HEALTH SELECT COMMISSION

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Thursday, 6th December, 2012**

Time: **9.30 a.m.**

A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of previous meeting (Pages 1 - 4)

8. Health and Wellbeing Board (Pages 5 - 13)

   - Minutes of meeting held on 31st October, 2012.

9. Rotherham Foundation Trust (Pages 14 - 43)

   - Kerry Rogers, Executive Director, will be in attendance to discuss announced job cuts;
   - Quality Accounts (report attached).

10. Update on Health Select Commission Reviews (Pages 44 - 51)

    - Chair and Vice-Chair of the Health Select Commission and Scrutiny Manager, Legal and Democratic Services, Resources Directorate, to report.

11. Work programme - update (verbal update)

The Chairman authorised consideration of the following urgent item received after the deadline in order to progress the matters referred to.

12. Review of Children's Congenital Cardiac Services in England: update (Pages 52 - 55)

    - Caroline Webb, Senior Scrutiny Adviser, Scrutiny Services, Legal and Democratic Services, Resources Directorate, and Member Working Group (Councillors Ali, Falvey and Sims), to report.

13. Date and time of the next meeting: -

    - Thursday 24th January, 2013, to start at 9.30 am in the Rotherham Town Hall.

HEALTH SELECT COMMISSION
25th October, 2012

Present:- Councillor Steele (in the Chair); Councillors Beaumont, Beck, Goulty, Hoddinott, Middleton, Roche and Wootton, Victoria Farnsworth (Speak Up) and Robert Parkin (Speak Up).

Apologies for absence were received from Councillors Dalton, Doyle, Kaye and Wyatt and Russell Wells (National Autistic Society).

30. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

31. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press present at the meeting.

32. COMMUNICATIONS

See Minute No. 33 for issues raised.

33. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 13th September, 2012.

Resolved:- That the minutes of the previous meeting be agreed as a correct record for signature by the Chairman.

Arising from Minute No. 21 (Maltby Ambulance Station), it was reported that a formal statement had been received from the Ambulance Trust as follows:-

"We would like to reassure members of the public that there are no firm plans in place to close any of our ambulance stations. We are simply planning for the future to ensure that we continue to meet the needs of our patients and the requirements of a modern ambulance service.

The Trust is looking at the possibility of introducing a 'hub and spoke' model in some more urban parts of the county but no firm plans have been discussed or approved at this stage.

Patients' interests are at the heart of everything we do and any plans to change our estates configuration would support our ability to continue to deliver the highest quality, safe and responsive service to those calling 999 in Yorkshire and the Humber.

We would also like to reassure members of the public that any plans to change our estates configuration would be subject to consultation with staff and stakeholder organisations."

Arsing from Minute No. 24 (Care for Our Future White Paper and Draft Care and Support Bill), it was noted that a sub-group had met and its comments incorporated into the consultation response.

Arising from Minute Nos. 26 (Day Service Proposal Learning Disability Services), 27 (Day Service Proposal Transport Services) and 28 (Continuing Healthcare Review), it was noted that reports would be submitted to the Select Commission's December meeting once it had been considered by the Cabinet Member for Adult Social Care.

34. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of the meeting of the Health and Wellbeing Board held on 5th September, 2012.

It was noted that the funding for the Alcohol Strategy – Local Implementation (Minute No. S24) would be from the Public Health ringfenced grant.

Resolved:- That the minutes of the Health and Wellbeing Board meeting be noted.

35. GOVERNMENT CONSULTATION - PROCESS LOCAL AUTHORITIES WILL USE TO CONSULT ON ANY FEASIBLE WATER FLUORIDATION SCHEMES

Dr. John Radford, Director of Public Health, presented a Government consultation paper on the process local authorities would be asked to use to consult on Water Fluoridation Schemes.

A response had to be submitted by 27th November, 2012.

The Health and Social Care Act 2012 gained Royal Assent on 27th March, 2012, with the large part of the changes it introduced coming into effect on 1st April, 2013. The effect of the Act was that the Secretary of State for Health had powers to make Regulations in relation to consultation and decision making on new and existing fluoridation proposals.

The 2012 Act also transferred responsibility for proposing Fluoridation Schemes and conducting consultations on such Schemes from Strategic Health Authorities to local authorities. Local authorities would be required to undertake Joint Strategic Needs Assessments that would determine whether it was appropriate to draw up proposals for all or part of their populations to receive fluoridated water.

Discussion ensued with the following comment discussed/raised;-

- There would be a framework on how local consultation should be undertaken

- When a decision was to be made, there should be specialist/professional advice available for Members

- When consultation was carried out the information needed to be in a format that was much easier to read/understand so all members of the community could engage in a meaningful way

- Previously, the Primary Care Trusts would have consulted with local authorities and the decision made by the Strategic Health Authority at a Yorkshire and Humber level

- Once the Government had received all the responses as to how the consultation should be conducted, it would make a decision on the consultation process. The Local Authority would then have to decide whether it wanted Fluoridation or not

- A Scrutiny Review was undertaken some time ago where evidence and arguments for and against were considered

- Concern that neighbouring local authorities may have differing views and reach a 'deadlock' situation

- It would be a decision for full Council

Resolved:- That a working group consisting of Councillors Beaumont, Roche and Steele and Robert Parkin meet on 2nd November, 2012, to consider the consultation document.

36. WORK PROGRAMME UPDATE

Deborah Fellowes, Scrutiny Manager, submitted an update on the 2012-13 Work Programme.

Work was underway on the draft Care and Support Bill, Autistic Spectrum Disorder and Residential Homes reviews. There were only 2 areas of work outstanding – Discharge Arrangements and Access to Healthcare Services.

It was suggested, given the limited staffing resources, that the Access to Healthcare Services should be the next piece of work in the form of a spotlight review and fed into the consultation currently being undertaken by the Clinical Commissioning Group.

Dr. John Radford, Director of Public Health, reported that the NHS was to make significant changes in the next few months in the way the out of hours services was accessed and, to some extent in-house care, with the launch of NHS 111. If you had an emergency out of hours that you did not feel required a 999 call, you would ring 111 and be triaged into 1 of the services i.e. either self-care, 1 of the emergency services, out of hours practice or given an appointment for your GP within 1/2 days.

Resolved:- (1) That the Select Commission undertake a spotlight review into Access to Healthcare Services.

(2) That the review into Discharge Arrangements take place early in 2013.

37. DATE AND TIME OF FUTURE MEETING:-

Resolved:- That the next meeting of the Health Select Commission be held on 25th October, 2012, commencing at 9.30 a.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
31st October, 2012

Present:-

Members:-

Ken Wyatt	Cabinet Member for Health and Wellbeing **In the Chair**
Jo Abbott	Public Health Consultant
Karl Battersby	Strategic Director, Environment and Development Services, RMBC
John Doyle	Cabinet Member, Adult Social Care
Phil Foster	NHS Commissioning Board
Brian James	Rotherham Foundation Trust
Paul Lakin	Cabinet Member, Children, Young People and Families Services
Shona McFarlane	Director of Health and Wellbeing
David Polkinghorn	Rotherham Clinical Commissioning Group
Janet Wheatley	Voluntary Action Rotherham

Officers:-

Kate Green	Policy Officer, RMBC
Fiona Topliss	Communications, NHS Rotherham
Howard Woolfenden	Director of Safeguarding, Children and Families, RMBC

Together with:-

Robin Carlisle	Rotherham Clinical Commissioning Group
Nick Hunter	Chief Officer, Rotherham Local Pharmaceutical Committee
Mike Wilkerson	Chief Executive, Rotherham Hospice

Apologies for absence were received from Chris Bowell, Tom Cray, Andrew Denniff, Chris Edwards, Martin Kimber, John Radford, Joyce Thacker,

S32. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

Arising from Minute No. S29 (Rotherham HealthWatch), it was reported that the specification for HealthWatch commissioning had been agreed.

S33. COMMUNICATIONS

Welfare and Benefit Reform Roadshow
The Rotherham Partnership Governance Board was to host the above Roadshow at RCAT on 30th November, 2012. The Welfare and Benefit Reforms would affect Rotherham greatly and had become a priority for the Partnership. Organisations would be welcome to send a representative if they so wished.

Fluoridisation
The Health Select Commission had set up a small group of Members to look at the consultation arrangements for Fluoridisation.

S34. JOINT COMMUNICATIONS PLAN

Fiona Topliss, NHS Communications, reported that a meeting had taken place with the Council's Communications lead to discuss the above. A report would be submitted to the next Board meeting.

Due to the diminishing resources of both organisations, it was important to work together to maximise what was available and avoid duplication.

Resolved:- That a report be submitted to the next meeting of the Board.

S35. HEALTH AND WELLBEING MEMBERS' GROUP

The notes of the first regional network for Health and Wellbeing members meeting held on 1st October, 2012, in Wakefield, were submitted for information.

S36. POLICE AND CRIME COMMISSIONER

The Board considered a report submitted by Marie Carroll, Partnership Officer, South Yorkshire Joint Secretariat, on the role of the Police and Crime Commissioner.

The Commissioner, unlike the Police Authority, would not be a statutory partner on Community Safety Partnerships (CSPs) but must co-operate with and have regard to their priorities in the Policing area. Chairs of all CSPs could be called together to discuss specific issues and may require a CSP to provide a written report around a specific issue if the Commissioner was not satisfied that it was meeting its duties.

The Police Authority had developed an awareness raising campaign which endeavoured to engage members of the public and partners around the generalities of the election and what the change in police governance might mean to them (http://www.southyorks.gov.uk/thinkpcc/home.aspx).

As part of the wider "& Crime" element of their role, Commissioners would consider the impact other partnerships, statutory boards and criminal justice organisations/partnerships may have on policing and crime in that area.

The Police and Crime Commissioner was obligated to publish a 5 year Police and Crime Plan by March, 2013, setting out the priorities for policing and crime in the force area. This would be key in holding the Chief Constable to account for delivery against the Commissioner's priorities and would outline allocation of resources along with local priorities. Consultations with partners and partnerships were ongoing and the priorities of other organisations and/or partnerships, where available, would be taken into consideration. A copy of the Rotherham Health and Wellbeing Strategy had been provided for consideration.

It was noted that the Commissioner would be attending a Board meeting in the New Year.

Resolved:- That the report be noted.

S37. NORTH TRENT NETWORK OF CARDIAC CARE AND NORTH TRENT STROKE STRATEGY PROJECT

Dr. Phil Foster presented the annual report of the major Cardiac and Stroke work undertaken by the Network from April, 2011 to March, 2012, highlighting key achievements and outcomes:-

Cardiac Care

- Collaborative project with the Yorkshire and the Humber Specialised Commissioners, the West Yorkshire and North East Yorkshire and Northern Lincolnshire Networks to develop 3 Clinical Thresholds for Revascularisation – aim to develop a set of clinical guidelines and thresholds, based on evidence-based best clinical practice, to reduce the variation

- As a result of the above, guidelines and thresholds developed and agreed and to be implemented during 2012/13

- The Network User Group now influenced the development of Network strategic plans in order to improve the experience and outcomes for future cardiac patients

- Reviewing and developing Heart Failure Services, closer working with the tertiary centre on the PPCI pathway and efficient tertiary centre referral

- Agreed procedures for the introduction of new drug treatments and improving the patient/carer engagement and interaction

- Focus on improving the patient experience in relation to the Heart Failure pathway

- Provides peer support and guidance for managers

- Close work with the Stroke Strategy Project

- Successfully implemented NICE Guidance for a range of drugs including Ticagrelor and development of a clinical consensus approach towards the implementation of NICE guidance for new oral anticoagulants

Stroke Strategy Project

- Successful implementation of the Peer Review process

- Introduction of 24/7 acute thrombolysis service across North Trent

- Stroke Telemedicine project introduced in February, 2010, to support delivery of the Hyperacute Stroke Pathway specifically thrombolysis

- For the period 9th January-30th June, 2012, 94 patients had been admitted out of hours, 17 patients benefitted from an analaysis of thrombolysis and 7 patients were thrombolysed with an age range from 23 years to 89 years

– National Stroke Strategy launched in December, 2007, providing a national quality framework through which local services could, over a 10 year period, secure improvements across the stroke pathway against quality markers

– All 5 local hospitals had achieved accreditation for their Stroke Assurance Framework plans

– Stroke Improvement Programme launched in 2009 as a national initiative designed to accelerate improvement of services across the whole pathway of stroke and TIA care

– Work on stroke fell into 3 domains – prevention, acute care, post hospital and long term care

Resolved:- That the report be received.

S38. HEALTH AND WELLBEING STRATEGY

Kate Green, Policy Officer, presented the final version of the Joint Health and Wellbeing Strategy including the outline implementation plan which included the role of the Health and Wellbeing Strategy Steering Group and proposals for the Health and Wellbeing Board's work plan.

The document had been amended following the consultation, mainly the language, but also the inclusion of "Ageing and Dying Well" within the Live Course Framework and also an acknowledgement that people died over the whole life course and not just over 65. The actions were now all listed under their respective Strategic Priority and not given a specific year to be achieved; it would be for the individuals within that workstream to determine how their actions would be achieved/prioritised as long as they were within the 3 year Strategy.

Each of the 6 Strategy priorities now had a strategic lead who would co-ordinate and provide leadership to the workstreams, ensure work plans aligned and implement new ways of working to bring about culture change.

The Steering Group was made up of the 6 lead officers plus representatives from the Council's Policy, Performance and Commissioning Team, Public Health and the NHS. The Group would co-ordinate and lead the Strategy implementation plan, be accountable to the Board and provide assurance in relation to delivering Strategy outcomes.

The draft work plan had been developed from the outcomes of the self-assessment process and feedback from the Department of Health representative.

Due to it being a "living" document there would not be a significant number of copies produced but a current version would be available on the website.

Discussion ensued on the need for the Board to receive the 2013 Public Health Commissioning Plan although it was acknowledged that the settlement for Public Health was still awaited. The statutory duties would be included but

until the funding was known nothing else could be planned.

Resolved:- (1) That the Joint Health and Wellbeing Strategy be approved for submission to Cabinet for recommendation to Council for adoption.

(2) That the format of the 2012/13 Health and Wellbeing Board work plan be approved.

(3) That the Strategy implementation plan be noted.

(4) That the 2013 Public Health Commissioning Plan be submitted to the January, 2013 Board meeting.

S39. 'END OF LIFE'

Mike Wilkerson, Chief Executive, Rotherham Hospice, stated that he had been invited to the Board to address how the Board could help deliver end of life care and was pleased to see the inclusion of "Dying Well" in the Joint Health and Wellbeing Strategy.

The end of life experience for some was not always appropriate; patients were sometimes admitted to Casualty when it would have been better for them to have remained at home.

Discussion ensued with the following issues raised/highlighted:-

- There had been stories in the press recently about Liverpool Care Pathway. It was used in the Hospice and by the Rotherham Foundation Trust as well as in people's homes

- The vast majority of people wanted to remain at home to die but that was not being delivered

- Care packages (including Liverpool Care Pathway) had been thought out very carefully and adapted to the patient. The patient and their carer(s) signed up to it

- Feedback from the Patient Representative Group was good - it allowed people to die with dignity and ideally at home

- Very effective tool for the last days of a patient's live and allowed families to be actively involved in the care

- Dying was 1 of the remaining taboo subjects and people should be encouraged to talk about it and what they wanted to happen when their time came

- There should be a common approach

- As well as the medical aspect there were the emotional and practical issues, such as wills and probate, which were not talked about and assumption that everyone knew what to do and where to go. A package of care encompassing all the aspects was required

- The Pathway was really a checklist/reference point which highlighted the important elements to address for patients and carers

- Rotherham Case Management pilot for End of Life Care for those most at risk of admission to hospital

- The Hospice was working with the CCG on Integrated End of Life pathway

- Acknowledgement that some died in hospital because they were frightened to die at home or their carers were frightened/could not cope

Brian James felt that there was a need for a discussion/review on how partner agencies could improve co-ordination around this topic. Robin Carlisle reported that the Unscheduled Care Group had carried out such a review in the Summer, the results of which were to be submitted to the Group shortly.

