You are hereby summoned to a meeting of the Health Select Commission to be held on:-

Date:- **Thursday, 16 April 2015** **Venue:-** **Town Hall, Moorgate Street, Rotherham S60 2TH**

Time:- **9.30 a.m.**

HEALTH SELECT COMMISSION AGENDA

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 the Previous Meeting (Pages 1 - 28)
   Minutes of meetings held on 15th and 22nd January, 2015

8. Healthwatch Issues

9. Rotherham Foundation Trust Quality Accounts (Pages 29 - 138)
   Tracey McErlain-Burns, Chief Nurse, to present

10. Nurses in Special Schools (Pages 139 - 143)
    Juliette Penney, Clinical Services Manager, Children and Young Peoples Services/Rotherham Foundation Trust, to present

11. RDaSH Quality Account (Pages 144 - 156)
    Karen Cvijetic, Head of Quality Improvement, to present

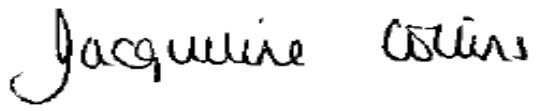
Jacqueline Collins

Jacqueline Collins,
Director of Legal and Democratic Services.

12. Scrutiny Review - RDaSH CAMHS (Pages 157 - 198)

13. Scrutiny Review - Access to GPs - Updated Response (Pages 199 - 213)

14. Date and Time of Next Meeting
    - Thursday, 11th June, 2015 at 9.30 a.m.



Jacqueline Collins,
Director of Legal and Democratic Services.

HEALTH SELECT COMMISSION
15th January, 2015

Present:- Councillor Watson (in the Chair); Councillors Havenhand, Kaye, Sansome, Swift, M. Vines and Whysall.

Apologies for absence were received from Councillors Dalton, Hunter, Jepson and Wootton.

67. DECLARATIONS OF INTEREST

There were no declarations of interest made at this meeting.

68. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

69. COMMUNICATIONS

There was nothing to report.

70. RESPONSE TO ACCESS TO GPS SCRUTINY REVIEW

The Chairman introduced the Cabinet's response to the Access to GPs Scrutiny Review and representatives present who would respond to issues raised by Select Commission members. The representatives included:-

Richard Armstrong	NHS England
Carys Murray Cook	South Yorkshire and Bassetlaw, Care Quality Commission
Chris Edwards	Rotherham Clinical Commissioning Group
Dawn Anderson	Rotherham Clinical Commissioning Group
Jacqui Tuffnell	Rotherham Clinical Commissioning Group

Recommendation 1. Patients' experiences of accessing GPs vary from practice to practice therefore NHS England needs to ensure that patients' views on access are reflected in the forthcoming Personal Medical Services contract re-negotiations and five year commissioning plan

Chairman – 1 of my concerns is the national GP survey. Whilst it gives the big picture I am concerned that in some of our practices we do not have that many responses. In some of the practices there are 30 responses which only have to have 1 or 2 patients who think differently on a certain day and it can switch a percentage. What are we doing to make sure we get big numbers in each practice?

Richard Armstrong – It is very complicated. The survey is run twice a year and Ipsos Mori, the company who conduct the survey do a detailed analysis of what has happened in the past. The survey has been taking place 6-7 years and they target those populations and practices to try and get a statistical and valid response i.e. where there were lower response rates they will survey more patients in that practice and will target in terms of trying to get a range of ages and sexes etc. They boost the survey every time for every practice to try and get that statistical validity. It was still dependent upon patients returning the surveys but there had been a fairly consistent response rate over the years fluctuating between 43-46%. It tended to be young minority ethnic communities for the lower response rate so there would be a big boost to try and improve that rate.

Councillor Sansome – Will the report come back here so we can see where the problems lay or where the best practice was that needed to be shared across other practices?

Carys Murray Cook – We are planning the Care Quality Commission inspection for Rotherham at the moment. There were 36 GP practices in the Rotherham area and we plan to inspect 18 of them in the first quarter of 2015/16. The inspections would be carried out from April onwards and we will be liaising with the Clinical Commissioning Group 2 weeks prior to the inspection starting regarding the practices we will be inspecting and notifying them. Following an inspection, a very detailed report was written which goes through our quality process and then made available to the public so will be available on our website.

Councillor Sansome – I think what is very key to this review, and the reason why it has been referred back, is that the people of the Borough need to see some clarification and conviction that this will be an exercise that people want. We need to see that it was something that all partners are taking as seriously as possible to make sure the care and treatment is there. The response we have given through our own individual input shows that we are serious and certain that we are going to improve access to GPs and the services they have got.

Councillor Kaye – Is the profile of the patients different within practices and is there a difference in an urban profile or a rural profile? When I visit my practice there are a lot of young people in there and lot of old people and I am looking for a % mix of that and whether that has an overall impression on what patients say and need from their GP

Richard Armstrong – There are different groups of patients who expect different things at different stages of their life. The biggest indicator of patient satisfaction of their experience of a GP is age. As the patient got older the way GPs offered services for that age range was quite convenient for them and, therefore, a much higher satisfaction levels than the younger population. The population that had the lowest satisfaction rate was 18-24 years from a minority ethnic background. They had the lowest satisfaction levels because they were expecting a different service.

