Quality goals/priorities 2024-25

The report clearly demonstrates the work of the Trust in providing clinical effectiveness; patient safety; person centred care; and improving quality across the Trust. The Committee notes that the majority of indicators/actions attached to the priorities have been achieved and that there are plans in place to address those that have not been achieved in the coming year.

The Committee welcomes the work done to improve end of life care and looks forward to seeing the impact of the identified improvements in the medicine at discharge process.

There are still concerns around the Trusts performance against national indicators, particularly given that performance has decreased compared to last year for some of the measures. Whilst the Committee is already aware of plans for A&E, and the report outlines plans to tackle C.difficile, we would hope the Trust has robust plans in place to significantly impact on the indicators relating to 18 week waits and cancer. We will keep a watching brief on these as part of our work in 2025-26, along with our specific work on non-surgical oncology, haematology, and the lung clinic.

The Committee also has concerns that there has been an overall deterioration across the general health questions for patients undergoing total hip and total knee replacements, and for the Oxford hip and knee scores (PROM – Patient Reported Outcome Measures) for the last couple of years. Again, we will keep a watching brief on this as part of our work in 2025-26.

Following our work on Autism, and our upcoming work on health inequalities, the Committee are pleased to see that a Structured Judgement Review (SJR) will be conducted for all deceased in-patients with a learning disability and/or autism or a serious mental illness.

Important omissions

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

Patient and public engagement

The report demonstrates the Trusts commitment to supporting service improvement by using information obtained through patient, family, carer, and employee feedback, insight, and engagement. The Committee would expect that consultation and engagement exercises are of sufficient quality and quantity to represent the community as a whole.

Work of the Overview & Scrutiny Committee (OSC) in 2024-25

During 2024-25, the Trust has supported the Overview & Scrutiny Committee to scrutinise the following topics: -

- Safeguarding Adults board annual report (September 2024)
- Safeguarding Children's partnership annual report (September 2024)
- Autism (all-age) Task and Finish group (Autumn/Winter 2024)
- Cancer services at Barnsley Hospital (December 2024)
- Stroke (December 2024)
- Managing demand on urgent and emergency care in Barnsley (April 2025)
- Proposals for haematology inpatient services (April 2025)

We look forward to working in partnership with the Trust throughout 2025-26.

Part 4: Glossary

4AT	A rapid clinical test for delirium detection.
Acute Kidney Injury (AKI)	AKI has now replaced the term acute renal failure. AKI is characterised by a rapid reduction in kidney function.
'All About Me'	A hospital passport used to share person centred information.
Avoidable Harm	A harm occurring to a patient which could have been prevented.
BadgerNet NHS	An electronic system for pregnancy records.
Capsule Endoscopy	A test that involves swallowing a capsule which looks for abnormalities in the bowel.
Cardiotocography (CTG)	A monitoring technique used during pregnancy and labour to assess fetal wellbeing.
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.
Chief Clinical Information Officer (CICO)	A senior clinical leader responsible for bridging the gap between clinical staff and ICT professionals, ensuring that digital projects and initiatives are designed with the user's needs in mind and are both safe and clinically effective.
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 Support Volunteer	Ward based volunteer providing an enhanced level of support to patients and families
Electronic Prescribing and Medicines Administration (EPMA)	An electronic medicines management system.
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.
Further Faster Programme (FFP)	A programme which undertakes clinically led reviews of specialties to examine how things are currently being

	done and how they could be improved.
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.
Hospital Episode Statistics (HES)	A data warehouse containing details of all admissions, outpatient appointments and Emergency Department attendances at NHS hospitals in England.
Hospital Standardised Mortality Ratios (HSMR)	The HSMR measures whether or not the mortality rate at the hospital is higher or lower than expected. A measure that is too high or too low would warrant further investigation.
Human Factors (HF)	Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.
ICE	ICE is the software system used within the Trust for reporting most test results.
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.
Ionising Radiation Medical Exposure Regulations IR(ME)R	These are the regulations that provide safeguards for individuals exposed to ionising radiation from medical equipment for imaging.
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.
Learn From Patient Safety Events (LFPSE)	The national NHS system launched in 2021 for the recording and analysis of patient safety events in healthcare.