Resolved:- (1) That the inclusion of "Dying Well" in the Joint Health and Wellbeing Strategy be noted.

(2) That the outcome of the Unscheduled Care Group review be submitted to a future meeting of the Board.

S40. COMMUNITY PHARMACY IN ROTHERHAM

Nick Hunter, Chief Officer, Rotherham Local Pharmaceutical Committee, gave the following powerpoint presentation:-

Introduction to the Profession
Medicines

- Medicines still the most common therapeutic intervention but 30-50% were not taken as intended and 4-5% of hospital admissions were due to preventable adverse effects of medicines. However, 41% of patients: little or no explanation of side effects
- 961.5M NHS prescriptions dispensed in England by community pharmacies (2011) – 3.8% increase on previous year

Pharmacist Education

- 23 Schools of Pharmacy
- 4 year MPharm Degree
- Pre-registration year in practice
- GPhC Exams
- Registration

Rotherham Local Pharmaceutical Committee

- Body recognised in statute since the beginning of the NHS
- Support community pharmacists in doing their job
- Work with the NHS to co-ordinate local service provision
- Coterminous with RMBC
- Provide expertise and experience
- Elected by local professionals

Pharmacy and the NHS
- Community pharmacies are independent contractors
- Each pharmacy enters into a 'contract' with the NHS
- Control of entry
- Only a handful of pharmacies without NHS contracts
- Terms of Service set down in legislation

Working Together
- Community pharmacies located in the heart of every community
- Unique access to the well
- Support development of the JSNA and PNA
- Understanding of the profession

Community Pharmacy in Rotherham
- 63 pharmacies
- Half were national multiples
- Quarter were regional multiples
- Quarter were independents
- NHS income accounted for >90% of turnover

Pharmacy Support Staff
- Medicines Counter Assistants
- Dispensers
- Pharmacy Technicians
- 'Checking Technicians'

Essential Services
- Dispensing
- Repeat Dispensing
- Support for self-care
- Signposting patients to other healthcare professionals
- Healthy Lifestyles service (Public Health)
- Waste medication disposal
- Clinical governance including audit

Public Health Campaigns
- Early diagnosis
- Stopober
- Early detection of bowel cancer
- Breastfeeding

Advanced Services
- Medicines Use Review
- New Medicine Service

Public Health/Wellbeing Services
- Sexual health
- NHS Health Check

- Weight management
- Stop smoking services
- Immunisation
- Alcohol screening and support
- Substance misuse

Discussion ensued with the following highlighted:-

- Contracted for 6 Public Health campaigns a year – get smarter and plan ahead - South Yorkshire approach?

- It was originally supported by Department of Health grants to pilot a number of aspects 1 of which was to create a brand or image to enable marketing for using pharmacies for more than collecting prescriptions

- National programme but very much for local delivery and local use as to what went in it with a national set of quality criteria

- 900 consultations a day in the community pharmacies for lifestyle advice

- The Pharmacy Needs Assessment by Statute had to be done, traditionally, under the PCT. That was transferring with Public Health into the Local Authority. The Medicine Management Team would have worked on it but they were staying with the CCG to look at commissioning the work

- From a NHS Commissioning Board point of view, the relationships between Public Health, Local Pharmaceutical Committee and the Clinical Commissioning Group would be quite challenging and the Board had a role to play in holding the system to account

- Wastage of prescriptions/repeat prescriptions was a big issue

- There were no sites currently in Rotherham operating electronic patient prescription

Nick was thanked for his presentation.

S41. ANY OTHER BUSINESS

Robin Carlisle, CCG, presented an update on Rotherham Clinical Commissioning Group's 2013 Annual Commissioning Plan.

Discussions had commenced with its members practices, the public, stakeholders and providers on the Annual Plan.

It was expected to receive the annual mandate for the NHS Commissioning Board around the 12th December, 2012, which would set out national expectations on the Clinical Commissioning Group and financial and contracting rules. Around the same time, the Group also expected to receive its financial allocation.

It was hoped that it would be submitted to the January Board meeting for approval.

S42. DATE OF NEXT MEETING

Agreed:- That the next meeting of the Health and Wellbeing Board be held on Wednesday, 28th November, 2012, commencing at 1.00 p.m. in the Rotherham Town Hall.

Agenda Item 9

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	Meeting:	Health Select Commission
2.	Date:	6th December, 2012
3.	Title:	Update on progress of Quality Accounts
4.	Directorate:	The Rotherham NHS Foundation Trust

5. Summary

Annually we prepare a Quality Account report as part of our mandatory requirements in relation to improving and monitoring the quality of our care. Meetings with the Health Select Committee have been annual and just prior to decision making about which quality improvement programmes we should include in the following year's programme.

It was decided that an update on progress should be made bi-annually and in time to fully consider the programmes of work their current status and what programmes the HSC would consider as worthy of inclusion in 2013/14 quality accounts.

Good progress has been made in meeting our targets this year and we are confident that we will achieve all of those set by March 2013.

6. Recommendations

The HSC are recommended to read the attached report, prepare questions and identify what they consider are important quality issues that they would like to see developed and included in the programmes for next year.

7. Proposals and Details

We are likely to continue with our work on medicines management as the size and scope of this agenda is considerable. All directorates and service areas have also been set to improve targets on length of stay, re-admission rates and a number of key quality indicators. The overarching aim of the organisation is to reduce avoidable deaths, reduce harm, improve patient experience and staff satisfaction (set out in our Quality Strategy attached).

8. Finance

Meeting our quality agenda objectives will bring not only considerable improvements in the quality of care we provide but also subsequent financial savings due to:

- Reducing re-admissions
- Reducing length of stay
- Reducing the number of harm events that can lead to extended length of stay
- Reduced cost of claims/litigation and complaints handling
- Efficiencies in the system from system re-design i.e. care pathways

9. Risks and Uncertainties

The risks to the organisation in maintaining quality whilst reducing staffing levels and overall savings to meet the government efficiency targets cannot be underestimated.

We have a whole programme of risk management and monitoring processes to ensure that we are aware of the risk, we can mitigate them as much as possible and we can monitor them so that we are aware of any deterioration as soon as possible.

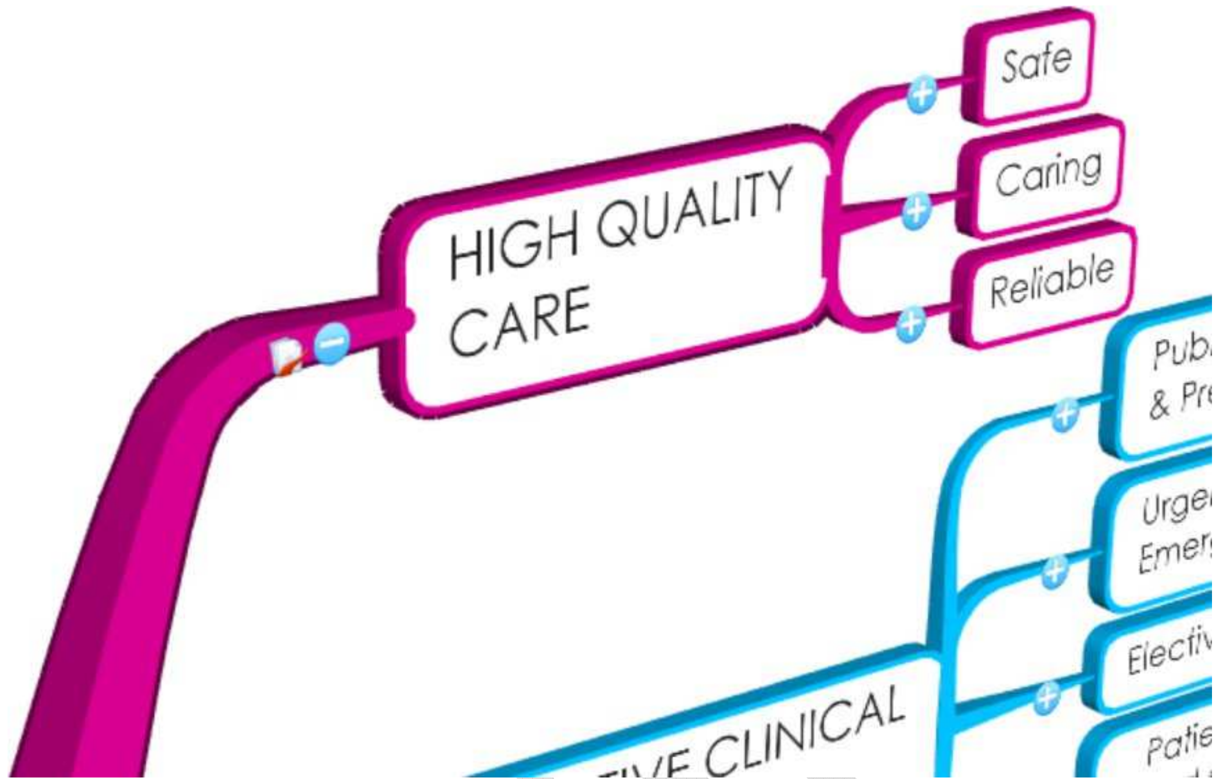
10. Policy and Performance Agenda Implications

The performance and quality of a key partner such as the Rotherham Foundation Trust has a particular impact on the delivery of Rotherham's Health and Well Being Strategy.

11. Background Papers and Consultation

The two attached reports highlight progress made during quarters one and two in relation to the Quality Accounts of The Rotherham NHS Foundation Trust. The accounts include executive summaries. The Quality Strategy also sets out the aims of the Trust over the next three years.

Contact Name: Dr Patricia Bain, Director of Quality and Standards
Tel: 01709 427389, patricia.bain@rothgen.nhs.uk



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Quality Strategy 2012-15:

A framework for delivering High Quality Care

Dr Patricia Bain

Director of Quality and Standards

April 2012

Background:

The Trust has a strong track record on improving the quality of its systems for delivering safe, reliable and patient-centred care, but recognises that there is still much more to be done. The Trust's new Service Development Strategy (SDS 3), covering the period 2012 to 2015, reinforces our commitment to further developing a strong culture of quality within the organisation and sets out a range of initiatives designed to ensure the Trust is offering services comparable to the best in the United Kingdom.

The term "Quality" as used in this document is defined as the systems and processes deployed within the Trust that:

- Improve safety by reducing the potential of harm to patients caused by the risks inherent in delivering often complex treatments and procedures (**Safe** Care)
- Involves patients and carers in the choices they need to make, in ways that respect their dignity as human beings, and that the care we provide is coordinated and organised in ways that are personal to each individual. Ensure that our staff are supported, trained and have the behaviours to provide high quality care (Patient and staff focused **Caring**)
- Ensure that the systems and processes we use in delivering care achieve the best outcome possible for patients through the systematic delivery of care based upon what is known to work best (**Reliable** Care)

At the heart of this strategy is the need for strong clinical and managerial leadership, the alignment of system incentives to support and encourage behaviour and culture change, and the strengthening of compliance through robust assurance and governance systems and the implementation of National and International learning that can bring world class measurable improvements in care to patients.

Critical to success will be high quality data to monitor and report progress against specific and measureable objectives. Our vision is to eventually develop self-managing, self-sustaining staff, structures and accountabilities in which every member understands their role in delivering clinical quality, and works towards delivering the 'best in class' care every day.

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What is the aim of our Strategy?

Our strategy aims to sets out where we are trying to get to in the long-term. It will guide how we organise our resources either financial, people, estates or equipment, information and technology to ensure that we benefit patients.

Our overarching aim is to:

1. ***Provide safe care by reducing the risk of harm***
2. ***Own and enhance the patient experience, end to end***
3. ***Deliver effective care systematically and consistently***

Working with our key partners to ensure we have productive working relationships will be critical as will be harnessing innovation and diversification. Our clinical system and business processes all need to be efficient and effective. In order to sustain change we need to engage staff fully in the improvement agenda.

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Our desired outcomes for delivering Safe, Caring, Reliable services.

In developing this strategy, our aims are aligned to the Trusts' vision and mission statement and relate specifically to three 'high quality care' domains: ***Safe, Caring and Reliable.***

SAFE Do no Harm	CARING Patient and Staff Focused	RELIABLE Consistent care
• Establishing patient safety as the Board's highest priority; • Creating an effective infrastructure at corporate and CSU level to ensure the Trust effectively coordinates safety and risk reduction strategies; • Ensuring the Trust complies with the quality and safety standards set by organisations such as the CQC, NPSA, and other authorised regulatory bodies; • Harnessing the power of Information Technology to increase safety and reduce the risk of harm; • Ensuring compliance with the Trust's risk management systems and using "Community to Board" feedback from those systems to drive safety improvements across the Trust; • Ensuring that the environment we provide is clean and safe for both patients and staff; • Creating a "fair blame" culture in which staff feel confident of fair treatment when reporting errors, but which also makes unacceptable non-disclosure of those errors.	• Respect for patient-centred values, preferences, and expressed needs, including: cultural issues; the dignity, independence and privacy of patients and service users; awareness of quality-of-life issues; and shared decision making; • Ensure coordination and integration of care across the health and social care system; • Enhance information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion; • Ensure we provide physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings; • Provide emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances; • Welcoming the involvement of family and friends, on whom patients and service users rely, and demonstrating awareness and accommodation of their needs as care-givers; • Enable transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions; • Improved access to care	• Getting it right first time, because anything else potentially harms the patient, damages the reputation of the Trust and wastes valuable resources i.e. that required to put it right; • Ensure treatments comply with that which is known to work best i.e NICE Quality Standards; • Pathway driven i.e. developed in collaboration with key partners to ensure that the journey is as seamless as possible for patients and that interventions occur in the most appropriate setting to maximise the resources available for health care • Pro-actively seek out and identify variation and its impact on patients, in particular where outcomes are not in line with expectations.

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What will we do differently to enable this change?

Developing Leaders

Executive leadership, with clear accountability for all aspects of the quality agenda will be clarified, supporting matrix working, collaborative approaches and the elimination of silo working. We will further develop our corporate leadership structures, led by the Chief Medical Officer (CMO) and Chief Nurse (CNO), that is streamlined, more transparent and Clinical Directors, with the support of senior nursing staff, taking a clear lead for improving the quality of care within their systems. Effective collaboration between clinicians, patients and others to facilitate shared decision making in every care setting will be the objective of leadership at all levels.

Introducing new structures and processes

We have already introduced a quality governance team to support the development and implementation of key policies. An important aspect of ensuring robust quality and performance management will be a root and branch review of our committee structures with the aim of rationalising the numbers and ensure more effective information sharing and monitoring with the added benefit of allowing more time for quality initiatives.

An **Investigation and Learning Unit (ILU)** will be introduced to ensure we have high quality, consistent investigations, the learning from which will be shared actively with CMO and CNO and clinical directors to implement rapid change. This will support the development of more effective, efficient feedback systems.

We will develop clinical processes that provide innovative end to end care by developing integrated pathways. Engagement of clinicians and key stakeholders has, and will continue to be, key to the development of these care pathways.

Embedding Strategies and Policies

We will ensure that all of our policies (supported by the newly developed quality governance team) and strategies are aligned to the quality agenda, the key strategies being: Patient Experience, Patient Safety, Clinical Audit and Effectiveness, Business Intelligence and Data Quality, Health and Safety, Workforce Development.