They wanted something different from the practices other than what was usually provided. They wanted to be able to walk in, book in, have an appointment and leave and were less concerned with who they saw as long as they could be seen. We must try to get practices to provide a range of ways patients could be seen. As patients got older they normally wanted to see the same person but when younger and working they wanted appointments that were convenient.

Councillor Swift – We have done a similar survey at Treeton practice but not many people wanted to fill the survey in so it can skew the results.

Richard Armstrong – The GP survey is produced by Ipsos Mori. They design the surveys using GPs and academic professionals and have done a whole series of work with patient groups and individuals to ensure that the range of people can explain the questions they were seeking to get an answer to. They work on that throughout the year and keep refining and improving surveys so can normally see when a patient answered a question that is what they actually intended to say. Response rates were still an issue but we have tried to do everything we can – you can request the survey in different languages, by telephone etc. Most practices want to respond to their patients. Practices look at the results. We try to publish the results in a comparative way as well because GP practices do not want to be different from their colleagues.

Councillor Kaye – Can you explain the reinvestment of any funding released from one practice into primary medical care?

Richard Armstrong – Historically GP practices have been funded differently and the idea of bringing in new contracting arrangements in 2004 was to move to a more fair and equitable funding per capita. For a variety of reasons we got it wrong and as part of implementation there was a predominant variety in practices so there was an inequality in funding. There was some relationship between more underfunded practices in urban areas and more highly funded practices in more rural areas and the idea of moving to per capita and redistribution would mean some lost and some gained. We had been trying to do this since 2008 and still had a differential in funding between practices so the idea of successive Governments had been to say we would achieve fair funding between practices by this date. The commitment is we do not take funding out of GP practices but reinvest in the practice to buy in services and improvement in care. There was no relationship between how much money comes into the practice and how well that practice performed either in terms of service offer or satisfaction of patients.

Jacqui Tuffnell – We work with NHSE in terms of premia on services and what was happening across the wider community to ensure services are provided. We look to ensure better spend and medical services.

Chair – How will you look at cost in your inspection?

Carys Murray Cook –Our inspection was not just about arriving on the day; we do a lot of homework beforehand so we do send out comment cards to the practices and ask them to place them for patients to complete. We look at patient surveys, Clinical Commissioning Group data about the profile of patients and get a lot of other data as well. Patients/carers/relatives can also give us information about the practice. The practice should also be informing us of any Safeguarding incidents they have had within the practice and also any significant events so we should have some knowledge about those as well.

The inspection process went into a practice and left no stone unturned. We look at the practice and staff. We specifically look at patient themes of vulnerable, mental health illness, work age population, children, adults over 75 and those with long term conditions. The inspection itself would gather as much data as it could around those areas. The key to the inspection was to speak to all the staff in the practice and patients on the day. We like to speak to 8-10 patients on the visit about their experience and use of the practice. The process was very in depth. If inspectors did find anything within the Regulations that was not being met, then we can produce warnings and also take enforcement action.

Chair – When you do that do you then work with the Clinical Commissioning Group and NHS for future plans?

Carys Murray Cook - When we have completed the inspection of the GP practice we meet with the respective Clinical Commissioning Group to feed back the information on what we have found in that area.

Richard Armstrong – What would happen in most visits was there were some things to be addressed which could be improved and an action plan would be developed with the practice to work through to make the improvements/address the issues so by the time the Care Quality Commission went back some would have been addressed and improved and try and get continuous improvement in the practice. These would then be owned by the Clinical Commissioning Group in future work.

Chairman – What if there was a common theme amongst practices?

Carys Murray Cook – We would look at it on an individual basis and collaborative basis.

Councillor Kaye – What “teeth” did you have?

Carys Murray Cook – From our inspection we do not just take the practice’s word; we want to see it written down, to see policies, procedures and processes on how they captured feedback from patients, how they investigated their incidents, look at their outcomes, how they measured actions and implementation so it was a very robust process. Not just about them telling us but corroboration and evidence.

Richard Armstrong – Most GPs, Drs, nurses etc. have not trained for 10 years to deliver poor care to their patients and usually when you point something out to them they will address it themselves. As part of the developed action plan we will work with the practice to implement it. If the practice is working to try and implement it and were struggling there would be support to try and keep helping them.

If they did not recognise there was a problem, then we get into contract sanctions. If they did not co-operate we would serve a Breach Notice on them which is a warning which says they are in danger of losing their contract. Normally that is enough. If not, and we think it was sufficiently serious, we can withhold some element of the funding to them as a penalty. In terms of financial sanctions we can remove the contract saying to them in this case we do not think you are an appropriate provider and we will remove the contract. We have a duty to put a new contract in place. A practice must be registered with the Care Quality Commission for a Clinical Commissioning Group to hold a contract with them. If they did not listen the Care Quality Commission would deregister them and they could not hold a contract.

Janet Spurling – In relation to the minimum practice income guarantee (MPIG) was this generally in relation to GMS contracts?

Richard – PMS contracts before 2003 and into the GMS contract in 2003. Some practices took their historical income into their new contractual arrangements.

Across the country 50% of practices lost and 50% gained. The difference could be quite small in some places but in others very big and adjustments would be made for practices which have an atypical population. Where it was about the range of services they offered and services, if the Clinical Commissioning Group's wished to continue to buy these they would be explicitly commissioned and funded so practices may not see a change in funding but it would be commissioned by them. This enabled NHS England to see if the practice was funded fairly and all being treated fairly.

Councillor Kaye – Equality and the difference between different practices is that just within a geographic area or country wide in relation to funding?