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.
Martha's Rule	A patient safety initiative in that empowers patients, families, and healthcare staff to request a rapid review by a critical care outreach team if they have concerns about a patient's deteriorating condition.
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.
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 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 Reporting and Learning System (NRLS)	A patient safety reporting system within the NHS in England and Wales. NRLS was replaced by the LFPSE service in 2024.
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.
Perinatal Mortality Review Tool (PMRT)	A tool to support the review of baby deaths from 22 weeks gestation onwards.
PRactical Obstetric Multi-Professional Training (PROMPT)	An evidence based MDT training package for obstetric emergencies.
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.
Red Flags	A red flag event would occur if 11 hours or less of registered nurse time is available for any given shift.
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'.
Situation, Background, Assessment and Recommendation (SBAR)	A structured communication framework that supports teams to share information about the condition of a patient.
Secondary Uses Service (SUS)	The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Sentinel Stroke National Audit Programme (SSNAP)	The single source of stroke data in England, Wales and Northern Ireland.
Sepsis	A potentially life-threatening condition triggered by an infection.
Serious Incident	An incident where one or more patients, staff members, visitors or members of the public experience serious or permanent harm, alleged abuse or where a service provision is threatened.
Stakeholders	A person, group or organisation that has interest or concern in the Trust.
Structured Judgement Review (SJR)	A process to effectively review the care received by patients who have died. It also aims to improve learning and understanding about problems and processes in healthcare that are associated with mortality and share best practice.
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

The information below is based upon the latest published figures from the national audit providers, which often run two to three years in retrospect.

<table>
<tr><th colspan="2">Project title: ID 2123/2411 National Epilepsy 12</th></tr>
<tr><td>Purpose</td><td>The purpose of the audit is to improve the standard of care for children and young people with epilepsies. The audit collects and processes data to highlight areas where hospitals and clinics are doing well and also identify areas in which they need to improve. The audit results focus on performance indicators relating to the first paediatric assessments for children and young people diagnosed with epilepsy and their first year of care.</td></tr>
<tr><td>Performance</td><td>The latest results show significant improvement in compliance with the key performance indicators which gives assurance that children and young people are receiving the expected standard of care. This is as a result to changes in the care pathway implemented during May 2021 and changes made to streamline the process for managing the care in a more collaborative way with community partners.

There has been improvement against a number of key performance indicators from previous results and local compliance is also higher than national average for a number of the standards, including:

<table>
<tr><th></th><th>2019-20 (Cohort 3)</th><th>2021-22 (Cohort 5)</th><th>2021-22 (National)</th></tr>
<tr><td>• Tertiary involvement was requested in the first year of care, if required</td><td>0%</td><td>75%</td><td>49%</td></tr>
<tr><td>• The child had an appropriate first paediatric assessment</td><td>58%</td><td>88%</td><td>64%</td></tr>
<tr><td>• Children with convulsive seizures and epilepsy had an ECG within the first year of care</td><td>25%</td><td>86%</td><td>72%</td></tr>
<tr><td>• Evidence of an agreed and up to date care plan</td><td>84%</td><td>100%</td><td>81%</td></tr>
<tr><td>• Children aged ≥ 5 years had evidence of a school individual healthcare plan by their first year of care</td><td>77%</td><td>92%</td><td>39%</td></tr>
</table>

Overall the new systems that have been introduced have improved the care and compliance expected for children and young people. Work continues within the South Yorkshire Integrated Care Board Children and Young People Epilepsy Core group to improve pathways for mental health support and for transition, supporting the new key performance indicators in this audit.</td></tr>
<tr><td>Reviewed by</td><td>• Children’s services (acute) Business and Governance group on 14 February 2025
• CBU3 Business and Governance group on 26 February 2025
• Clinical Effectiveness group on 16 April 2025</td></tr>
</table>

<table>
<tr><td>Actions</td><td>

Implement the new care bundle developed by the South Yorkshire Integrated Care Board Children and Young People Epilepsy Core group, including:

new pathway for transition
new mental health assessment proforma
ensure all documentation is available the electronic patient record

Complete the Integrated Care Board epilepsy gap analysis. Review where improvements for Barnsley Hospital are required and develop an action plan to address these