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Developing our Workforce

We will ensure we recruit staff with the right attributes and behaviours and ensure a reward system reflects the value we place on this. Training and education of staff in systematic application of known safe working practices with the aim of creating and embedding a **safety culture** within the organisation will be developed and delivered. The training will include team-working, **human factors** and encouraging more open and transparent reporting of incidents. Staff will be provided training in custom care to make sure every interaction is positive for patients. Continuing Professional Development (CPD) will be supported by providing time to allocated quality improvement activities as part of re-validation and clinical excellence awards. Nursing and Midwifery reviews will include consideration of staffing level to allow these staff time to engage in the quality improvement agenda.

Improving Patient Access

We will make it easier for patients to navigate the healthcare system and to get information they need through the introduction of a **Single Point of Access**. Ensuring that the **Equality and Diversity System** action plan is implemented across all our activity will ensure appropriate, timely and equitable access to all patients.

Information and Technology Development

We will continue to develop Electronic Patient Record (EPR) and SystmOne, and similar information technology to support clinicians in making better decisions and delivering safer services (through patient monitoring, risk scoring, triggers/alerts and decision support tools. The Datix web based risk management system will be more effectively utilised to capture incidents and potential risks, and sharing information by the development of safety dashboards, with clinical directors held to account for remedial action. Better and faster systems to provide feedback will be provided through the establishment of a new **Business Intelligence Unit**

Improving Measurement and performance management

All operational quality objectives will align to our strategic quality objectives so that we have information to support total quality management approach. This will be supported by the development of benchmarks and dashboards, with clinical directorates and specialities developing their own quality improvement strategies with clear, measurable objectives and targets to manage performance within their services accordingly. The implementation of re-validation will extend this to individual clinicians.

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What are our strategic quality improvement programme objectives? The table below sets out specific improvement targets over the next 3 years to support the activities set out in this strategy. An additional quality improvement plan will set out the programmes of work in more detail. The targets relate to specific improvement objectives included in programmes aligned to our **Quality Account**, **CQUIN** and **National Outcomes Framework** requirements.

Domain and programmes	Targets 2012/13	Targets 2013/14	Targets 2014/15	NHS Outcomes Framework Domains	Supporting Strategies
Safe				1 and 3	Patient Safety Health and Safety
Reducing mortality	SHMI<85	SHMI<80	SHMI<75		
Never Events	Zero	Zero	Zero		
Medicines Management Code Standards	90% compliance	100%	100%		
NHS Safety Thermometer: Falls, Pressure Ulcers, UTI VTE Harm Free Patients (HFP)	>30% reduction all 4 topics 80% HFP	>40% 90% HFP	>50% 100% HFP		
Caring				3 and 4	Patient Experience Workforce Development
End of Life Care Pathway Indicators	95% compliance	100%	100%		
Patient Responsiveness	Top 20% National Survey	Top 15%	Top 10%		
Dementia CQUIN & NICE Standards	90% compliance	100% compliance	100% Compliance		
Staff national survey	Top 20%	Top 15%	Top 10%		
Reliable				2 and 3	Clinical Audit Effectiveness
NICE Quality Standards (40 per year)	80% reliability	85% reliability	90% reliability		
5 Long Term Condition pathways	80% reliability	85%	90% reliability		
NHS Outcomes Framework	Domain 1: Preventing People from dying prematurely Domain 2: Enhancing the quality of life for people with long term conditions Domain 3: Helping people to recover from episodes of ill health following injury Domain 4: Ensuring that people have a positive experience of Care Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm				

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Conclusion

The environment in which we provide services is changing very rapidly and we need to ensure that we are responsive and flexible to the external challenges to ensure we continue to consistently deliver high quality care for all our patients. We will constantly explore opportunities to become more efficient and effective in how we work. Providing high quality care for all of our patients will be the driving force at the forefront of everything we do.

We will therefore review the strategy and our implementation plan on an annual basis as part of our Quality Account consultation process and to ensure that it continues to fit with the changing demands of the NHS and always meets the needs of our patients.

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The Rotherham NHS
NHS Foundation Trust

Quarterly Quality Report: Integrated Services

Quarter 1

April - June | 2012-13

The Rotherham NHS
NHS Foundation Trust

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1. Executive Summary

Summary of the main issues contained in this report

Quality at a Glance measures

- Qtr1 reflects 1 MRSA bacteraemia in May, This has been agreed by the HPA to be community acquired; however IP&C are not removing this from their reporting systems until the HPA website has been amended.
- The rate of patient safety incidents per 1,000 admissions has increased in Qtr1, although the percentage where serious harm is caused has decreased.
- Qtr1 nutrition assessment performance dropped below baseline, whilst completion/ calculation of fluid balance charts has increased, these areas are currently subject to improvement programmes.
- SHMI (CHKS Live - in hospital deaths only) value for the quarter has increased slightly, more detailed review of the underlying causes is underway to understand which CCS groups are influencing this situation.
- Overall IR1 reporting is down on the previous quarter, although the Trust is still likely to exceed it's target of increased reporting year on year if volumes continue at the present rate.

CQUINs & Mandated National Quality Board indicators

- Safety Thermometer monthly data submissions, managed by the Quality & Standards analyst team, have been successful so far - laying solid foundations for full achievement of it's £250K financial incentive at the end of the year.
- A slight improvement is evident for inpatient CQUIN and Community Universal Services tempate - however Community Adult Services template has decreased to 91.8 from 97.2 the previous Qtr. More detailed updates are included in the HoT Board PMO update report.
- Performance against the relevant domains of indicators, selected by the National Quality Board (NQB) - is generally on par or exceeding National Peer performance.
- One exception to this performance is hip surgery Patient Reported Outcomes Measures (PROMs), where the Trust is slightly below the National average for EQ-5D Health Gain Index.
- Areas of partcularly strong performance are C. Difficile rates against the national average.
- Reporting of patient incidents per 100 admissions has increased, but is below the National average; however - the percentage of patient incidents resulting in severe harm or death is considerably lower than the National average.

Improvement Programmes

- Medications Management has improved in it's second audit, with only two areas not reflecting improvement - namely drugs stored in other locations (fridges & trolleys) found unlocked at the time of audit and instances where the Drug Disposal Unit was located in a room with a locked door; full compliance is not evident in all wards. A task/finish group is taking forward all medicines management improvements.
- Safety Thermometer data submissions (a National CQUIN) are also reflected on the Trust intranet, this work is being used to drive improvement through the trust - 14 of 17 indicators have reflected improvement against baseline in Qtr1. Areas requiring further focus are completion/acting upon nutritional assesment and VTE prophylaxis (where required) - our VTE prophylaxis remains higher than the National average.
- Liverpool Care Pathway metrics reflect an improvement, up by 2.1% on the previous Qtr. Much work remains to hit th 65% target by year end however.
- The dementia CQUIN (also an Improvement Programme) is due to commence data capture in Qtr3, with roles being recruited to support this at the end of Qtr2.

Internal and National Benchmarking - Safety Thermometer (Monthly point prevalence)

- Falls performance internally is good, with only Urology falling below the 95% no harm target for the quarter.
- Only the Community North team have not achieved the 95% target in relation to pressure ulcers.
- Several locations within Acute and Community have not achieved targets in relation to Urinary Tract Infections (UTIs). VTE assessment and prohylaxis significantly exceeds National performance and that of the SHA Cluster.
- Falls resulting in harm also perform strongly against National and SHA cluster peers, with the exception of May 2012 where TRFT was slightly above the National average.
- In terms of overall Harm Free Care - the Trust lags slightly behind National And SHA cluster peers; pareto analysis points towards pressure ulcers as the main influencing factor (in terms of Safety Thermometer data) - where they form approximately 75% of the burden of harm, against approximately 55% for the SHA cluster. Very few of the comparator organisations are integrated with Community Services, which will skew the comparison slightly for TRFT.

2. Quality at a Glance: Acute & Community

Key indicators for review

Domain	Ref	Indicator	Baseline period	Baseline value	Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating	Data Quality Rating
Patient Safety	PS_1	Compliance against all of the standards set out in relation to safe and secure storage of medications (composite %)	Qtr4 2011-12	68.0%	90%	60.9%				60.9%			
	PS_2a	Have zero 'Never Events'	2011-12	1	0	0				0			
	PS_2b	Rate of patient safety incidents per 1,000 admissions	2011-12	78	Reduce	85				85			
	PS_2c	Percentage of patient safety incidents resulting in severe harm (semi permanent/permanent) or death (Datix)	2011-12	3.1%	Reduce	2.3%				2.3%			
	PS_3	Number of patients with attributable C. Difficile	2011-12	50	Reduce	5				5			
	PS_4	Number of patients with attributable MRSA	2011-12	1	0	*1*				*1*			
	PS_5	Number of complaints	2011-12	650	Increase	213				213			
Patient Experience	PE_1	Increasing our responsiveness to our patients needs using a composite indicator of care (PET)	Apr-12	82.9	Increase	85.0				85.0			
	PE_2	Increasing compliance to 65% of 5 key measures on the Liverpool Care of the Dying Pathway (LCP) by April 2013	2011-12	38.4%	65%	40.5%				40.5%			
	PE_3	Increase the proportion of community OT visits for assessment within 28 days	April 2012	98.5%	95%	98.7%				98.7%			
	PE_4	Increase the number of Health Visitor first visit within 10-14 days of birth	2011-12	94.9%	97%	96.8%				96.8%			
	PE_5a	Increase in the proportion of patients assessed using the MUST nutritional tool (every 7 days, as a minimum)	April 2012	89.4%	Increase	83.2%				83.2%			
	PE_5a	Increase in the proportion of patients with completed (and calculated) fluid balance charts	April 2012	61.1%	Increase	73.8%				73.8%			
Clinical Effectiveness	CE_1	Reducing the number of hospital re-admissions from care homes within 30 days	April 2012	3.0%	Reduce	5.0%				5.0%			
	CE_2	Reducing emergency re-admissions to hospital within 28 days of discharge (CHKS Live)	2011-12	7.6%	Reduce	Not yet available							
	CE_3a	Reduction in Mortality: SHMI value (CHKS Live)	2011-12	74.1	<100	Not yet available							
	CE_6	Reducing weekend mortality rates	April 2012	24.7%	Reduce	23.4%				23.4%			
Culture	C_1	Applicable staff to have in year PDR (end of Qtr snapshot)	Qtr4 2011-12	49.0%	100%	50.0%				-			
	C_2	IR1 reporting (all types)	2011-12	7511	Increase	1878				1878			
	C_3	Staff to maintain compliance against MAST training (end of Qtr snapshot)	Qtr4 2011-12	75.0%	100%	77.0%				-			
	C_4	Employee sickness rates	2011-12	4.3%	Reduce	4.3%				4.3%			
Data Quality	DQ_1	Data Quality index - CHKS Live (HRG4 based)	2011-12	93.8	Increase	Not yet available							
	DQ_2	Blank, invalid or unacceptable primary diagnosis rates - CHKS Live (HRG4 based)	2011-12	0.2%	Reduce	Not yet available							
	DQ_3	Depth of coding: average diagnosis per coded episode - CHKS Live (excludes Breathing Space)	2011-12	3.2	Increase	Not yet available							
	DQ_4	SystmOne Data Quality	2011-12	97.4%	Increase	97.1%				97.1%			

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3. Mandated indicators - National Quality Board

Areas selected by the National Quality Board for national comparison and inclusion in the Quality Account

Domain	Indicator	Measure	Latest reporting period	Trust value	Target	National peer average	Trust Vs Peer	Comments
Domain 1: Preventing people from dying prematurely	Summary Hospital-Level Mortality Indicator	SHMI value (includes deaths in the community within 30 days)	Jan 11 - Dec 11	1.0	<1.0	1.0	⇨	Comparative peer group consists of 143 acute trusts (including teaching hospitals) who submit data via SUS - analysis performed by NHS IC.
		SHMI banding (1 = higher than expected, 2 = as expected, 3 = lower than expe	Jan 11 - Dec 11	2	3	2	⇨	
	Percentage of admitted patients where palliative care was included in diagnosis or treatment specialty		Jan 11 - Dec 11	0.9%	n/a	0.9%	⇨	
	Percentage of admitted patients (whose deaths were inc. in SHMI), where palliative care was included in diagnosis or treatment specialty		Jan 11 - Dec 11	17.0%	n/a	17.0%	⇨	
Domain 3: Helping people recover from periods of ill health or following injury	Patient Reported Outcomes Measures (PROMs) for:	Groin hernia surgery (provisional EQ-5D Index Health gain)	Jan 11 - Dec 11	0.087	Increase	0.089	⇨	National Peer value are derived from all England (ENG) aggregated results for providers of NHS funded procedures, including private hospitals - analyisis performed by NHS IC.
		Varicose vein surgery (provisional EQ-5D Index Health gain)	Jan 11 - Dec 11	-	-	0.094	-	
		Hip replacement surgery (provisional EQ-5D Index Health gain)	Jan 11 - Dec 11	0.354	Increase	0.423	⇩	
		Knee replacement surgery (provisional EQ-5D Index Health gain)	Jan 11 - Dec 11	0.313	Increase	0.313	⇨	
Domain 4: Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs	National inpatient survey analysis tool - overall index	2011-12	76	Increase	78	⇨	Comparative peer group index is 80th percentile of all responses nationally
	Staff recommending provider to others	Q21b (Percentage of staff who strongly agree that they would recommend the hospital for treatment to a friend or relative)	2011-12	61%	Increase	62%	⇨	Peer response based on acute trusts in Yorkshire & Humber SHA
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	Percentage of admitted patients risk-assessed for Venous Thromboembolism		Qtr3 2011-12	91.3%	Increase	90.7%	⇨	National Acute performance (funded NHS providers) - data collated by the DoH
	Rate of C. Difficile	Rate of *trust apportioned* cases for patients aged 2-65, per 100,000 bed days	2011-12	35	Reduce	46	⇧	National Acute average rate (HPA)
		Rate of *all cases* for patients 65+, per 100,000 bed days	2011-12	53	Reduce	85	⇧	National Acute average rate (HPA)
	Rate of patient safety incidents (per 100 admissions)		Apr11 - Sep11	5.5	Increase	6.5	⇧	Medium Acute trusts (NPSA)
	Percentage patient safety incidents resulting in severe harm or death		Apr11 - Sep11	0.1%	Reduce	0.7%	⇧	Medium Acute trusts (NPSA)

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4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