Richard Armstrong – There was no divide across the country and it was nothing to do with how the funding formula worked. If you were trying to get a practice to improve you had to try and get a level playing field. When we talk about core funding this was the 55% of funding a practice got for baseline services. On top of that they received additional funding for enhanced services; funding through Quality Outcomes Framework; for premises costs; and for IT costs. If a practice said its funding had been reduced they were referring to the 55%. We are trying to get all the core funding equitable and anything released to invest in better services and care.

Chairman – Where are we with the 5 year area based commissioning plan?

Clinical Commissioning Group – The ability to have varying co-commissioning services has been incorporated into the 5 year strategy. NHS England was to discuss the strategy later that day.

Richard Armstrong – It is confirmed in the Clinical Commissioning Group's commissioning plan and an application for co-commissioning, access and improving access was highlighted.

Recommendation 2 – The continuation of the Patient Participation Directed Enhanced Service in 2014/15 should be used to ensure patients are well informed and empowered through the Patient Participation Groups to challenge poor access and suggest improvements. All practices should be encouraged either to participate in the PPDES or to establish other effective mechanisms for ensuring patient engagement

Councillor Kaye – I only found out this morning that my Doctor's practice had a website which contained all the information about the practice. I was unaware that that facility was available. I wonder whether there was a need for better publicity? It was a question of communication and how we meet nearly everybody's needs?

Richard Armstrong – Practices had been obliged to produce patient leaflets since 2004 and all the information should be within that leaflet. This was also checked by the Care Quality Commission on their inspection. We had been increasingly encouraging practices to use the internet to facilitate more access and make more information available. Having information available on the practice website was the best way for it – being able to book appointments, order repeat prescriptions and do more on electronic communication. Also had to recognise that not all patients wanted to do that and information was available through NHS Choices on the various helplines available. We could still do more to improve communications – NHS England to practices and practices to patients - and we will continue to work on that.

Carys Murray Cook – The Care Quality Commission looked at the information provided to patients and if it was not seen we give practices feedback.

Chairman – There was an original suggestion that NHS England look at developing an app. The demographic group that have said they were less satisfied were probably the group that would use it.

Richard Armstrong – It was part of the current Government's Policy to make more raw data available about the NHS but, rather than all do that, to allow commercial organisations to access that information and for them to develop apps, web tools etc. to put the data together. The 1 thing public surveys were not so good at was understanding the different sets

of data in order to tell you something additional to what the numbers said. There were already a number of apps that looked at GP improvement. They were available without the NHS spending any money. The data was made available for others to use.

Councillor Sansome – What died each practice offer when it put out the information online? Was it the same template which each practice had? Was there good practice issues and was there a local template?

Richard Armstrong – The contract specified what data had to be provided but not in what format. Some practices were better than others. The GPC provided a template for all practices that met the minimum standard. Those practices that were more pro active and probably looking for more patients and were better at explaining what they were and what they wanted and met the cost. There were organisations such as NHS IQ (Innovation and Quality), part of NHS England, whose job it was to support and innovate by supporting training to practices and how they could be better in responding to patients' needs and be more efficient in running their business. There was a whole programme of support which took best practice across the country. There was probably more that could be done to support those practices to access that but the tools were available.

Councillor Kaye – How many practices in Rotherham have availed themselves of that support?

Richard Armstrong – The relationship was between the practice and NHS IQ and not something NHS England would necessarily have information on.

Recommendation 3 – Although recognising the importance of clinical need, the expectations and preferences of patients are changing and practices should explore more hybrid and flexible approaches to appointments

Chairman – When this was discussed elsewhere 1 of the things mentioned quite strongly that there should be "sit and wait slots" at all practices. Having read your response the survey does not seem to support that.

Recommendation 4 – NHS England should maintain access to interpretation services for GPS with an emphasis on professional services, supported by training for GPs and practice staff to increase confidence in using telephone services where appropriate

Recommendation 5 – NHS England should review their current interpretation provision to see if economies could be achieved through signing up to Rotherham MBC's framework agreement which is open to partner agencies

Chairman – Having read the original response I would see this as 1 area that I felt disappointed in. Is anything actually going to happen? Have we a way to move forward?

Richard Armstrong – We inherited a whole range of different Interpretation Services and arrangements. One of the first things NHS England said was that we needed a master list and work commencing on defining a definitive list of Interpretation Services. 2 years later we are still waiting for that document. There was now a nationally agreed specification and the main players had been asked to procure a framework contract for the NHS people to use a group of providers who could meet that Service specification.

NHS England wanted a single Interpretation Service which covered your population and our population because they were the same patients. Richard needed to understand whether we could all use the same framework contract and have a Rotherham Interpretation Service that met all our requirements and gave access to our patients. Although the summary of details had only come out the previous week, NHS England were committed as a Clinical Commissioning Group and NHS England to get a better Interpretation Services due to the wasted money between the 2 in buying different services.

Councillor Sansome – What was behind the statement and what did it mean and what services did it provide? I appreciate the feeling of being hamstrung by the delay in policy but the population needed to be clear what this meant.

Recommendation 6 – GP practices should regularly showcase best practice and share successes on providing good access to patients through existing means such as the practice manager forum and Protected Learning Time events.
Chairman – Were the events held frequently?