</td></tr>
<tr><td colspan="2">Project title: ID 2560 Royal College of Emergency Medicine (RCEM): Infection Prevention and Control (IPC)</td></tr>
<tr><td>Purpose</td><td>
This national RCEM led Quality Improvement Project (QIP) is the concluding report for data collected over a three-year period and builds upon previous cycles which were completed in 2020-21 and 2021-22.
RCEM’s overall aim was to identify trends over time and allow emergency departments to reflect on these, at a local level, in the context of local and national challenges. The purpose of this QIP is to improve patient safety and quality of care as well as workspace safety.
During the previous two cycles, key areas requiring improvement were identified; patient screening and the isolation of patients with identified vulnerabilities.
</td></tr>
<tr><td>Performance</td><td>
The Trust’s audit results provided significant assurance. Over the three years, national results have deteriorated across all standards.
The Trust has not followed the national trend with significant improvement in compliance with the standards.
<table>
<tr><th></th><th>2020-21</th><th>2021-22</th><th>2022-23</th><th>National</th></tr>
<tr><td>Screening on arrival for Covid-19</td><td>23%</td><td>69%</td><td>96%</td><td>45%</td></tr>
<tr><td>Identified vulnerable patients isolated</td><td>86%</td><td>27%</td><td>86%</td><td>19%</td></tr>
<tr><td>Infectious patients transferred to a cubicle</td><td>71%</td><td>75%</td><td>85%</td><td>65%</td></tr>
</table>
</td></tr>
<tr><td>Reviewed by</td><td>

Emergency Department Governance group on 20 May 2024
CBU 1 Governance Group on 26 July 2024
Clinical Effectiveness Group on 18 September 2024

</td></tr>
</table>

<table>
<tr><td>Actions</td><td>

- Embed the use of a ‘screened for Covid-19 symptoms’ checkbox on the electronic triage screen.
- Develop a poster to demonstrate a patient should be screened, and the location they should be nursed and where this should be documented.

</td></tr>
<tr><td colspan="2">Project title: ID 2463 Round 5 National Audit of Dementia (NAD)</td></tr>
<tr><td>Purpose</td><td>The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to the delivery of care which is known to impact upon people with dementia whilst in hospital. The overall purpose is to improve the care provided to patients who have a dementia diagnosis and are admitted to hospital, ensuring that the patient’s dementia diagnosis is considered whilst providing care to them in an in-patient setting.</td></tr>
<tr><td>Performance</td><td>A significant improvement has been noted across the audit when compared to the results of round four. Local performance has exceeded the national benchmark for multiple indicators.

Round five results highlight the impact of the actions agreed and the resulting improvements in care provided across the Trust. This includes screening for pain and delirium within 24 hours of admission.

<table>
<tr><th></th><th>Round 5
Local results</th><th>National</th></tr>
<tr><td>Delirium screen completed</td><td>97%</td><td>87%</td></tr>
<tr><td>Initiation of discharge plan in first 24 hours</td><td>26%</td><td>45%</td></tr>
<tr><td>Carer rating overall care quality</td><td>94%</td><td>66%</td></tr>
<tr><td>Carer rating communication</td><td>96%</td><td>60%</td></tr>
</table>

Further improvement is required in relation to early discharge planning. The Trust recognises the importance of patient and carer feedback to improve services for dementia patients. Although the Trust participated in the patient and carer feedback element of the audit national returns were low.</td></tr>
<tr><td>Reviewed by</td><td>

- Dementia Strategy group on 17 October 2024
- Care of the Elderly Business and Governance group on 18 November 2024
- CBU 1 Governance group on 29 January 2025
- Clinical Effectiveness group on 19 February 2025

</td></tr>
</table>

Actions	• The Trust's Admiral Nurse will work alongside the Patient Experience team to continue engagement events with patients and carers to understand more about their experiences and identify how improvements to care can be made. • Training and education about the initiation of early discharge planning with the aim of recording the expected date of discharge either at the post take ward round or within 24 hours of admission will be delivered.
Project title: ID 2583 National Audit of Inpatient Falls (NAIF) 2023	
Purpose	The National Audit of Inpatient Falls focuses on the continuous audit of the care and management of patients who sustain a hip fracture in an in-patient setting. The NAIF aims to improve in-patient falls prevention and post fall care through audit and quality improvement.
Performance	The Trust's results provided significant assurance with the results in line with, or exceeding national results. Work is ongoing to ensure patients are cared for safely with the aim of avoiding an in-patient fall. There has been notable improvement in the Trust's compliance with continence assessment achieving 100% in round five, compared to 55% in round four. Compliance for lying/standing blood pressure and mobility assessment has remained consistent scoring 100% in both rounds of the audit. There has been an increase from 67% to 89% in delirium assessment compliance using the 4AT delirium screening tool. The 4AT delirium screening tool has been embedded and is completed on admission trustwide. There was a slight reduction in compliance around the use of flat lifting equipment following an in-patient fall. Education around the use of flat lifting equipment has been disseminated to staff via patient safety bulletins and posters alongside training for relevant staff.
Reviewed by	• Falls Prevention group on 9 August 2024
Actions	• Education about the safe use of flat lifting equipment via patient safety bulletin and posters. • Extend the provision of training on the flat lifting equipment to relevant staff.