			Baseline period	Baseline value	Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating	Data Quality Rating
Medications Management	*To ensure that all Trust medicine management systems and processes adhere to The Royal Pharmaceutical Society Safe and Secure Storage and Handling of Medicines guidance (2005)*												
	MM_1	Number of days where there no check of controlled drugs (mean average across areas checked)	Qtr4 2011-12	13.1	0	6.4				6.4			
	MM_2	Percentage of drug cabinets locked	Qtr4 2011-12	56.1%	100%	57.9%				57.9%			
	MM_3	Percentage of instances where medications are left out on a counter in the clean utility	Qtr4 2011-12	70.4%	0%	25.0%				25.0%			
	MM_4	Percentage of instances where the clean utility was locked	Qtr4 2011-12	63.0%	100%	67.9%				67.9%			
	MM_5a	Drugs stored in other locations, percentage of instances where locked - Bedside lockers	Qtr4 2011-12	94.1%	100%	100.0%				100.0%			
	MM_5b	Drugs stored in other locations, percentage of instances where locked - Drugs trolleys	Qtr4 2011-12	90.9%	100%	85.7%				85.7%			
	MM_5c	Drugs stored in other locations, percentage of instances where locked - Fridges	Qtr4 2011-12	75.5%	100%	72.5%				72.5%			
	MM_5d	Drugs stored in other locations, percentage of instances where locked - Other	Qtr4 2011-12	29.4%	100%	100.0%				100.0%			
	MM_6	Number of days where there no check of fridge temperature (mean average across areas checked)	Qtr4 2011-12	12.5	0	6.4				6.4			
	MM_7	Percentage of instances where Drug Disposal Unit was located in a room with a locked door	Qtr4 2011-12	75.0%	100%	51.0%				51.0%			
Safety Thermometer	*Introduce and improve data collection in relation to falls, pressure ulcers, UTIs and VTE assessments in acute and community setting from April 2012 baseline*												
	ST_1	No Harm - Falls	April 2012	97.7%	Increase	97.9%				97.9%			
	ST_2	No Harm - New pressure ulcer	April 2012	96.8%	Increase	97.2%				97.2%			
	ST_3	Patient observations taken	April 2012	94.7%	Increase	96.9%				96.9%			
	ST_4	No Harm - VTE	April 2012	93.2%	Increase	94.6%				94.6%			
	ST_5	No Harm - UTI	April 2012	93.9%	Increase	94.1%				94.1%			
	ST_6	Tissue Viability assessment completed	April 2012	98.3%	Increase	94.0%				94.0%			
	ST_7	No Harm - Old pressure ulcer	April 2012	97.3%	Increase	92.6%				92.6%			
	ST_8	Nutritional assessment acted upon	April 2012	95.8%	Increase	91.7%				91.7%			
	ST_9	Bed rails assessment completed and acted upon	April 2012	92.9%	Increase	92.4%				92.4%			
	ST_10	Individual care plan reviewed and completed	May 2012	91.9%	Increase	93.2%				93.2%			
	ST_11	Falls assessment completed and acted upon	April 2012	97.7%	Increase	90.8%				90.8%			
	ST_12	Patient templates completed and reviewed	May 2012	88.7%	Increase	86.8%				86.8%			
	ST_13	Patients on VTE prophylaxis where required	April 2012	94.2%	Increase	88.5%				88.5%			
	ST_14	Nutritional assessment (MUST) completed	April 2012	89.4%	Increase	83.2%				83.2%			
	ST_15	Fluid balance assessment acted upon	April 2012	72.8%	Increase	80.7%				80.7%			
	ST_16	VTE risk assessment completed	April 2012	81.4%	Increase	85.1%				85.1%			
	ST_17	Fluid balance completed with daily totals	April 2012	61.1%	Increase	73.8%				73.8%			

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4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

Area	Code	Measure	Baseline period	Baseline value	Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating	Data Quality Rating
Liverpool Care Pathway (Governor indicator)		*Increasing compliance to 65% for 5 key measures of the Liverpool Care of the Dying Pathway (LCP) by April 2013. Also reducing the number of inappropriate Fast Track discharges to Community Health Care (CHC)*											
		Number of deceased (mortality DB - excludes deaths occuring in Accident & Emergency)	2011-12	1,055	Reduce	261				261			
		Proportion of those deceased, who were on the LCP	2011-12	47.0%	Increase	56.7%				56.7%			
	LC_1	Has the patient had the opportunity to discuss what is important to them and their wishes? (Q5)	2011-12	42.7%	65%	41.9%				41.9%			
	LC_2	Has the relative/carer had the opportunity to discuss what is important to them ans their wishes? (Q6)	2011-12	42.7%	65%	43.2%				43.2%			
	LC_3	The patient has medication prescribed on a PRN basis for the following:	2011-12	35.6%	65%	40.7%				40.7%			
		Pain (Q7a)	2011-12	40.9%	65%	43.9%				43.9%			
		Agitation (Q7b)	2011-12	38.7%	65%	41.2%				41.2%			
		Respiratory tract secretions (Q7c)	2011-12	36.1%	65%	41.2%				41.2%			
		Nausea/vomiting (Q7d)	2011-12	31.9%	65%	39.9%				39.9%			
		Dyspnoea (Q7e)	2011-12	29.6%	65%	37.2%				37.2%			
	LC_4	Has a full explanation of the current care plan been given to the relative/carer? (Q13)	2011-12	41.9%	65%	43.9%				43.9%			
	LC_5	Has the LCP 'Coping with death' leaflet been given to the relative/carer? (Q14)	2011-12	39.5%	65%	43.2%				43.2%			
		Average across 5 key measures	**2011-12**	**38.4%**	**65%**	**40.5%**				**40.5%**			
Patient Responsiveness		*Increasing our responsiveness to out patients needs using a composite indicator of care, from April 2012 baseline*	JG	TB									
	PR_1a	Did a member of staff tell you about medication side effects to watch for when you went home?	April 2012	84.3	Increase	84.7				84.7			
	PR_1b	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	April 2012	68.9	Increase	72.2				72.2			
	PR_1c	Did you find someone on the hospital staff to talk to about your worries and fears?	April 2012	87.3	Increase	87.8				87.8			
	PR_1d	Were you given enough privacy when discussing your condition and treatment?	April 2012	80.5	Increase	83.0				83.0			
	PR_1e	Were you involved as much as you wanted to be in decisions about your care and treatment?	April 2012	78.5	Increase	79.5				79.5			
	PR_1	**Inpatient CQUIN template overall score**	**April 2012**	**79.1**	Increase	**80.9**				**80.9**			
	PR_2a	Have you been involved as much as you wanted to be in decisions about your care and treatment?	April 2012	94.6	Increase	88.9				88.9			
	PR_2b	Were you given enough time to discuss your condition with healthcare professionals?	April 2012	96.3	Increase	87.1				87.1			
	PR_2c	Do you know what number/who to contact if you need support out of hours (after 5pm)?	April 2012	96.5	Increase	93.6				9.36			
	PR_2d	Overall, have staff treated you with dignity and respect?	April 2012	99.6	Increase	95.5				95.5			
	PR_2e	Overall, are you satisfied with the personal care and treatment you have received from community services?	April 2012	98.9	Increase	94.0				94			
	PR_2	**Community Health Adult Services overall score**	**April 2012**	**97.2**	Increase	**91.8**				**91.8**			
	PR_3a	Were you given enough time to discuss your child's health with the healthcare professionals?	April 2012	94.4	Increase	95.2				95.2			
	PR_3b	Did staff clearly explain the purpose of their contact with you in a way that you could understand?	April 2012	98.4	Increase	98.2				98.2			
	PR_3c	Do you know what number/who to contact if you need support out of hours (after 5pm)?	April 2012	85.2	Increase	86.8				86.8			
	PR_3d	Overall, have staff treated you and your family with dignity and respect?*	April 2012	97.6	Increase	98.4				98.4			
	PR_3e	Overall, are you satisfied with the service you have received from community services?	April 2012	96.8	Increase	96.1				96.1			
	PR_3	**Community Health Universal Services**	**April 2012**	**94.7**	Increase	**95.1**				**95.1**			

5. Clinical Effectiveness Work Programmes

Summary of Clinical Effectiveness, NICE and NCEPOD work programmes during the quarter

Clinical Audit Activity

61 clinical audit projects have been completed during Q1 2012/13, for which the Clinical Effectiveness Department have an action plan.
Five clinical audits have been completed where the results have confirmed no action plan is required.
A further 8 clinical audit projects have been published/ presented. An action plan has been requested.
CEG receives a report monthly of clinical audits that have been presented that the Clinical Effectiveness department have not received an action plan for.
In addition to the Annual Clinical Audit plan a further 30 new projects have been registered with the Clinical Effectiveness Department between 1/4/2012 and 30/6/2012.

Clinical Outcome Review Programmes

Child Health programme: Royal College of Paediatrics and Child Health (RCPCH) - No reports published during Q1 2012/13.
Maternal, New-born and Infant programme: MBRRACE-UK - No reports published during Q1 2012/13.
National Confidential Enquiries into Patient Outcome & Death (NCEPOD) - recommendations are monitored through Clinical Effectiveness Group.

Mortality

CHKS data for mortality was not available for Q1 2012/13 at the time of writing this report. From Q4 11/12 mortality data, Integrated Medicine have been asked to lead on a review of deceased patients coded as acute renal failure (which has since been presented in July).
There are 4 patients who passed away during EPR cutover that are still not on MEDITECH and therefore have not been through the mortality review. This has been logged with MEDITECH.
Delays in clinical coding continue to add an increased delay to cases going through the mortality review process . This has been escalated to the Clinical Coding Manager and the Head of Information & Performance.
During Q2 12/13, there will be a full review of the mortality review process to allow more granular level analysis at CSU level and the identification of themes.
Mortality review data shows an increase in falls within hospital – the same trend as incident data; an increase in the number of patients not reviewed every 48 hours; a reduction in the number of post operative deaths (compared to the same quarter last year).

Other Activity

Three policies for NHSLA are in draft format, for approval at CEG in July before ratification at Document Ratification Group
The Clinical Audit & Effectiveness Annual report 11/12 & Annual Clinical Audit plan 12/13 have both been received by CEG & CSEC
The Clinical Effectiveness Department continue to support Medical re-validation (providing evidence for), Document reviews for Document Ratification Group/ Quality Standards Policy Implementation Group, Ward Safety Thermometer (distribution, receipt, scanning & validation)

NICE Quality Standards:
Self Assessment of Compliance by Lead

Following CBPIC approval, NICE: Assure was implemented by Allocate Software during May 2012. Data collection requirements for NICE Quality Standards presents an enormous challenge for CSUs.
The *Depression in adults* and the *Service User Experience in Adult Mental Health* Quality Standards are considered not applicable to TRFT

Title	Lead	Last Updated	Overall	Statements applicable	Red	Amber	Yellow	Green
Alcohol Dependence and Harmful Alcohol Use	B Höroldt	21/6/2012		17	2	4	0	11
Breast Cancer	P Dudani	15/6/2012		18	0	0	3	15
Chronic Heart Failure	R Muthusamy	28/6/2012		14	0	1	4	9
Chronic Kidney Disease	S Muzulu	9/7/2012		4	0	0	0	4
Chronic Obstructive Pulmonary Disease	P Bardsley	4/7/2012		23	0	3	3	17
Dementia	Dementia Care Group	2/7/2012		11	0	9	2	0
Diabetes in Adults	B Franke	Awaiting update		17	1	3	0	13
End of Life Care in Adults	R Broadhurst	3/7/2012		26	1	4	10	11
Glaucoma	M Jabir	9/7/2012		13	0	0	3	10
Hip Fracture for Adults	S Blair	*Compliance to be established*						
Lung Cancer for Adults	N Qureshi	23/7/2012		15	0	0	0	15
Ovarian Cancer	C Ramsden	3/7/2012		5	1	0	1	3
Patient Experience in Adult NHS Service	B Reid	2/7/2012		17	3	2	11	1
Specialist Neonatal Care	K Parke	20/7/2012		19	7	5	2	5
Stroke	J Okwera	10/7/2012		12	0	0	1	11
VTE Prevention	VTE Steering Group	20/6/2012		8	0	5	0	3

GREEN: Evidence available shows the outcome is met.
YELLOW: Evidence available shows the outcome is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Action required is minimal.
AMBER: Evidence available shows the outcome is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Action required is moderate.
RED: Evidence available shows that the outcome is at risk of not being met or there is no available evidence that the outcome is met.

NICE Guidance

Compliance responses returned to Clinical Effectiveness for guidance published Q4 11/12 & Q1 12/13 (data extracted from Clinical Effectiveness Database 23/7/2012)

Awaiting reply	10
Fully implemented	12
Partially implemented	4
Not implemented	1
For information	17

For NHSLA level 2, as documented in the NICE Guidance Policy, it is necessary to ensure there is a comprehensive action plan in place for non-compliance with NICE guidance. Where necessary non-compliance will be risk assessed and recorded on the appropriate risk register.

6. Internal Benchmarking - Safety Thermometer indicators (monthly point prevalence audit)

Comparison at CSU level to identify areas for improvement

No Harm - Falls

		YTD	Apr	May	Jun	Jul
Acute	⊞ Specialist medicine	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Obstetrics & Gynaecology	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	98.1 %	100.0 %	94.0 %	100.0 %	97.8 %
	⊞ Alternative level of care	98.0 %	95.8 %	100.0 %	96.0 %	100.0 %
	⊞ Integrated Medicine	96.9 %	98.4 %	94.0 %	97.1 %	98.3 %
	⊞ General surgery	96.6 %	91.1 %	97.8 %	98.1 %	100.0 %
	⊞ Urology	94.5 %	93.8 %	100.0 %	91.7 %	92.9 %
Community	⊞ Community South	100.0 %	-	100.0 %	100.0 %	100.0 %
	⊞ Community North	100.0 %	-	100.0 %	100.0 %	100.0 %
	⊞ Community Central	98.7 %	-	98.0 %	99.2 %	99.1 %
The Rotherham NHS Foundation Trust		98.2 %	97.7 %	97.1 %	98.7 %	99.1 %

No Harm - Pressure Ulcers

		YTD	Apr	May	Jun	Jul
Acute	⊞ Obstetrics & Gynaecology	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ General surgery	99.5 %	98.2 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	99.0 %	98.0 %	98.0 %	100.0 %	100.0 %
	⊞ Urology	98.2 %	93.8 %	100.0 %	100.0 %	100.0 %
	⊞ Specialist medicine	97.7 %	90.9 %	100.0 %	100.0 %	100.0 %
	⊞ Theatres & Anaesthetics	97.5 %	100.0 %	100.0 %	88.9 %	100.0 %
	⊞ Integrated Medicine	97.4 %	95.5 %	97.9 %	99.2 %	97.0 %
	⊞ Alternative level of care	97.0 %	100.0 %	96.2 %	100.0 %	92.3 %
Community	⊞ Community South	96.0 %	-	94.1 %	96.6 %	96.1 %
	⊞ Community Central	95.5 %	-	96.0 %	94.7 %	95.7 %
	⊞ Community North	94.2 %	-	93.1 %	93.9 %	96.4 %
The Rotherham NHS Foundation Trust		97.2 %	96.8 %	97.0 %	97.6 %	97.1 %

No Harm - Venous Thromboembolism

		YTD	Apr	May	Jun	Jul
Acute	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	98.5 %	98.0 %	98.0 %	100.0 %	97.8 %
	⊞ Obstetrics & Gynaecology	96.0 %	90.0 %	93.1 %	100.0 %	100.0 %
	⊞ Theatres & Anaesthetics	95.0 %	100.0 %	81.8 %	100.0 %	100.0 %
	⊞ Integrated Medicine	93.5 %	92.6 %	90.1 %	97.1 %	93.9 %
	⊞ Specialist medicine	93.2 %	100.0 %	70.0 %	100.0 %	100.0 %
	⊞ General surgery	92.8 %	89.3 %	93.3 %	94.3 %	94.4 %
	⊞ Alternative level of care	92.1 %	95.8 %	88.5 %	92.0 %	92.3 %
	⊞ Urology	90.9 %	81.3 %	100.0 %	91.7 %	92.9 %
Community	⊞ Community South	96.8 %	-	100.0 %	95.2 %	97.4 %
	⊞ Community Central	96.5 %	-	96.0 %	96.2 %	97.4 %
	⊞ Community North	94.7 %	-	93.1 %	95.1 %	96.4 %
The Rotherham NHS Foundation Trust		95.0 %	93.2 %	93.3 %	96.5 %	96.1 %