Richard Armstrong – The NHS met infrequently. There were a number planned across the north of England during February and March to try and showcase what practices were doing and learn from each other. However, the events only ever can get to 100 GPs at a time so was much more reliant on what the Clinical Commissioning Group had been and were doing,

Dawn Anderson – The Clinical Commissioning Group had a regular programme of events for GPs – there was a Protected Learning Time event that day – that took place bi-monthly. In between practices were encouraged to hold their own in-house events with the Clinical Commissioning Group monitoring what topics were being discussed. There was also a Practice Managers' Forum held on a bi-monthly basis with best practice as a standing item on that agenda. There was a regular programme of events and although the Clinical Commissioning Group scheduled items space was left for topical issues.

Recommendation 7 – Patient information and education is important, both generic information about local services and specific information about how their surgery works

Chairman – I think we have covered most of that in the previous discussion.

Janet Spurling – 1 thing that we have not really touched upon was around the growing numbers of people not attending for appointments. I know a lot of practices had information on their screens about missed appointments and when speaking with the NHS England at the time of the Scrutiny Review they said they were going to talk to practices and get a flavour of how they were doing in terms of non-attendance. There was a recommendation about a campaign to raise public awareness of the importance of attending appointments. Again this linked in with "sit and wait" slots.

Richard Armstrong – Data was not collected on missed appointments in a consistent manner and where there had been such an exercise it showed that the rate had not increased or changed. It was a bugbear for GPs that patients did not attend but also for many it meant that the 10-15 minutes of no patient meant they could catch up. We had to make the best use of the capacity available and sometimes having that free slot allowed the practice to get back on time.

1 of the reasons patients were less satisfied was because of longer waiting times. Clearly there was pressure on practices with the number of people going attending having increased. This was 1 of the main reasons why it was thought that the solution was to improve the access and convenience, increase capacity and to get more people who walked into GP practices to make better use of the practice nurses, doctors from hospitals, physiotherapists and other health professionals. The Prime Minister's Challenge Fund was starting to demonstrate that with a whole new skill mix placed in and around the GP practice it could relieve some of the pressures and ensure patients still saw a clinician.

Carys Murray Cook – From a personal point of view it is around the sharing of what worked well across the board. From the inspections completed some quite innovative ways of working with other members of allied health professionals in health practices could be seen but what met the needs of the health population? Agencies needed to look at what the needs of patients were and how it was best met with the relevant development of staff within the practice. There were good examples of meeting patients' needs such as dementia screening appointments.

Councillor Kaye – Was there any comparison with what happened in GP practices to dentists for example? Were missed appointments right across the board?

Carys Murray Cook – The Care Quality Commission also regulated dentists but the missed appointment rate, compared to GPs, was significantly lower probably due to there being a cost involved with dental care and a patient making contact with the dentist when they had a problem and wanted the pain to be relieved so they would make sure they attended that appointment. There may be some best practice to share but the best practice seen was about informing patients of the impact that missing their appointment would have upon the practice.

Another good example was online booking appointments.

Richard Armstrong – That had been showed through GP surveys on how practices could improve satisfaction. Those practices that made more use of online booking had higher satisfaction levels.

Councillor M. Vines – Do you have a lot of missed appointments because you were so long waiting for 1?

Richard Armstrong – I think undoubtedly if a patient could get the convenience and access they wanted it inevitably impacted upon their immediacy or need to see a doctor. Practices were encouraged to try and meet that need. There was evidence from the survey that showed that nearly every patient wanted to see their doctor but that if they were offered an appointment earlier to see the nurse and they take it they were more satisfied rather than waiting longer to see the doctor. Practices needed to understand that quite often the customer wanted to be seen conveniently rather than waiting longer and that an offer to see another clinician would be better.

Chairman – Was there any evidence of lower satisfaction rates with single handed practice?

Chris Edwards – The advantage of a single handed practice was that the patient saw the same doctor every time so tended to be more satisfied.

Carys Murray Cook – From personal experience single handed practices had a smaller population size but still may have other health professionals working at the practice so I would see no difference.

Richard Armstrong – The data showed 2 interesting things; 1 that a smaller practice had higher satisfaction levels but also had greater variability. It came down to what the patient was looking for – if they wanted to see the same doctor but there may be a longer waiting time.

Janet Spurling on behalf of Councillor Hunter – Receptionist were very often performing the role of a triage nurse over the phone which affected who got what slot in the GP timetable with many then going to A&E or the Walk-in Centre

Richard Armstrong – Most practices had tried to create a slight barrier between the Reception to enable privacy for the customer. Receptionists did what their employers requested of them. If patients had concerns they should be expressing it to their GP not the receptionist and more feedback to the employer might affect that. The data suggested the biggest factors influencing a patient were (1) can I get an appointment (2) whether they were timely are not (3) can I get through on the telephone (4) what was my experience of the reception. These had an impact on how patients saw their GP.

Janet Spurling on behalf of Councillor Hunter – The District Nurse Team's role was changing in a way that meant they may not enjoy the very close working relationship with GPs they currently enjoyed which could increase pressure on GPs (more home visits etc.) which meant they could be less available for appointments. Ultimately District Nursing being GP based but not based in GP surgeries could have a massive impact on working relationships to the detriment of the patients.

Richard Armstrong – Personally I think we need better links across all health professionals and those working in the community whether it be the District Nurse, Social Workers, physiotherapist etc. There needed to be a key relationship knowing that you are working with the same patients for whatever reason. Those services were not stitched together for local patient needs and would bring more efficiency.