	• Work with the clinical lead for to introduce the 4AT delirium screening tool as a mandatory field on the electronic patient record for patients aged 65 and over.
Project title: ID 2787 NHS Learning Disability Improvement Standards 2022-23 (year 6)	
Purpose	The Improvement Standards were launched in 2018 by NHS Improvement to ensure the provision of high quality, personalised and safe care from the NHS for both adults and children with learning disabilities and autism across England.
Performance	The learning disability and autism service has made good progress against the NHS England improvement standards over the period of 2022-24. Engagement with experts by experience remains difficult due to the limited number of participants in local learning disability and autism groups. Work has been ongoing to network with a range of services to work collaboratively to support patients with a learning disability and/or autism. The Trust has made significant improvements within the delivery of reasonable adjustments for patients with a learning disability and/or autism. There has been an improvement in trustwide culture and reasonable adjustments have become business as usual across a number of services. Further work to ensure compliance with the Accessible Information Standards (2016) is required for patients with learning disabilities and autism.
Reviewed by	• Learning Disabilities Operational group on 8 January 2025 • Clinical Effectiveness group on 12 March 2025
Actions	• Continue to support staff to attend the NHS England Oliver McGowan Training. • Continue to engage with and promote the role of experts with experience. • Establish a MDT to improve Accessible Information Standards (2016) compliance.
Project title: ID 1835/2032/2279 National Bowel Cancer Audit 2019-22	

Purpose	The National Bowel Cancer audit measures the quality and outcomes of care for patients diagnosed with bowel cancer in England and Wales. The audit supports hospitals in England and Wales to improve the quality of the care received by patients.
Performance	During 2020 most endoscopic procedures were suspended nationally due to unprecedented measures placed upon the NHS throughout the Covid-19 pandemic. The bowel cancer team maintained high standards of care and worked to ensure patients continued to be diagnosed and treated in a timely manner. Standards reviewed for 2021-22 evidence that the Trust's performance is above or equal to national benchmarking. The National Cancer Audit Collaborating Centre released new reporting dashboards in 2024 which aim to monitor data completeness and data quality.
Reviewed by	• Cancer Performance group on 4 February 2025 • Clinical Effectiveness group on 4 April 2025
Actions	• The bowel cancer nurse specialist team will review staffing and the support provided to wards. • The bowel cancer nurse specialist team will offer support and education to ensure effective delivery of the enhanced recovery programme. • National and local promotions will be shared with patients on the importance of early presentation of symptoms. • The bowel cancer services team will undertake data quality reviews.

Appendix B

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

Project title: ID 2646 Audit of Situation, Background, Assessment and Recommendations (SBAR) Handover Stickers	
Purpose	This audit measured the standards of care and documentation for the transfer of a pregnant person between clinical areas or clinical staff. The audit focused on the quality of the documented handovers. This included a review of the patient's needs and plan of care and clear documentation of the cardiotocography (CTG) with consistent and clear recording of the length, strength and frequency of contractions in both the latent and active phases of labour during the SBAR handover to ensure that patients are managed appropriately.
Performance	A total of 1575 handovers were reviewed, only one was found not to include an SBAR sticker. This provided assurance that handovers were compliant with the recommendation from a SI investigation '*The Trust is to ensure that when a mother is transferred between clinical areas or clinical staff, there is a documented handover including a summary of her needs and plan of care.'* The audit commenced in January 2023 and data was collected for 15 consecutive months to monitor the impact of any changes made for improvement and to ensure practice was embedded. Results were reviewed on a monthly basis by the Women's Business and Governance group. Throughout this time, a review of the SBAR sticker was completed and improvements were made to the design which were found to have a positive effect on completion.
Reviewed by	• Women's Business and Governance group from February 2023 to May 2024. • Women's Business and Governance group on 21 June 2024. • CBU 3 Business and Governance group on 24 July 2024 • Clinical Effectiveness group on 21 August 2024.
Actions	• Provide education to midwives to ensure understanding of what is required in a SBAR handover including: o Develop and share a pictorial image of what is expected from all SBAR handovers o Include the requirement for staff to document strength, length and frequency of contractions in the PRactical Obstetric Multi-Professional Training (PROMPT) o Share with staff the importance of the assessment and documentation of the duration of contractions