No Harm - Urinary Tract Infection

		YTD	Apr	May	Jun	Jul
Acute	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Obstetrics & Gynaecology	98.4 %	100.0 %	100.0 %	94.6 %	100.0 %
	⊞ Child health	98.0 %	100.0 %	100.0 %	100.0 %	90.5 %
	⊞ General surgery	95.2 %	100.0 %	91.1 %	92.5 %	96.3 %
	⊞ Orthopaedics	95.1 %	95.9 %	92.0 %	93.4 %	100.0 %
	⊞ Specialist medicine	93.2 %	90.9 %	100.0 %	81.8 %	100.0 %
	⊞ Alternative level of care	91.1 %	87.5 %	96.2 %	96.0 %	84.6 %
	⊞ Integrated Medicine	90.7 %	92.6 %	91.0 %	87.2 %	92.2 %
	⊞ Urology	80.0 %	68.8 %	84.6 %	83.3 %	85.7 %
Community	⊞ Community South	98.9 %	-	100.0 %	97.9 %	99.3 %
	⊞ Community North	98.7 %	-	100.0 %	97.6 %	98.2 %
	⊞ Community Central	96.0 %	-	96.0 %	98.5 %	93.0 %
The Rotherham NHS Foundation Trust		94.4 %	93.9 %	94.8 %	93.7 %	95.0 %

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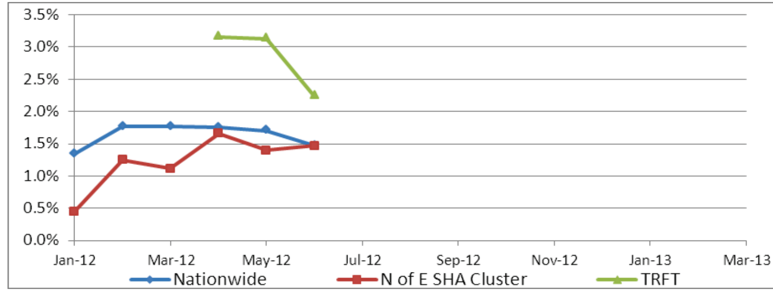
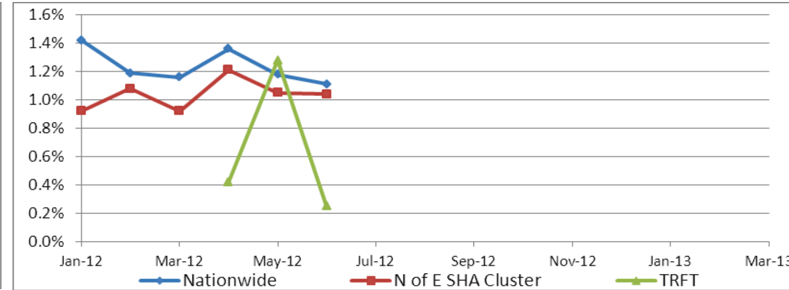
7. National & Regional Benchmarking - Safety Thermometer indicators

Comparison at National & SHA level to identify areas for improvement

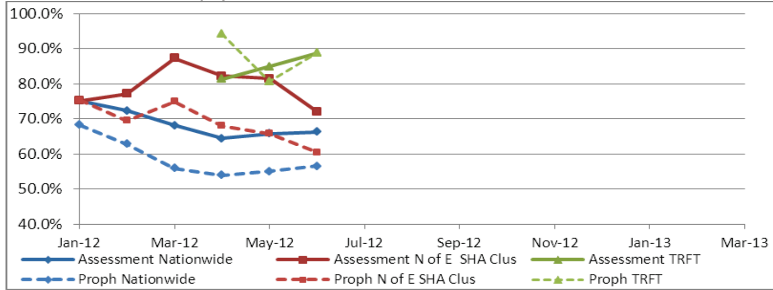
Pressure Ulcers (new) - All grades



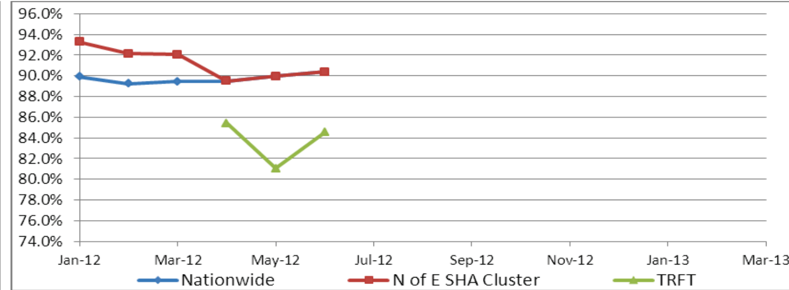
Falls resulting in harm



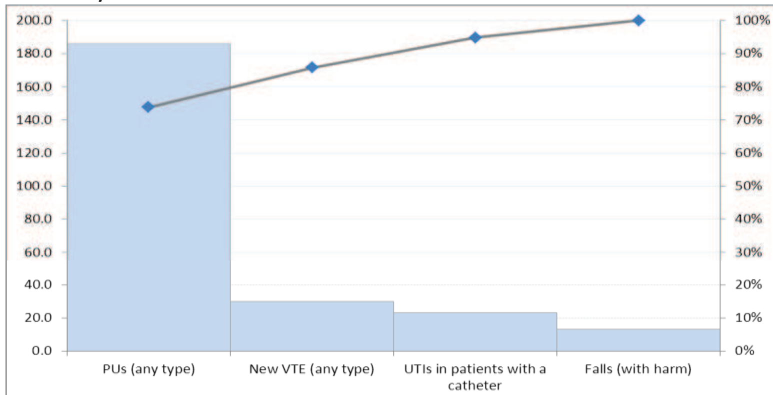
VTE Assessment and Prophylaxis



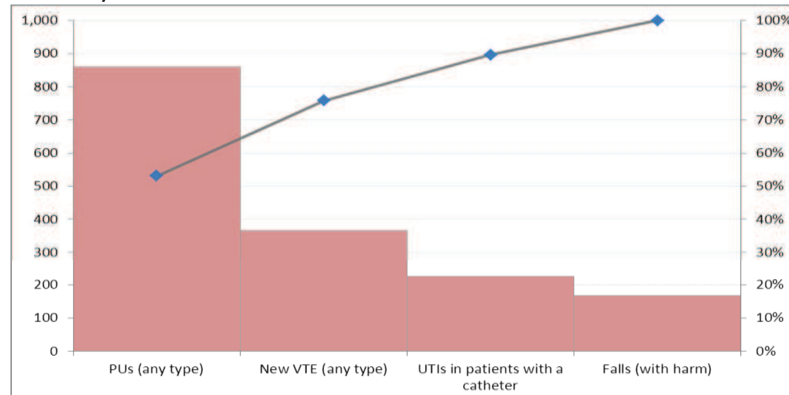
Harm free' care



Pareto analysis - burden of harms - TRFT



Pareto analysis - burden of harms - Yorkshire & Humber SHA



- The NHS QUEST Safety Thermometer, previously piloted as NHS Safety Express, is now a national CQUIN. £250k of income is attached to fulfilling the requirements of data submission - which includes provision of a monthly dataset to the NHS Information Centre, including harm data for every Acute patient occupying a bed and each Community patient seen, on the second Tuesday of every month.
- Minor discrepancies may exist between values reflected for TRFT from 'official' Safety Thermometer publications (used to generate charts shown), and our own Reporting Services intranet reports - this is due to the fact that ST place a 'cap' on the number of patient records which can be reported per area (40), whereas we are able to report *all* records captured through Reporting Services. This issue mainly impacts on Community surveys due to the number of patients surveyed - but is soon to be resolved as ST are working to remove the cap on their reportable record capacity.Any discrepancy is likely to be within 0.5%
- It must be borne in mind that whilst efforts have been made to ensure consistency of data capture across all organisations taking part in the ST surveys - some definitional issues do exist and this is likely to result in a small degree of variation in how issues are captured/counted between different Trusts - for example 'old' and 'new' harms, and how these are counted for patients who are on a ward long term and thus feature in several monthly surveys.
- Very few of the comparator organisations are integrated with Community Services; unfortunately it is not possible to adjust the peer groups to enable more appropriate comparison.
- Whilst these caveats are important - ST data is still one of the only timely, comprehensive means of benchmarking between national peers and SHA cluster on a focussed group of issues.

The Rotherham NHS
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Quarterly Quality Report: Integrated Services

Quarter 2

July - September | 2012-13

The Rotherham NHS
NHS Foundation Trust

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1. Executive Summary

Summary of the main issues contained in this report

Quality at a Glance measures

- Incident reporting per 1,000 admissions reflects a significant improvement against the previous Qtr and baseline - whilst the proportion of patient safety incidents resulting in severe harm has decreased. YTD performance for severe harm is now below baseline.
- C. Diff incidences have increased against the previous Qtr, but are also above the planned TRFT trajectory for the Qtr, unlike the previous period.
- Patient Experience scores, currently measured by Dr Foster PET - have reflected an improvement on the previous Qtr.
- Qtr2 nutritional assessment performance is improving, moving closer to baseline, whilst completion/ calculation of fluid balance charts has increased significantly in relation to last Qtr, from circa 74% to 83%.
- Weekend mortality rates have increased on the last Qtr, with YTD rate now significantly above the April baseline. **Action:** EMD to take forward with 24/7 project
- MAST completion rates have dropped this Qtr, from 77% to 70%. **Action**: Ongoing work to raise compliance across trust by POD
- Blank, invalid or unacceptable primary diagnoses rates (CHKS Live) have jumped *significantly* in Qtr2, it is likely that further data refreshes will improve the situation, but this remains to be confirmed by future monitoring. **Action**: Data Quality Group IT/EPR taking forward.

CQUINs & Mandated National Quality Board indicators

- Risk assessment for VTE is slightly down for TRFT at 92.4% for Qtr1, and below the National average for the same period of 93.4% (publication of National figures is always subject to delay). This is one of the few National Quality Board mandated indicators that has been subject to update for the period.
- A slight improvement is evident for inpatient CQUIN and Community Adult Services for Qtr2, whilst Community Universal Services have witnessed a slight decrease in positivity of response by a small margin. YTD results for the Community Adult Services template remain below the April 2012 baseline. More detailed updates are included in HoT Board PMO updates.
- NRLS data reflects that the Trust has a higher than average reporting rate compared to medium acute peers(6.9 vs 6.7) - with the proportion of incidents resulting in severe harm or death being significantly lower than the peer average (0.4% vs 0.8%).
- Most recently published data for NHS IC's SHMI shows that the Trust is in band 2 (mortality 'as expected') this is in line with the National average; actual SHMI value of 1.0 is comparable to National acute peers.
- PROMs publication, national inpatient and staff surveys have not been subject to an update in the period.

Improvement Programmes

- Medications Management has continued to reflect improvement for the second time against baseline; the only areas not reflecting improvement being % of instances where drugs fridges are not locked. Whilst improved - further progress must be made in % of instances where Clean Utility/Drug Dsposal Unit room is secure. **Action**: All action plans now taken forward to performance meetings ML/JG
- Liverpool Care Pathway metrics reflect a significant improvement, with performance for the Qtr against the 5 measures being 88.5% against the previous 42.8%. YTD performance now remains just under target at 64.1%.
- Data capture for the dementia F.A.I.R initiative has commenced, arrangements are currently underway to derive robust reports in support of this objective.
- Data quality issues have resulted in the inability to produce robust performance metrics to date, migration of the current arrangement to SystmOne is due to take place in December, but will not enable retrospective reporting back to the beginning of the year.

Internal and National Benchmarking - Safety Thermometer (Monthly point prevalence)

- Specialist Medicine and ALOC did not achieve target for Pressure Ulcers and VTE respectively, both attaining performance of 94.6%.
- National and regional benchmarking has reflected significant improvement for TRFT.
- VTE assessment and prohylaxis continues to significantly exceed National performance and that of the SHA Cluster, both of whom reflect a continued downward trend in Qtr2, whilst TRFT shows sustained improvement.
- Falls resulting in harm also perform strongly against National and SHA cluster peers, with two thirds less falls resulting in harm against both peer groups in Qtr2.
- New pressure ulcers are declining, continued improvements in this area will result in TRFT being below the National and SHA Cluster average by the close of Qtr3
- In spite of very strong performance in several areas of Safety Thermometer metrics, overall TRFT 'Harm Free Care' is below target at 88% YTD - though significant improvements are evident this Qtr against SHA Cluster and the National average, which are also below the 95% target - at circa 91% in September.
- For the purposes of parity in peer comparison - in this instance, all metrics are derived from NHS IC data rather than internally published figures (see National Benchmarking page for full details).

2. Quality at a Glance: Acute & Community

Key indicators for review

			Baseline period	Baseline value	Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating	Data Quality Rating
Patient Safety	PS_1	Compliance against all of the standards set out in relation to safe and secure storage of medications (composite %)	Qtr4 2011-12	68.0%	90%	60.9%	68.4%			64.4%			
	PS_2a	Have zero 'Never Events'	2011-12	1	0	0	0			0			
	PS_2b	Rate of reported patient safety incidents per 1,000 admissions	2011-12	78	Increase	83	92			87			
	PS_2c	Percentage of patient safety incidents resulting in severe harm (semi permanent/permanent) or death (Datix)	2011-12	3.1%	Reduce	2.3%	1.9%			2.1%			
	PS_3	Number of patients with attributable C. Difficile	2011-12	50	=<32	5	7			12			
	PS_4	Number of patients with attributable MRSA bacteraemia	2011-12	1	0	1	0			1			
	PS_5	Number of complaints	2011-12	650	Increase	213	261			474			
Patient Experience	PE_1	Increasing our responsiveness to our patients needs using a composite indicator of care (PET)	Apr-12	82.9	Increase	85.0	89.1			87.5			
	PE_2	Increasing compliance to 65% of 5 key measures on the Liverpool Care of the Dying Pathway (LCP) by April 2013	2011-12	38.4%	65%	42.8%	88.5%			64.1%			
	PE_3	Increase the proportion of community OT visits for assessment within 28 days	April 2012	98.5%	95%	98.7%	99.8%			99.2%			
	PE_4	Increase the number of Health Visitor first visit within 10-14 days of birth	April 2013	97.0%	97%	96.8%	95.2%			96.0%			
	PE_5a	Increase in the proportion of patients assessed using the MUST nutritional tool (every 7 days, as a minimum)	April 2012	89.4%	Increase	83.2%	84.9%			84.1%			
	PE_5b	Increase in the proportion of patients with completed (and calculated) fluid balance charts	April 2012	61.1%	Increase	73.8%	83.1%			78.3%			
Clinical Effectiveness	CE_1	Reducing the number of hospital re-admissions from care homes within 30 days	April 2012	3.0%	=<3.0%	5.0%	2.7%			3.8%			
	CE_2	Reducing emergency re-admissions to hospital within 28 days of discharge (CHKS Live)*	2011-12	7.6%	Reduce	5.5%	5.8%			5.6%			
	CE_3a	Reduction in Mortality: SHMI value (CHKS Live)	2011-12	74.1	Reduce	80.7	75.8			78.3			
	CE_6	Reducing weekend mortality rates	April 2012	24.7%	Reduce	23.8%	29.5%			26.5%			
Culture	C_1	Applicable staff to have in year PDR (end of Qtr snapshot)	Qtr4 2011-12	49.0%	100%	50.0%	54.0%			n/a		-	
	C_2	IR1 reporting (all types)	2011-12	7511	Increase	1878	2079			3957			
	C_3	Staff to maintain compliance against MAST training (end of Qtr snapshot)	Qtr4 2011-12	75.0%	100%	77.0%	70.0%			n/a		-	
	C_4	Employee sickness rates	2011-12	4.3%	Reduce	4.3%	4.2%			4.3%			
Data Quality	DQ_1	Data Quality index - CHKS Live (HRG4 based)*	2011-12	95.9	Increase	94.2	85.1			89.7			
	DQ_2	Blank, invalid or unacceptable primary diagnosis rates - CHKS Live (HRG4 based)*	2011-12	0.2%	Reduce	1.9%	10.3%			6.1%			
	DQ_3	Depth of coding: average diagnosis per coded episode - CHKS Live (excludes Breathing Space)	2011-12	3.2	Increase	3.2	3.1			3.2			
	DQ_4	SystmOne Data Quality	2011-12	97.4%	>97%	96.6%	97.1%			96.9%			