Chris Edwards – In Rotherham there had been great changes made – integration of the Hospital and Community Trust and everything the Clinical Commissioning Group was trying to do to integrate Primary and Community Care. It was such a big task that it would take a couple of years to achieve but it was a priority. In Rotherham the Clinical Commissioning Group was GPs led so the duplication would be found. There was a thread throughout the planned integration of Primary Care, Social Care and Community Care.

Recommendation 8 – In light of the future challenges for Rotherham outlined in the report the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care
No comments.

Recommendation 9 – NHS England should consider incentives to attract GPs to start their career in Rotherham following training in the area to help address the demographic issues of our current GPs
Chris Edwards – For every 100,000 patients in Sheffield there were roughly 70 GPs. In Rotherham there were 58. In Yorkshire and the Humber the average was 58. Rotherham had some very challenging communities which were difficult to attract GPs to; Sheffield attracted more. There was 1 big advantage in Rotherham in that there was a training scheme which had 14 registrar GPs training. Rotherham was the only 1 to have it fully staffed and was perceived to be the best training

scheme in the Yorkshire and the Humber. The Clinical Commissioning Group had tried to get the 14 GPs to stay and embrace Rotherham and feel a sense of ownership. Financial incentives had been considered but extra funding could not be attracted for such payments. Hull only had 40 GPs for 100,000 and Rotherham had more than Doncaster and Barnsley. It was still tough and Primary Care staffing levels were not where we would want them to be.

Recommendation 10 – Rotherham CCG should collect and analyse monitoring information to ensure services are resourced to meet peaks in demand during protected learning time at the new Emergency Care Centre from 2015

Chris Edwards/Dawn Anderson – NHS 111 carried out the call handling and gave the Clinical Commissioning Group a summary of calls. Regular discussions were held with the Walk-in Centre to ascertain if demand had been catered for. There were not seen to be any issues with that.

Recommendation 11 – NHS England needs to be more proactive in managing increases in GP demand due to new housing developments rather than waiting for existing services to reach capacity

Councillor Swift – I was at a meeting last week at Treeton Health Centre. We have patients coming from the Waverley development but we are full and they are building more houses in Treeton and Catcliffe (which does not have a surgery). We cannot manage the appointments because there are so many people wanting to come. We have planning permission to build a new health centre but it has been suspended.

Chris Edwards – When the Primary Care Trust was dissolved in 2012 1 of the final acts was to prioritise 2 capital projects – Dalton and Treeton health centres, and funding was identified to put new builds in. Dalton had progressed and I believe starting construction. Treeton was still being discussed. This was the responsibility of NHS Property Services who the Clinical Commissioning Group consistently challenged and would continue to challenge. It was the understanding that funding was identified 2.5 years ago.

Councillor Kaye – As a member of the Planning Board I am aware of the number of houses to be built on the Waverley site in the next 25 years. When and where would be a tipping point? When was it big enough to have its own practice?

Richard Armstrong – There was no magic number but clearly as properties started to be built then work should be taking place to plan when the ideal time was to put a GP practice in place. However, it was an economic decision for a practice as they needed sufficient patients to register with them to generate income which allowed them to employ staff, therefore, there became a point when it was the right time to make such facility available. It took 9 months to carry out the procurement so there should be planning at least a year ahead. 1 of the difficulties had always

been the inertia of getting patients to move and change facilities and had to find a way of overcoming that and encourage patients to register.

Councillor Kaye – Waverley was quite near the boundary of Sheffield. Would Rotherham work closely with Sheffield or be separate?

Chris Edwards – It would be a question for NHS Property Services. Should they be invited to a future meeting as to how they approached capital build across the piste? It would be beneficial to see the strategy they had for South Yorkshire.

Richard Armstrong – Patients had the right to register with a GP practice where they wanted to. It was not just planning and the Rotherham/Sheffield boundary but understanding what the patients wanted as well as what NHS England wanted.

Recommendation 12 – Rotherham MBC when considering its response to the scrutiny review of supporting the local economy, should ensure health parents are invited by the Planning department to be part of the multi-disciplinary approach to proposed new developments
Chairman – A meeting was already in place.

Richard Armstrong then drew attention to Potential Actions of NHS England as follows:-

- Increasing the overall supply of clinicians in primary care including
  - Increase the number of training places for GPs
  - Increasing number of doctors qualifying that wish to enter general practice
  - Changes to the induction and returner scheme to enable GPs to return more swiftly to the GP perfomers list
  - New models of care which meet demand differently including through widening skill mix (e.g. minor ailments services, direct physio access and e-consultations)

- Looking to extend the availability of general practice
  - Expanding the Prime Minister Challenge Fund pilots – exploring models for 7-day access to general practice (year 1: £50M established 20 pilots nationally (7 in north) covering 7M patients. Year 2: additional £100M available to expand number of pilot areas)
  - 'Doctor First' – this is now being used by some practices. This enables same day telephone triage with around 2/3s of patients being dealt with by phone

- Ambition of 'Patient Online' – providing the ability to book appointments prescriptions and view medical records online

- Right Care: clearer to patients and the population how best to access the right care to meet their needs

- Using 111 can direct people to get the right care which can include self-care

- Encouraging use of pharmacy as an alternative to GP
  - Feeling Under the Weather is a national campaign focussing on the management of winter illnesses
  - Treat Yourself Better is a national campaign led by the industry focussing on the management of illness without expectation of antibiotics
  - Pharmacy First is a national 'brand' used by many CCGs which encourages patients with some minor ailments to use the pharmacy. Patients who are exempt from prescription charges receive free medicines from the pharmacist

Councillor Sansome – I have been doing a lot of research on the services of actual access to GPs and 1 issue was that of a confederation where GPs, the CCG and NHSE are 1 body. I would like the opportunity to discuss whether there was an opportunity going forward in Rotherham.