	• Amend the SBAR sticker to ensure all relevant information can be recorded. • Provide individual feedback to staff on how to complete the SBAR stickers to the required standard. • Ensure elements on the SBAR sticker are transferred to the new electronic system 'BadgerNet' system. • Ensure all elements of the SBAR handover are being completed consistently when the 'BadgerNet' system is implemented .
Project title: ID 2925 Re-audit of the Use of Slit Lamps Pre-operatively for Complex Cataracts	
Purpose	Following a change to the pathway for cataract surgery, audits were undertaken to ensure that the change had been embedded in practice. The change in pathway was the addition of a pre-operative examination by slit lamp for all patients with complex cataracts. This was to assess the complexity of the cataract immediately prior to surgery.
Performance	The second audit cycle, performed in 2022 showed a compliance rate of 64%. Individual feedback was given to clinical staff and the service raised the awareness of the change in practice. There was an increase in compliance rate to 76% in the audit undertaken in June 2023. The audit undertaken in 2024 showed that the change in practice was fully embedded with a 100% compliance rate.
Reviewed by	• Ophthalmology Business and Governance group 17 September 2024 • CBU 2 Business and Governance group 25 September 2024 • Clinical Effectiveness group 16 October 2024
Actions	• None required
Project title: ID 2875 Joint Advisory Group (JAG) – Gastric Ulcer Outcomes	
Purpose	It is recommended that patients with a diagnosis of a gastric ulcer undergo a follow-up endoscopy within 12 weeks. This is to monitor the ulcer and to rule out any sign of malignancy. This is an ongoing to assess if patients are having repeat procedures in a timely manner, providing assurance that patients are cared for safely and appropriately.

Performance	The initial results identified a number of areas of improvements were required. Following focused discussions about the pathway and implementing actions to drive improvement subsequent audit cycles have shown a sustained improvement. The continuous audit cycles have allowed the service to identify the success of changes introduced and to monitor performance. The initial audit results in 2020 demonstrated 36% compliance with the standards. Subsequent audit cycles have demonstrated an improvement in compliance; 59% in 2021, 83% in 2022 and 97% in 2024. Actions have been agreed following each audit which have improved the effectiveness of the service and the safety for patients who require repeat procedures.
Reviewed by	• Endoscopy User group 9 July 2024 • CBU1 Business and Governance group 27 September 2024 • Clinical Effectiveness group 20 November 2024
Actions	• To continue the audit in line with the JAG requirements and to maintain a high standard of patient care. • To continue to report and investigate all cases where patients have not had a re-scope within 12 weeks.
Project title: ID 2904 Patients Presenting with Inadequate Bowel Preparation for Colonoscopy Procedures	
Purpose	The purpose of the audit was to ensure that patients are adequately prepared for colonoscopy procedures to allow a full and thorough examination of the bowel. A colonoscopy is a key investigative procedure to identify bowel disease and is key to the early diagnosis of colorectal cancer. Colorectal cancer is the third most commonly diagnosed cancer with colonoscopies being the most effective screening tool for this. Poor quality bowel preparation is detrimental to both the patient and the service. The endoscopy service recognised an increase in the number of patients attending for a colonoscopy with inadequate bowel preparation. These patients had attended a pre-assessment appointment prior to the colonoscopy. The audit attempted to identify any pre-disposing factors that may contribute to inadequate bowel preparation.

Performance	The audit did not identify individual reasons why patients had poor bowel preparation. The audit identified that the pre-assessment process was not consistent and improvements to standardised patient information for bowel preparation were required. A robust action plan was produced to improve patient experience, reduce the number of repeat procedures and improve the efficiency and effectiveness of the service.
Reviewed by	• Endoscopy User group 9 July 2024 • CBU 1 Business and Governance group 8 November 2024 • Clinical Effectiveness group 24 January 2025
Actions	• Update the existing standard operating procedure. • Create visual aids to support the pre-assessment process. • Standardise the recommended low residue diet protocol. • Standardise the bowel preparation protocol. • Encourage service user engagement in the review of the process. • Update the electronic pre-assessment care plan to ensure consistent and clear documentation.