*NB - it is known that EPR implementation will affect outputs for these indicators, amongst others, further monitoring will confirm the extent of the impact

3. Mandated indicators - National Quality Board

Areas selected by the National Quality Board for national comparison and inclusion in the Quality Account

Domain	Indicator	Measure	Latest reporting period	Trust value	Target	National peer average	Trust Vs Peer	Comments
Domain 1: Preventing people from dying prematurely	Summary Hospital-Level Mortality Indicator	SHMI value (includes deaths in the community within 30 days)	Apr11 - Mar12	1.0	<1.0	1.0		Comparative peer group consists of 142 acute trusts (including teaching hospitals) who submit data via SUS - analysis performed by NHS IC.
		SHMI banding (1 = higher than expected, 2 = as expected, 3 = lower than expe	Apr11 - Mar12	2	3	2		
	Percentage of admitted patients where palliative care was included in diagnosis or treatment specialty		Apr11 - Mar12	1.0%	n/a	1.0%	-	
	Percentage of admitted patients (whose deaths were inc. in SHMI), where palliative care was included in diagnosis or treatment specialty		Apr11 - Mar12	20.3%	n/a	17.9%	-	
Domain 3: Helping people recover from periods of ill health or following injury	Patient Reported Outcomes Measures (PROMs) for:	Groin hernia surgery (provisional EQ-5D Index Health gain)	Jan11 - Dec11	0.087	Increase	0.089		National Peer value are derived from all England (ENG) aggregated results for providers of NHS funded procedures, including private hospitals - analyisis performed by NHS IC.
		Varicose vein surgery (provisional EQ-5D Index Health gain)	Jan11 - Dec11	-	-	0.094	-	
		Hip replacement surgery (provisional EQ-5D Index Health gain)	Jan11 - Dec11	0.354	Increase	0.423		
		Knee replacement surgery (provisional EQ-5D Index Health gain)	Jan11 - Dec11	0.313	Increase	0.313		
Domain 4: Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs	National inpatient survey analysis tool - overall index	2011-12	76	Increase	78		Comparative peer group index is 80th percentile of all responses nationally
	Staff recommending provider to others	Q21b (Percentage of staff who strongly agree that they would recommend the hospital for treatment to a friend or relative)	2011-12	61%	Increase	62%		Peer response based on median average for acute trusts in the UK
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	Percentage of admitted patients risk-assessed for Venous Thromboembolism		Qtr1 2012-13	92.4%	Increase	93.4%		National Acute performance (funded NHS providers) - data collated by the DoH
	Rate of C. Difficile	Rate of *trust apportioned* cases for patients aged 2-65, per 100,000 bed days	2011-12	35	Reduce	46		National Acute average rate (HPA)
		Rate of *all cases* for patients 65+, per 100,000 bed days	2011-12	53	Reduce	85		National Acute average rate (HPA)
	Rate of patient safety incidents (per 100 admissions)		Oct11 - Mar12	6.9	Increase	6.7		Medium Acute trusts (NPSA)
	Percentage patient safety incidents resulting in severe harm or death		Oct11 - Mar12	0.4%	Reduce	0.8%		Medium Acute trusts (NPSA)

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4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

Area	Ref	Indicator	Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating	Data Quality Rating
Medications Management		*To ensure that all Trust medicine management systems and processes adhere to The Royal Pharmaceutical Society Safe and Secure Storage and Handling of Medicines guidance (2005)*											
	MM_1	Number of days where there no check of controlled drugs (mean average across areas checked)	Qtr4 2011-12	13.1	0	6.6	4.3			5.5			
	MM_2	Percentage of drug cabinets locked	Qtr4 2011-12	56.1%	100%	57.9%	80.9%			68.3%			
	MM_3	Percentage of instances where medications are left out on a counter in the clean utility	Qtr4 2011-12	70.4%	0%	25.0%	15.4%			20.4%			
	MM_4	Percentage of instances where the clean utility was locked	Qtr4 2011-12	63.0%	100%	67.9%	75.0%			71.4%			
	MM_5a	Drugs stored in other locations, percentage of instances where locked - Bedside lockers	Qtr4 2011-12	94.1%	100%	100.0%	100.0%			100.0%			
	MM_5b	Drugs stored in other locations, percentage of instances where locked - Drugs trolleys	Qtr4 2011-12	90.9%	100%	85.7%	100.0%			92.3%			
	MM_5c	Drugs stored in other locations, percentage of instances where locked - Fridges	Qtr4 2011-12	75.5%	100%	72.5%	72.5%			72.5%			
	MM_5d	Drugs stored in other locations, percentage of instances where locked - Other	Qtr4 2011-12	29.4%	100%	100.0%	-			100.0%	-		
	MM_6	Number of days where there no check of fridge temperature (mean average across areas checked)	Qtr4 2011-12	12.5	0	6.4	4.3			5.3			
	MM_7	Percentage of instances where Drug Disposal Unit was located in a room with a locked door	Qtr4 2011-12	75.0%	100%	51.0%	62.5%			56.2%			
Safety Thermometer		*Introduce and improve data collection in relation to falls, pressure ulcers, UTIs and VTE assessments in acute and community setting from April 2012 baseline*											
	ST_1	No Harm - Falls	April 2012	97.7%	Increase	97.9%	98.9%			98.4%			
	ST_2	No Harm - New pressure ulcer	April 2012	96.8%	Increase	97.2%	97.6%			97.4%			
	ST_3	Patient observations taken	April 2012	94.7%	Increase	96.9%	97.9%			97.4%			
	ST_4	No Harm - VTE	April 2012	97.7%	Increase	98.5%	98.9%			98.7%			
	ST_5	No Harm - UTI	April 2012	93.9%	Increase	94.1%	95.4%			94.8%			
	ST_6	Tissue Viability assessment completed	April 2012	98.3%	Increase	94.0%	90.3%			92.1%			
	ST_7	No Harm - Old pressure ulcer	April 2012	97.3%	Increase	92.6%	92.3%			92.5%			
	ST_8	Nutritional assessment acted upon	April 2012	95.8%	Increase	91.7%	93.9%			92.8%			
	ST_9	Bed rails assessment completed and acted upon	April 2012	92.9%	Increase	92.4%	90.4%			91.5%			
	ST_10	Individual care plan reviewed and completed	May 2012	91.9%	Increase	93.2%	93.5%			93.4%			
	ST_11	Falls assessment completed and acted upon	April 2012	97.7%	Increase	90.8%	90.2%			90.5%			
	ST_12	Patient templates completed and reviewed	May 2012	88.7%	Increase	86.8%	89.4%			84.9%			
	ST_13	Patients on VTE prophylaxis where required	April 2012	94.2%	Increase	88.5%	86.7%			87.6%			
	ST_14	Nutritional assessment (MUST) completed	April 2012	89.4%	Increase	83.2%	84.9%			84.1%			
	ST_15	Fluid balance assessment acted upon	April 2012	72.8%	Increase	80.7%	86.4%			83.5%			
	ST_16	VTE risk assessment completed	April 2012	81.4%	Increase	85.1%	83.8%			84.4%			
	ST_17	Fluid balance completed with daily totals	April 2012	61.1%	Increase	73.8%	83.1%			78.3%			

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4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

Area	Ref	Measure	Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating	Data Quality Rating
Liverpool Care Pathway (Governor indicator)		*Increasing compliance to 65% for 5 key measures of the Liverpool Care of the Dying Pathway (LCP) by April 2013. Also reducing the number of inappropriate Fast Track discharges to Community Health Care (CHC)*											
		Number of deceased (mortality DB - excludes deaths occuring in Accident & Emergency)	2011-12	1,055	Reduce	261	234			495			
		Proportion of those deceased, who were on the LCP	2011-12	47.0%	Increase	58.2%	56.8%			57.6%			
	LC_1	Has the patient had the opportunity to discuss what is important to them and their wishes? (Q5)	2011-12	42.7%	65%	43.4%	91.7%			66.0%			
	LC_2	Has the relative/carer had the opportunity to discuss what is important to them ans their wishes? (Q6)	2011-12	42.7%	65%	44.7%	89.5%			65.6%			
	LC_3	The patient has medication prescribed on a PRN basis for the following:	2011-12	35.6%	65%	41.4%	86.8%			62.6%			
		Pain (Q7a)	2011-12	40.9%	65%	45.4%	90.2%			66.3%			
		Agitation (Q7b)	2011-12	38.7%	65%	42.8%	88.7%			64.2%			
		Respiratory tract secretions (Q7c)	2011-12	36.1%	65%	41.4%	86.5%			62.5%			
		Nausea/vomiting (Q7d)	2011-12	31.9%	65%	40.1%	85.0%			61.1%			
		Dyspnoea (Q7e)	2011-12	29.6%	65%	37.5%	83.5%			58.9%			
	LC_4	Has a full explanation of the current care plan been given to the relative/carer? (Q13)	2011-12	41.9%	65%	45.4%	92.5%			67.4%			
	LC_5	Has the LCP 'Coping with death' leaflet been given to the relative/carer? (Q14)	2011-12	39.5%	65%	44.7%	88.7%			65.3%			
	Average across 5 key measures		**2011-12**	**38.4%**	**65%**	**42.8%**	**88.5%**			**64.1%**			
Patient Responsiveness		*Increasing our responsiveness to out patients needs using a composite indicator of care, from April 2012 baseline*											
	PR_1a	Did a member of staff tell you about medication side effects to watch for when you went home?	April 2012	84.3	Increase	84.7	83.6			84.1			
	PR_1b	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	April 2012	68.9	Increase	72.2	77.4			74.6			
	PR_1c	Did you find someone on the hospital staff to talk to about your worries and fears?	April 2012	87.3	Increase	87.8	85.9			86.9			
	PR_1d	Were you given enough privacy when discussing your condition and treatment?	April 2012	80.5	Increase	83.0	81.4			82.2			
	PR_1e	Were you involved as much as you wanted to be in decisions about your care and treatment?	April 2012	78.5	Increase	79.5	80			79.8			
	PR_1	**Inpatient CQUIN template overall score**	**April 2012**	**79.1**	Increase	**80.9**	**81.4**			**81.1**			
	PR_2a	Have you been involved as much as you wanted to be in decisions about your care and treatment?	April 2012	94.6	Increase	88.9	91.5			90.8			
	PR_2b	Were you given enough time to discuss your condition with healthcare professionals?	April 2012	96.3	Increase	87.1	91.6			90.4			
	PR_2c	Do you know what number/who to contact if you need support out of hours (after 5pm)?	April 2012	96.5	Increase	93.6	94.8			94.5			
	PR_2d	Overall, have staff treated you with dignity and respect?	April 2012	99.6	Increase	95.5	97.8			97.2			
	PR_2e	Overall, are you satisfied with the personal care and treatment you have received from community services?	April 2012	98.9	Increase	94.0	96.8			96.1			
	PR_2	**Community Health Adult Services overall score**	**April 2012**	**97.2**	Increase	**91.8**	**94.5**			**93.8**			
	PR_3a	Were you given enough time to discuss your child's health with the healthcare professionals?	April 2012	94.4	Increase	95.2	96.2			95.8			
	PR_3b	Did staff clearly explain the purpose of their contact with you in a way that you could understand?	April 2012	98.4	Increase	98.2	95.3			96.5			
	PR_3c	Do you know what number/who to contact if you need support out of hours (after 5pm)?	April 2012	85.2	Increase	86.8	84.8			85.6			
	PR_3d	Overall, have staff treated you and your family with dignity and respect?*	April 2012	97.6	Increase	98.4	98.8			98.6			
	PR_3e	Overall, are you satisfied with the service you have received from community services?	April 2012	96.8	Increase	96.1	97.7			97.0			
	PR_3	**Community Health Universal Services**	**April 2012**	**94.7**	Increase	**95.1**	**94.8**			**94.9**			

5. Clinical Effectiveness Work Programmes

Summary of Clinical Effectiveness, NICE and NCEPOD work programmes during the quarter

Clinical Audit Activity

- 49 clinical audit projects have been completed during Q2 2012/13, for which the Clinical Effectiveness Department have an action plan. 7 clinical audits have been completed where the results have confirmed no action plan is required.
- A further 19 clinical audit projects have been published/presented. An action plan has been requested.
- CEG receives a monthly report of clinical audits that have been presented that the Clinical Effectiveness department have not received an action plan for.
- In addition to the Annual Clinical Audit plan a further 12 new projects have been registered with the Clinical Effectiveness Department between 01/07/2012 and 30/09/2012.

Clinical Outcome Review Programmes

- Child Health Programme: Royal College of Paediatrics and Child Health (RCPCH): No reports published during Q2 2012/13
- Maternal, New-born and Infant Programme (MBRRACE-UK): No reports published during Q2 2012/13
- National Confidential Enquiries into Patient Outcome & Death (NCEPOD): Recommendations are monitored through Clinical Effectiveness Group.

Mortality

- Following a recent external alert from Dr Foster, a review of patients who died with a primary diagnosis of Septicaemia is being carried out by a Consultant Microbiologist and the Clinical Coding Manager.
- Delays in clinical coding continue to add an increased delay to cases going through the mortality review process. This has been escalated to the Clinical Coding Manager and the Head of Information & Performance.
- A full review of the mortality review process is underway. Concerns regarding the current process include time demands; Clinical Effectiveness Department staff interpretation of clinical 'triggers'; the quality of information generated by the process, some of which is now routinely monitored through alternative sources; and that the process does not prevent additional focused reviews following external alerts. A reduction in WTE staff in the Clinical Effectiveness Department will significantly impact on the delivery of the Mortality Review process post December 2012.

Other Activity

- The process for the introduction of new clinics and clinical procedures has been reviewed and updated. One new clinic was approved by the Clinical Effectiveness and Research Group (CEG) during Quarter 2: Haematology Virtual Clinic.
- The Clinical Audit Policy, NICE Policy and Confidential Enquiry Policy have been updated and ratified.
- Regular research updates have been incorporated as a standard agenda item at CEG, including target recruitment figures.
- Staffing levels within the Clinical Effectiveness department are due to reduce from 6.7 to 5.2 WTE from 1st December 2012 due to staff retirement, maternity leave and cost improvements.

NICE Guidance

Compliance responses returned to Clinical Effectiveness for guidance published Q2 2012-13 (data extracted from Clinical Effectiveness Database 05/11/2012):

Awaiting reply	5
Fully implemented	2
Partially implemented	4
Not implemented	0
For information	9

NICE Quality Standards: Self Assessment of Compliance by Lead

A compliance review has been undertaken for the new Quality Standards on: Bacterial Meningitis and Meningococcal Septicaemia in Children and Young People; Colorectal Cancer; and Hip Fracture.