Chris Edwards - The current landscape was a bit confusing – it went from a Primary Care Trust to NHSE doing Primary Care, the Clinical Commissioning Group and then NHS Property Services. As from 1st April, 2015, the Clinical Commissioning Group would be taking delegated responsibility for NHS England which would join up the Clinical Commissioning Group and Primary Care. There would be Rotherham people making decisions about Rotherham services. There needed to be continued work with the Council. Property Services was not included in the delegated responsibility.

36 Rotherham GP practices had looked at forming a confederation. Currently a Limited Liability Partnership had been formed which was a local vehicle that allowed the GP practices to bid for business together. The Clinical Commissioning Group had assisted and had given 1 off funding for the legal costs. They expected to form the Limited Liability Partnership by the end of January.

The Chairman thanked everyone for their attendance.

Resolved:- (1) That a presentation be made to the June meeting on the Limited Liability Partnership.

(2) That the Rotherham Clinical Commissioning Group and NHS England contact NHS Property Services with regard to their plans for the development of Treeton Health Centre and supply the Select Commission with their response.

(3) That NHS Property Services be requested to attend the June meeting to inform the Select Commission of their strategy for Rotherham.

71. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 22nd January, 2015, commencing at 9.30 a.m.

HEALTH SELECT COMMISSION
22nd January, 2015

Present:- Councillor Watson (in the Chair); Councillors Kaye, Sansome, Swift, M. Vines and Whysall.

Apologies for absence were received from Councillors Havenhand, Hunter and Jepson.

72. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

73. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

The member of the press present at the meeting did not wish to ask any question at this point in the meeting.

74. COMMUNICATIONS

The Chair thanked the previous Chairman, Councillor Wyatt, for his work on the Health Select Commission.

Yorkshire Ambulance Service
The Chairman reported receipt of correspondence, both written and verbal, from Unite and Yorkshire Ambulance Service regarding the performance of the service and industrial relations.

The Care Quality Commission was to inspect the Service in March and the Select Commission needed to decide how it would respond to the issues raised.

Leeds City Council Scrutiny Committee was to consider Yorkshire Ambulance Service at a meeting shortly and had invited Rotherham but unfortunately it clashed with the Council meeting. Apologies for not attending would be conveyed to their Chairman and minutes of the meeting requested to help this Authority decide how to consider the Service.

Councillor Doyle, Cabinet Member for Adult Social Care and Health, reported that a performance update had been given to the Health and Wellbeing Board held the previous day. The report was available on the intranet. He had also had letters from Unite and had agreed to meet a representative of the union. It had been emphasised that he could not become involved in any trade union disputes but performance issues had been raised. Those issues had been conveyed to the Chief Executive of the Rotherham Clinical Commissioning Group asking that they be passed to the System Resilience Group. When a response was received it would be passed to the Chairman of this Select Commission.

Joint Health and Overview Scrutiny Commission
Resolved:- That the Chairman, Councillor Watson, (Vice-Chairman as substitute) represent the Health Select Commission on the above body.

Care Quality Commission
The Commission was to inspect Rotherham Hospital shortly. There was an event on 17th February at the Holiday Inn commencing at 6:30pm for the public to share their experiences of the Hospital.

Incontinence Review
The Cabinet had accepted all 6 Review recommendations and the response would be further discussed at the Overview and Scrutiny Management Board on the 23rd January with regard to monitoring arrangements. A copy of the response would be circulated to Select Commission members.

Refresh of the Health and Wellbeing Strategy
The Health and Wellbeing Board would commence scoping of the new Strategy at a workshop in mid-February and, following wider engagement with stakeholders, would be aiming to have the new Strategy in place by September, 2015.

Health, Public Health and Social Care Round Up
Mental Health
The NHS mandate for 2015-16 included the introduction of access and waiting time standards in Mental Health Services by March, 2016. 50% of people experiencing a first episode of psychosis were to receive a package of care within 2 weeks of referral and 75% of those referred to improving access to Psychological Therapies Services would be treated within 6 weeks of referral and 95% within 18 weeks.

New Models
A good summary contained within around the forward view for the NHS and new models of working and delivering health care.

Healthwatch
No issues were raised.

75. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting of the Health Select Commission held on 4th December, 2014.

Resolved:- (1) That the minutes of the meeting held on 4th December, 2014, be agreed as a correct record for signature by the Chairman.

Arising from Minute No. 58 (Care Home Pilot – Waste Medicine Management), it was noted that the Clinical Commissioning Group had held an event on 19th January for voluntary and community sector groups

to try and understand the reasons why patients received medicines they did not require. The comments and experiences would help the team design a Medicines Waste Campaign for Spring 2015 and would inform their work in the area.

Arising from Minute No. 59 (Community Transformation Programme), it was noted that this item had been deferred to the March meeting.

Arising from Minute No. 62 (Chantry Bridge GP Registered Patient Service), it was noted that the information requested from NHS England had not yet been received.

Resolved:- (2) That NHS England be contacted regarding this matter.

Arising from Minute No. 63 (Childhood Obesity Review Update), it was noted that the Cabinet had approved tenders for the supply of Weight Management Services across six lots procured by Rotherham MBC as follows:-

- Lot 1: Children Tier 2 to be awarded to Places for People Leisure (value £170K).
- Lot 2: Children Tier 3 to be awarded to MoreLife (£128K).
- Lot 3: Children Tier 4 to be awarded to MoreLife (£76K).
- Lot 4: Adult Tier 2 to be awarded to Places for People Leisure (£120K).
- Lot 5: Adult Tier 3 to be awarded to Clifton Lane Medical Centre (Rotherham Institute for Obesity) (£300K).
- Lot 6: Single Point of Access to be awarded to Places for People Leisure (£50K, of which 50% will be retained by the commissioner to purchase licensed software and support marketing of the new framework provision)

76. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of meeting of the Health and Wellbeing Board held on 3rd December, 2014.

Resolved:- That the minutes of the meeting be received and the contents noted.

77. MEETING OF HEALTH SELECT COMMISSION AND THE ROTHERHAM FOUNDATION TRUST

The minutes of the above meeting held on 24th November, 2014, were noted.

78. THE ROTHERHAM FOUNDATION TRUST - UPDATE ON ACTION PLAN PROGRESS

Louise Barnett, Chief Executive, Rotherham Foundation Trust, gave a powerpoint presentation illustrating the progress made on the 5 year strategic plan as follows:-

Option 1 – the preferred Option

- There was overwhelming support from the lead commissioner to retain locally run services for the population of Rotherham led and managed by the Trust
- There was a significant number of potential opportunities that would be realised through closer working and collaboration with other providers without recourse to merger

Option 1 – Financial Challenge and Progress

- Final Cost Improvement Programme for 2014/15 agreed in 5 year plan was £10.9M
- As at 30th November, 2014, Month 8, the Trust had delivered c£6.3M in-year against £6.1M plan
- Year end forecast at Month 8 was £10.1M and full year effect was £12.1M
- Month 9 on track and on target to achieve the full Cost Improvement Programme in-year of £10.9M including significant full year effect to support 2015/16
- All schemes were approved subject to Quality Impact Assessments with sign off by the Chief Nurse and Medical Director
- The Cost Improvement Programme for 2015/16 was currently £12.9M as stated in 2014/15 5 year plan for year 2
- This would be refreshed in line with sector business planning requirements
- Over performance in 2014/15 would support delivery of this requirement
- Capital spend was slightly ahead of plan in Month 8 but was being monitored and where possible consideration was being given to advancing schemes for next year
- Aims was to ensure a robust planned programme of capital expenditure to support Service delivery
- Reserves were being access to support delivery of the plan for 2014/15

Progress against Key Areas

- Clinical Speciality Reviews had been completed and the outcome would be shared with the Trust Board in January
- Emergency Centre Business Case agreed and expected to open in 2017
- Further work would be progressed during 2015/16 and the outer years to support the Trust's strategic direction to be a standalone Trust with collaboration

- Local context was compatible with national context – "Five Year Forward View" and the "Dalton Review" which supported local services and strived to achieve clinical and financial sustainability more broadly
- Benchmarking exercise undertaken with external input
- Identified opportunities for efficiencies compared with peer group
- Used to inform the cost improvement and transformation programmes for 2015/15 and beyond
- Importance of implementing Service Line Reporting and Patient Level Costing (PLiCS) to enable detailed understanding of cost base in 2015/16

Other Key Areas

- Monitor enforcement/undertakings
  Electronic Patient Record enforcement lifted
  Submitted documentation regarding Board Governance enforcement
  Financial enforcement remained in place
- Board Director appointment since the last formal meeting
  Simon Shepherd, Director of Finance
  Chris Holt, Chief Operating Officer
  Lynne Waters, Executive Director of Human Resources
  Donal O'Donaghue, Interim Medical Director
- Winter pressures
  A&E performance
  Support from health and social care partners
  Choose Well Campaign
- Sickness absence
- Recruitment and retention

Our Strategy and Goals

- Our Vision
  To ensure patients are at the heart of what we do, providing excellent clinical outcomes and a safe and first class experience
- Our Mission
  To improve the Health and Wellbeing of the population we serve, building a healthier future together
- Our Values
  Respect, Compassion, Responsible, Together, Right First Time and Safe
- Our Strategic Objectives
  Patients - Excellence in healthcare
  Putting our patients at the heart of what we do
  Care and compassion
  Every patient and their family is special
  Always ensuring we meet essential standards of care
  Embracing the future and leading the way

Colleagues - Engaged, accountable colleagues
Amazing colleagues delivering patient care every single day
Ensuring that is a really great place to work
Listening to you and supporting you to make decisions
Developing you to be the best you can be
Facing our challenges together

Governance - Trusted, open governance
Being open and transparent about what we do
Being responsible and accountable
Learning when things do not go well
Supported by clear policies and structures
Always compliant giving patient's confidence in all we do

Finance - Strong financial foundations
Using our money and resources wisely
Better understanding the costs of delivering services
Making savings safely and becoming more efficient
Investing in quality and improving our facilities
Value for money and planning for the future

Partners - Securing the future together
Understanding the needs of our community
Working with others to improve the health and wellbeing of our community
Looking ahead
Building partnerships to achieve clinical and financial sustainability
Embracing innovation