Title	Lead	Last Updated	Overall	Statements applicable	Red	Amber	Yellow	Green
Alcohol Dependence and Harmful Alcohol Use	B Höroldt	30/08/2012	[red]	18	2	4	0	12
Bacterial Meningitis and Meningococcal Septicaemia in Children and Young People	P Macfarlane	15/08/2012	[yellow]	14	0	0	8	6
Breast Cancer	P Dudani	15/06/2012	[yellow]	18	0	0	3	15
Chronic Heart Failure	R Muthusamy	28/06/2012	[amber]	14	0	1	4	9
Chronic Kidney Disease	S Muzulu	09/07/2012	[green]	4	0	0	0	4
Chronic Obstructive Pulmonary Disease	P Bardsley	04/07/2012	[amber]	23	0	3	3	17
Colorectal Cancer	R Slater	27/09/2012	[green]	7	0	0	0	7
Dementia	Dementia Care Group	13/08/2012	[amber]	11	0	9	2	0
Diabetes in Adults	B Franke	20/09/2012	Incomplete Analysis	17	0	4	0	12
End of Life Care in Adults	R Broadhurst	03/07/2012	[amber]	26	0	4	10	12
Glaucoma	M Jabir	09/07/2012	[yellow]	13	0	0	3	10
Hip Fracture for Adults	S Blair	13/09/2012	[amber]	13	0	1	0	12
Lung Cancer for Adults	N Qureshi	23/07/2012	[green]	15	0	0	0	15
Ovarian Cancer	C Ramsden	03/07/2012	[red]	5	1	0	1	3
Patient Experience in Adult NHS Service	B Reid	02/07/2012	[amber]	17	0	2	13	2
Specialist Neonatal Care	K Parke	20/07/2012	[red]	19	7	5	2	5
Stroke	J Okwera	10/07/2012	[yellow]	12	0	0	1	11
VTE Prevention	VTE Steering Group	10/09/2012	[amber]	8	0	4	0	4

GREEN: Evidence available shows the outcome is met.
YELLOW: Evidence available shows the outcome is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Action required is minimal.
AMBER: Evidence available shows the outcome is mostly met or there is not sufficient evidence to demonstrate the outcome is met. Action required is moderate.
RED: Evidence available shows that the outcome is at risk of not being met or there is no available evidence that the outcome is met

NICE Quality Standards with Red Ratings:

Alcohol Dependence and Harmful Alcohol Use: A risk assessment of non compliance with the suite of NICE guidance on Alcohol is being undertaken, including a review as to whether compliance can be achieved within existing resources.
Ovarian Cancer: Further discussion is scheduled to take place at Obstetrics & Gynaecology Clinical Effectiveness meeting regarding the disagreement with Standard 7: 'Women with an indeterminate adnexal mass on ultrasound should be offered MRI for further characterisation'.
Specialist Neonatal Care: Further compliance updates to be requested and survey work planned to commence at the end of 2012. A business case is being developed relating to the provision of a neonatal outreach service.

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6. Internal Benchmarking - Safety Thermometer indicators (monthly point prevalence audit)

Comparison at CSU level to identify areas for improvement

No Harm - Falls

		YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
Acute	⊞ Obstetrics & Gynaecology	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Specialist medicine	98.6 %	100.0 %	100.0 %	100.0 %	100.0 %	87.5 %	100.0 %	100.0 %
	⊞ Orthopaedics	98.6 %	100.0 %	94.0 %	100.0 %	97.8 %	100.0 %	100.0 %	97.7 %
	⊞ Alternative level of care	98.2 %	95.8 %	100.0 %	96.0 %	100.0 %	100.0 %	-	-
	⊞ General surgery	97.8 %	91.1 %	97.8 %	98.1 %	100.0 %	100.0 %	100.0 %	98.1 %
	⊞ Integrated Medicine	97.2 %	98.4 %	94.0 %	97.1 %	98.3 %	99.6 %	95.4 %	97.8 %
	⊞ Urology	96.8 %	93.8 %	100.0 %	91.7 %	92.9 %	100.0 %	100.0 %	100.0 %
Community	⊞ Community North	99.8 %	-	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	99.0 %
	⊞ Community South	99.8 %	-	100.0 %	100.0 %	100.0 %	99.4 %	100.0 %	99.2 %
	⊞ Community Central	98.5 %	-	98.0 %	99.2 %	99.1 %	98.4 %	95.7 %	100.0 %
The Rotherham NHS Foundation Trust		98.5 %	97.7 %	97.1 %	98.7 %	99.1 %	99.4 %	98.0 %	98.8 %

No Harm - Pressure Ulcers

		YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
Acute	⊞ Obstetrics & Gynaecology	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ General surgery	99.4 %	98.2 %	100.0 %	100.0 %	100.0 %	100.0 %	97.8 %	100.0 %
	⊞ Urology	98.9 %	93.8 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	98.6 %	98.0 %	98.0 %	100.0 %	100.0 %	95.6 %	98.1 %	100.0 %
	⊞ Integrated Medicine	97.9 %	95.5 %	97.9 %	99.2 %	97.0 %	98.2 %	99.2 %	98.2 %
	⊞ Alternative level of care	97.3 %	100.0 %	96.2 %	100.0 %	92.3 %	100.0 %	-	-
	⊞ Theatres & Anaesthetics	97.1 %	100.0 %	100.0 %	88.9 %	100.0 %	90.0 %	100.0 %	100.0 %
	⊞ Specialist medicine	94.6 %	90.9 %	100.0 %	100.0 %	100.0 %	75.0 %	90.9 %	100.0 %
Community	⊞ Community South	96.8 %	-	94.1 %	96.6 %	96.1 %	97.7 %	96.8 %	97.7 %
	⊞ Community Central	95.5 %	-	96.0 %	94.7 %	95.7 %	98.4 %	97.1 %	92.4 %
	⊞ Community North	95.0 %	-	93.1 %	93.9 %	96.4 %	94.3 %	95.7 %	96.9 %
The Rotherham NHS Foundation Trust		97.4 %	96.8 %	97.0 %	97.6 %	97.1 %	97.6 %	98.0 %	97.7 %

No Harm - Venous Thromboembolism

		YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
Acute	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ General surgery	99.7 %	100.0 %	100.0 %	100.0 %	98.1 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	99.4 %	98.0 %	100.0 %	100.0 %	97.8 %	100.0 %	100.0 %	100.0 %
	⊞ Obstetrics & Gynaecology	99.2 %	96.7 %	96.6 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Urology	97.9 %	93.8 %	100.0 %	100.0 %	100.0 %	90.9 %	100.0 %	100.0 %
	⊞ Integrated Medicine	97.8 %	96.7 %	96.1 %	98.8 %	95.7 %	99.1 %	99.2 %	99.1 %
	⊞ Specialist medicine	97.3 %	100.0 %	80.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Alternative level of care	94.6 %	100.0 %	92.3 %	96.0 %	92.3 %	90.9 %	-	-
Community	⊞ Community Central	100.0 %	-	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Community North	99.8 %	-	98.9 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Community South	99.4 %	-	100.0 %	99.3 %	100.0 %	98.3 %	99.4 %	100.0 %
The Rotherham NHS Foundation Trust		98.9 %	97.7 %	98.0 %	99.4 %	98.2 %	99.0 %	99.6 %	99.7 %

No Harm - Urinary Tract Infection

		YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
Acute	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-	-	-	-
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Child health	98.8 %	100.0 %	100.0 %	100.0 %	90.5 %	100.0 %	100.0 %	100.0 %
	⊞ Obstetrics & Gynaecology	98.7 %	100.0 %	100.0 %	94.6 %	100.0 %	100.0 %	97.6 %	100.0 %
	⊞ General surgery	96.7 %	100.0 %	91.1 %	92.5 %	96.3 %	96.2 %	100.0 %	100.0 %
	⊞ Specialist medicine	95.9 %	90.9 %	100.0 %	81.8 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	95.1 %	95.9 %	92.0 %	93.4 %	100.0 %	88.9 %	96.2 %	100.0 %
	⊞ Integrated Medicine	91.1 %	92.6 %	91.0 %	87.2 %	92.2 %	87.3 %	96.3 %	91.1 %
	⊞ Alternative level of care	89.3 %	87.5 %	96.2 %	96.0 %	84.6 %	72.7 %	-	-
	⊞ Urology	88.3 %	68.8 %	84.6 %	83.3 %	85.7 %	100.0 %	100.0 %	100.0 %
Community	⊞ Community North	98.3 %	-	100.0 %	97.6 %	98.2 %	96.2 %	97.9 %	99.0 %
	⊞ Community South	98.0 %	-	100.0 %	97.9 %	99.3 %	97.2 %	98.7 %	96.2 %
	⊞ Community Central	96.8 %	-	96.0 %	98.5 %	93.0 %	100.0 %	95.7 %	98.9 %
The Rotherham NHS Foundation Trust		95.0 %	93.9 %	94.8 %	93.7 %	95.0 %	93.6 %	97.5 %	96.3 %

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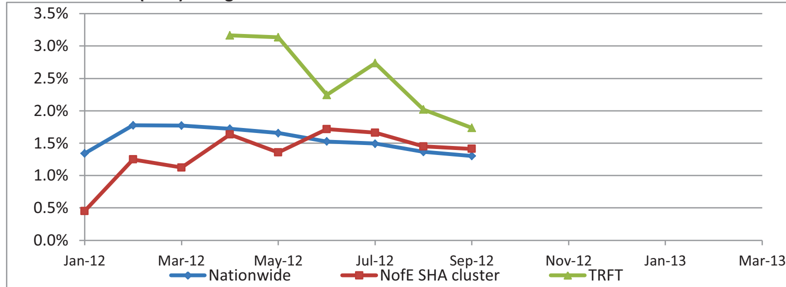
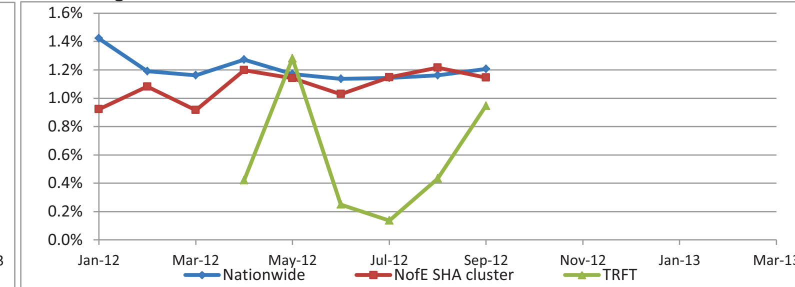
7. National & Regional Benchmarking - Safety Thermometer indicators

Comparison at National & SHA level to identify areas for improvement

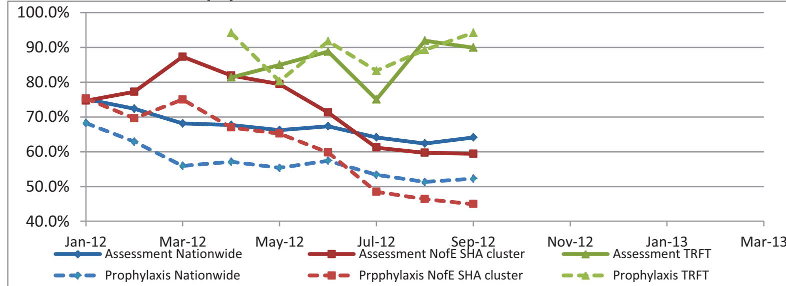
Pressure Ulcers (new) - All grades



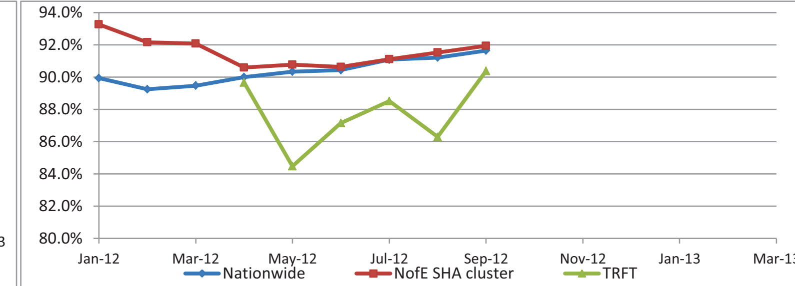
Falls resulting in harm



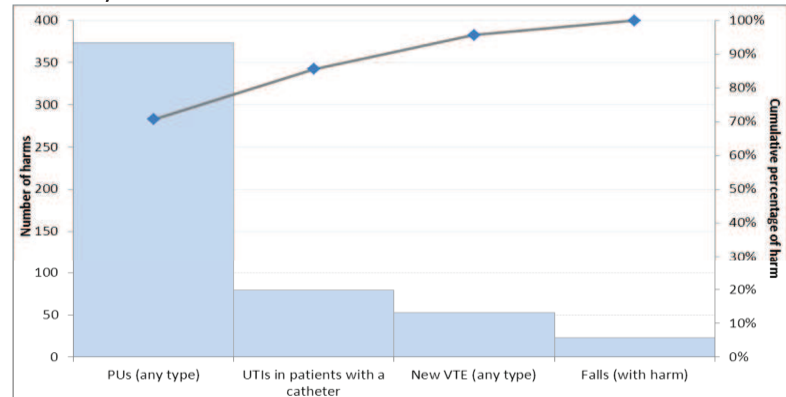
VTE Assessment and Prophylaxis



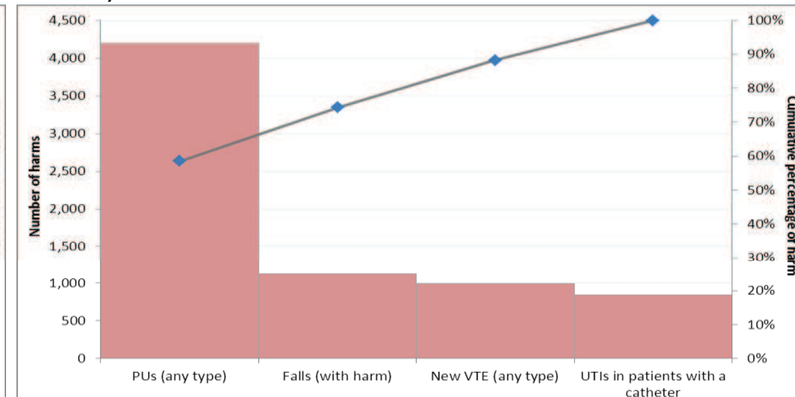
'Harm free' care



Pareto analysis - cumulative burden of harms - TRFT



Pareto analysis - cumulative burden of harms - Yorkshire & Humber SHA



- The Qtr ends with significant improvements across most areas of Safety Thermometer data.
- New pressure ulcers are reflecting a decrease to become more in line with National and SHA cluster performance - only 0.31% above SHA Cluster, against a variance of 1.53% in April 2012.
- VTE assessment and prophylaxis have been above the SHA Cluster and National average since ST began formally in April 2012. Both National and SHA Cluster performance has been in decline since the beginning of the year.
- Falls resulting in harm are significantly below National and SHA performance since the year began, bar an unsustained increase in May. This was subject to an increase in September, which will remain under close monitoring
- As a result of improved performance in most areas, TRFT has moved closer to National and SHA Cluster 'Harm Free Care' performance and is on a trajectory to exceed performance by the next Qtr.
- NHS ST has now removed the 'cap' on number of submissions per location, so *future* National monthly data releases will exactly match the Trust figures published on the intranet . NB - the intranet reflects some measures not formally reported by NHS IC , e.g 'new' Harm Free Care.
- It must be borne in mind that whilst efforts have been made by the NHS IC to ensure consistency of data capture across all organisations taking part in the ST surveys - some definitional issues do exist and this is likely to result in a small degree of variation in how issues are captured/counted between different Trusts - for example 'old' and 'new' harms, and how these are counted for patients who are on a ward long term and thus feature in several monthly surveys. Few of the comparator organisations are integrated with Community Services; unfortunately it is not possible to adjust the peer groups to enable a more appropriate comparison.
- Whilst these caveats are important - ST data is still one of the only timely, comprehensive means of benchmarking between national peers and SHA cluster on a focussed group of issues.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**6th December 2012**
3.	**Title:**	**Update on Health Select Commission Reviews**
4.	**Directorate:**	**Resources**

5. Summary

The purpose of this report is to provide Health Select Commission members with an update on two reviews currently taking place; Autistic Spectrum Disorder and Residential Homes. The first is being Chaired by the Commission's Vice Chair, Councillor Judith Dalton and the second is being Chaired by the Chair of the Commission, Councillor Brian Steele.

6. Recommendations

That members note the progress and timescales of the two reviews.

7. Proposals and Details:

Both of the reviews referred to in this report were identified as priority reviews in the work programme for 2012/13. They both started in September 2012 and are due to complete shortly.

Attached as appendices to this report are the scoping documents for both reviews. This paper provides members with the early findings of the reviews as they near completion.

Residential Homes.

The group has one more scheduled meeting to take place before it starts to formulate its findings and recommendations. It is anticipated that a final report will be presented to the Health Select Committee at either the January or March meeting.

Early findings:

- Staffing and cleaning and catering costs are high
- Restrictions exist regarding the use of YPO and Building works
- They are limited and tied into previous arrangements preventing their ability to shop around and achieve best value for money.
- Part time staff can be paid up to 41 hours per week when off sick.
- Terms and conditions differ from the independent sector e.g. out of hours enhancements
- Individual care requires extra staff but could it be used as a model of how it should be delivered.
- Being used as a good example or flagship by CQC and other professionals.
- Dementia training has been carried out with the aim of becoming specialists in dementia care – this is a growing area
- Staff feel the future is in enablement – working in partnership with health. Seems to be more funding around this.
- Good management model – enabling and developing staff. Staff are proud to work for Rotherham Council. Want to continue to doing this and doing their job.
- No continuing health care funding goes into the homes
- Residential clients still get paid their fuel allowance but doesn’t come to the home at all.
- Dementia support is linked to CHC – can we incorporate nursing care to qualify for this.
- End of life care – can they become this?
- Shifting to a needs led service for the requirements of local community. Buildings are designed to shift to allow for differing needs. Currently have a broad mix but aren’t getting access to the appropriate funding for it.
- The capital costs of the homes were part funded by Prudential borrowing which means that even if the homes were the close the debt would still have to be paid.

- The old buildings have been transferred to EDS but the Council as a whole is still paying for them. Some have been sold and the council has benefited from the capital receipt
- Staff would like the opportunity to come up with their own proposals

Autistic Spectrum Disorder.

The group has completed all of its scheduled meetings which have included visits to both Aughton Early Years and Winterhill School. It has received evidence from a wide number of witnesses and has been particularly successful at engaging parents in the review. It is anticipated that this review will be completed in January so will be reported to the Health Select Commission at either the January or March meeting.

Early Findings:

- Still need clarification of the figures for incidence and these need to be reflected in JSNA

- Gap between age 5 and beginning of work with CAMHS - Recommendation around continuous pathway.

- Professional development is key and needs to be ongoing

- NICE criteria should be used across all services

- Significant issue was the closer working between the two diagnosis routes

- Transitions between services

- Gap – support in family home e.g. homework

- Routes 16+ - gaps in that not all go through route such as RCAT.

- Job centre experience difficulties supporting adults that have not received a diagnosis.

- Crucial element of the review has been the parents' perspective

- Adults diagnosis – being worked on currently.

- Preventative services and funding is seen to be key

- Transition – adults and ageing population as they come through

- The concept of a Key worker needs to be explored and joint assessments (e.g. CAF)

- Significant money in school budgets

8. Finance

There are clear financial implications for the Council from the Residential Homes review as they operate with a budget deficit every year. The recommendations from this review will help to enable the Cabinet to take decisions regarding this position.

The ASD review will make recommendations that are cost neutral but that may involve utilising existing resources differently.

9. Risks and Uncertainties

As with most reviews the risks and uncertainties relate to the extent to which Cabinet will take on the recommendations of the reviews.

10. Policy and Performance Agenda Implications

The reviews have both been undertaken within the framework of the Health and Well Being Strategy and the Corporate Plan. Links to specific objectives can be found in the Appendices – Scoping documents.

11. Background Papers and Consultation

There are a number of these for both reviews that can be made available on request.

Contact Name : Deborah Fellowes, Scrutiny Manager
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Autistic Spectrum Disorder Review – scoping paper

Background
This review was requested by the Cabinet Member as a result of the apparent high levels of diagnosis in Rotherham. This was identified in a report to the Cabinet member and was explored further in a position paper to the Health Select Commission in July 2012. It was agreed at this meeting that a review would be required and this would investigate the steady increase in diagnoses in the last 10 years.

Subject of the review	Autistic Spectrum Disorder
Type of review	Full Review
Chair	Cllr Judy Dalton
Review group members	Cllrs Wootton, Beaumont, Roche, Kaye and Pitchley, Russell Wells
Officer contacts	Deborah Fellowes, Scrutiny Manager ext: 22769 Steve Mulligan, Principal Educational Psychologist ext: 22759
Purpose of the review	The four main aims of the review are to consider: • The reasons for the higher diagnosis rates • Services required at diagnosis stage and after • 16+ support and transition • Budget implications
Key questions and areas to focus on – based on previous member discussions	• How is referral and diagnosis achieved? • What is the need for the two different routes? • Have the NHS partners looked at reasons for high rates? • What is the cost to the authority? • What support services are provided? Are there any gaps? • Is this issue reflected in the JSNA? • Visits to Winter Hill school and Aughton Early Years • What is the experience of parents of Autistic children • Transition periods – aligning adults and CYPS.
Anticipated outcome(s)	Better understanding of patterns in Rotherham, leading to development of appropriate support and assistance to families affected by Autism. Effective use of existing resources.
What is the potential impact of the review on • **Residents** • **Equality issues eg access to services, vulnerable groups** • **Health inequalities** • **Adding value to the organisation** • **Partners** • **Any other key groups?**	• Greater understanding of the issue will provide better services for a group of vulnerable people • Parents and childrens needs being met • More seamless provision of services
Links to the council's corporate plan	o Ensuring care and protection are available for those people who need it most o Helping to create safe and healthy communities.

Methodology	Four separate meetings – one for each of the objectives of the review.
Press & publicity	There is potentially a positive message to be drawn from this – Rotherham is ahead of the game in terms of diagnosing and supporting children with Autism. Potential for Jane Asher (?) to be involved in publicising the final report – contact through National Autistic Society.
Key background papers (to be considered in advance of evidence gathering meeting)	Paper to Health Select Commission July 12
Written evidence to be provided by	Steve Mulligan
Oral evidence to be provided by	CAMHS CDC Autism Communications Team National Autistic Society Health Visitors Heads of schools – secondary, primary, special Parents and Carers Forum Parents
Potential partners	As above
Resources required	Time from Scrutiny and CYPS staff
Timetable	**October 2012 to January 2013**
Reporting mechanism	OSMB – Cabinet – HWB Board

Residential Homes Review – scoping paper

Background

This review was identified as part of the work programme for the year 2012/13 for the Health Select Commission. It was felt that the timing was right and in light of further budget cuts that will be required in 2013/14, an independent view of the financial viability of the two homes owned by RMBC would help to assist with these discussions. For this reason the review will be completed during the early Autumn 2012.

Subject of the review	RMBC Residential Homes
Type of review	Full Review
Chair	Cllr Brian Steele
Review group members	Cllrs Beck, Beaumont, Barron and Robert Parkin (co-optee – Speak Up)
Officer contacts	Deborah Fellowes, Scrutiny Manager ext: 22769
Purpose of the review	• To analyse the financial viability and value for money of the two homes • To make recommendations about the future of the homes to be considered as part of the budget process
Key questions and areas to focus on – based on previous member discussions	• Detail of the costings and how they are calculated • Value for money and outcomes. • Benchmarking with Independent and Public Sector providers. • Quality of care provided and evidence from residents.
Anticipated outcome(s)	Recommendations to Cabinet and SLT regarding the future of the homes and implications for budget discussions.
What is the potential impact of the review on • **Residents** • **Equality issues eg access to services, vulnerable groups** • **Health inequalities** • **Adding value to the organisation** • **Partners** • **Any other key groups?**	• Direct impact on residents of the homes and their families. • Impact on health and health partners including Intermediate Care services. • Future customers of residential care services.
Links to the council's corporate plan	o Ensuring care and protection are available for those people who need it most o Helping to create safe and healthy communities.
Methodology	
Press & publicity	
Key background papers (to be considered in advance of evidence gathering meeting)	
Written evidence to be provided by	
Oral evidence to be provided by	

Potential partners	
Resources required	Time from Scrutiny and NAS staff
Timetable	
Reporting mechanism	OSMB – Cabinet

 Agenda Item 12

ROTHERHAM BOROUGH COUNCIL – REPORT

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**6 December, 2012**
3.	**Title:**	**Review of Children's Congenital Cardiac Services in England: Update**
4.	**Directorate:**	**Resources** **All wards**

5. Summary

To update members of the Health Select Commission of developments with regards to the Joint Committee of Primary Care Trust (JCPCT) Review of Children's Congenital Cardiac Services in England and subsequent decision of the Joint Health Overview and Scrutiny to refer the JCPCT's decision to the Secretary of State for Health.

6. Recommendations

That the Health Select Commission

- Notes the update;
- Notes the referral of JCPCT's decision by the Joint Health Overview and Scrutiny Committee to the Secretary of State for Health;
- Considers making a submission to the Independent Review Panel outlining its concerns about the review process.

7. Background

7.1 In March 2011, a Joint Health Overview and Scrutiny Committee made up from the 15 top-tier local authorities across Yorkshire and the Humber, was formed as the statutory overview and scrutiny body to consider and respond to the Review of Children's Congenital Cardiac Services in England and the associated reconfiguration proposals.

The former Children and Young People's Scrutiny Panel (in its health scrutiny role) nominated one member from Rotherham Council (Cllr Shaukat Ali) to be part of this joint committee and formed a small member working group consisting of Cllrs Ali, Falvey and Sims to inform Rotherham's input to the process. The Health Select Commission agreed (in July 2011) that these arrangements should continue until the conclusion of the exercise.

7.2 Given the complexity and sensitivity of the issue, the working group held initial meetings with colleagues from Rotherham Foundation Trust and NHS Rotherham to discuss how the proposals may impact upon local services.

In particular, concerns have been raised about the following:–

- access to facilities for Rotherham children and families, particularly in emergency or acute situations;
- sustainability of local clinics;
- retention and future development of specialist skills;
- sustainability of intensive care facility at Leeds Teaching Hospital Trust should it no longer be a specialist facility.

A further meeting was held with local parents of children with congenital heart diseases who have accessed services in Leeds. Whilst many of the concerns reflected the views of clinicians, further questions were asked about:

- lengthy 'blue light' journeys across busy road networks;
- support networks for children and their carers and increased disruption and costs, particularly for families on low incomes, if services are re-located;
- collocation of services and whether sufficient emphasis had been placed on the benefits of this in the review;
- transition to adult services.

These comments were submitted to the Joint HOSC as part of its evidence gathering and reflected similar concerns raised in other parts of the Yorkshire and Humber region.

7.3 In early October 2011, the Joint HOSC presented its consultation response to the proposals and issued a formal report to the JCPCT – the decision-making body – for consideration. A copy of the full report is available on the Council's website using the following link:
http://www.rotherham.gov.uk/downloads/file/5872/review_of_childrens_congenital_cardiac_services

The Joint HOSC put made a number of recommendations, the major one being

the retention of specialist surgical children's heart services within Leeds.

7.4 The JCPCT at its meeting on 4 July 2012, agreed an option for implementation and the designation of congenital heart networks which did not include the retention of a specialist surgical centre at Leeds Teaching Hospital Trust.

Since that point, the Joint HOSC has met on a number of occasions to consider additional information and seek further details from the JCPCT and associated bodies.

7.5 On the basis of the JCPCT's decision and subsequent information, the Joint HOSC met on 16 November 2012 and reaffirmed its position (originally made on 24 July 2012) in support of its referral to the Secretary of State for Health of the decision of the Joint Committee of Primary Care Trusts (JCPCT).

(See attached link for further information http://democracy.leeds.gov.uk/documents/s85829/Review%20of%20Childrens%20Congenital%20Heart%20Services%20in%20England%202nd%20Report.pdf)

7.6 The Joint HOSC referred the JCPCT's decision on the basis that it was not in the best interest of local health services across Yorkshire and the Humber, nor the children and families they serve. This referral was made in accordance with the provisions set out in the Health and Social Care Act (2001) (as amended) and the associated regulations[1] (specifically regulation 4(7)) and current Department of Health guidance[2].

The conclusions reached by the Joint HOSC are as follows:

- The range of interdependent surgical services, maternity and neonatal services are not co-located at proposed alternative surgical centres available to Yorkshire and the Humber children and their families;
- The dismantling of the already well established and very strong cardiac network across Yorkshire and the Humber – and the implications for patients with the proposed Cardiology Centre at Leeds essentially working across multiple networks;
- The current seamless transition between cardiac services for children and adults across Yorkshire and the Humber;
- Considerable additional journey times and travel costs – alongside associated increased accommodation, childcare and living expense costs and increased stress and strain on family life at an already stressful and difficult time;
- The implications of patient choice and the subsequent patient flows – resulting in too onerous caseloads (i.e. overloading) in some surgical centres, with other centres unable to achieve the stated minimum number of 400 surgical procedures.

7.7 Throughout the process, concerns have been expressed about the availability and timeliness of information and lack of transparency about the decision making process. The Joint HOSC have reported it had not been able to consider all the

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[1] The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 – Statutory Instrument 2002/ 3048

[2] Overview and Scrutiny of Health – Guidance (Department of Health (July 2003))

information identified as being necessary to conclude its review and that all Joint HOSC Members felt that they have been unreasonably denied access to non-confidential information believed to be relevant to the review and the associated decision-making processes. A complaint has been lodged with the Information Commissioner's Office regarding the lack of disclosure.

7.8 Along with the Joint HOSC (Yorkshire and Humber), a number of HOSCs have subsequently referred the JCPCT's decision to the Secretary of State for Health. On the basis of these referrals, the Secretary of State has asked for the Independent Review Panel to examine the JCPCT's decision making process.

Members of the Joint HOSC may wish to contact the IRP to raise specific issues particularly relevant to their local areas. A letter has been previously submitted to the Secretary of State for Health outlining the Council's concerns about the process. This could be used as a basis, should the Commission be minded to contact the IRP. The deadline for submission of comments to IRP is 7 December, 2012.

7.9 Following the JCPCT's decision, a legal challenge was initiated by the Children's Heart Surgery Fund (now being taken forward by Save Our Surgery (SOS) Ltd.). The legal challenge is based on the premise that the decision making process was inconsistent and flawed. The hearing of the Judicial Review is deferred pending the outcomes of the Independent Review Panel.

8. Finance

8.1 The Joint HOSC believes that the overall financial implications associated with the proposed model of care are likely to be very significant – both in terms of establishing new arrangements and the on-going delivery of the proposed model of care. However, based on the information available during the inquiry and at the time of preparing its report, the Joint HOSC believed there had been insufficient consideration of the financial implications and that the level of detail publicly available to date has been inadequate.

9. Risks and Uncertainties

There are no specific considerations relevant to this report.

10. Policy and Performance Agenda Implications

There are no specific considerations relevant to this report.

11. Background Papers and Consultation

- A new vision for Children's Congenital Heart Services in England (March 2011)
- Scrutiny Inquiry Report: Review of Children's Congenital Cardiac Services (October 2011).
- Review of Children's Congenital Heart Services in England: 2nd report of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – draft (November 2012)

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