Next Steps

- 2015-16 business planning process
  Refresh of strategic plan to reflect newly introduced strategic objectives and aims for 2015/16 and beyond
  Quality priorities, workforce, operational governance and financial elements
  Build on feedback from partners, patients and colleagues
  High level draft operational plan – 27th February, 2015
  Final detailed operational plan – 10th April, 2015
- Achieve 2014/15 plan requirements for year 1

Discussion ensued with the following issues raised/clarified:-

- Patients had not been surveyed specifically in relation to the quality of service since the start of the Strategic Plan but there were regular surveys as well as the Friends and Family Test so as to provide a line of sight year on year

- There was £10M in the Trust's recurrent funding. The Trust did carry out non-recurrent activities and the commissioners did give non-recurrent funding every year. Winter pressures were an example of

that funding although that issue may be dealt with differently going forward. A more detailed understanding of the cost base was required so Service line reporting and patient reporting had been implemented so exact costings would be known for particular procedures and make it easier to manage the funding. At the moment there was still an underlying deficit of £6-8M which needed to be added and was masked by a whole raft of things that the Trust did

- A&E had the accommodation/ability to cater for 55,000 attendances a year – it was actually seeing around 75,000 therefore working in a constrained environment. The new Emergency Centre was critical and would open in 2017 although there had been an assurance that by the Winter of 2016 the environment would be sufficiently developed. Work was taking place on the possibility of more space for the Winter 2015 to try and cope more effectively

- The 4 hour access target was a metric giving line of sight on performance in the Emergency pathway because patients needed to be seen, treated, admitted or discharged within 4 hours. Currently the Trust was not consistently achieving the 95% target and would be the subject of discussions with their Regulator who was fully aware of performance. The Trust had achieved Q1 and Q2 but not Q3. Although there was a commitment to achieve Q4, the Trust could no longer achieve the target for the year but was not alone in the wider national context. Actions had been put into place internally to improve the way it worked which should make a significant difference the benefit of which was already being seen. There were now days where the Trust was achieving above 95% but there were difficult days. That would remain the focus throughout the year

- Work was underway on the financial planning and would be submitted to Monitor on 27th February. Discussions would then take place and the plan submitted on 10th April

- The Trust had a deficit but not a debt. There was an underlying deficit but because the Trust was in surplus it continued as it was, however, there was a need to be mindful that whilst it appeared to be fine, once it had been stripped back, the Trust was actually living over its means. Continued monitoring would take place whilst still aiming to be in a position of surplus

- It was incumbent upon the Trust and a statutory requirement to deliver services to the population of Rotherham as a community provider. In light of budget cuts, the services had to be continued but in a more efficient manner. Currently there were a number of long stay patients in hospital but if there was more effective multi-disciplinary working with partners then the length of stay should be able to be reduced, relocating them into the correct setting quickly and thereby reducing the resources of organisations and capacity to provide the care. It was also hoped that the transformation of Community Services would

avoid people coming into hospital as often people were in hospital because there was no other alternative at the time of admission

- The Trust recognised the national challenges around the financial position but it was not planning to cease providing particular services as it had an obligation to provide them

- As part of the development of the Emergency Centre there had been a commitment to provide additional car parking and work was ongoing with bus companies with regard to routing. Work would also take place with the workforce and ensuring staff were flexible in terms of how they worked as the Trust increasingly moved to 7 days working. Other forms of transport would be encouraged e.g. car sharing and cycling. The Trust agreed to provide further information

- The Enforcement had been extremely challenging over recent times and there were still things that could be done to improve performance particularly A&E performance. The Emergency Centre would help take the Trust in a significant direction

- There had been intensive support from Health and Social Care partners during the Winter so far. The Rotherham Clinical Commissioning Group had assisted when the Trust had raised concerns regarding the Walk in Centre and the ability for extra capacity had been provided to prevent people going to A&E which had made a real difference in managing the high spikes. GPs went into the Hospital 3 times a week to work as part of the multi-disciplinary teams to support long term patients to ensure the best possible care in the right place. With the assistance of the Hospital Consultants, senior GP, Head of Nursing in Communities Services, Social Services and Therapeutic Services, there was the ability to carry out focussed work and individual patient service which ensured the patient received the care needed very quickly. The Trust had also been provided with additional Social Workers and was really pleased with the package of support that had been available and felt very fortunate to have that level of co-operation from the local Health and Social Care economy

- Choose Well Campaign – need to keep getting the message out to the public

- The sickness absence rate was not good. Managers were being trained to manage this more effectively, strengthen the health and wellbeing offer to staff when not at work and take a very robust and supportive role. Sickness absence may impact on continuity of care and also leads to higher costs through the use of agency staff

- Recruitment and retention – there were national shortages in certain groups but the Trust continued to strive to recruit as many permanent staff as possible and was determined to ensure it had safe staffing

levels. There were approximately 20,000 nursing vacancies across the country. Rotherham continued with their recruitment campaign both nationally and internationally

- The Trust had faced a shortage of nurses and had done all it could to attract them to Rotherham. As many as the Trust could accommodate were recruited and there had been some very good student nurses within the organisation. It was acknowledged that there was more that could be in terms of unregistered staff, Health Care Assistants for example, who could be trained and not rely on agency staff. The market meant that nurses could go to agencies and work at a higher premium outside of their 'normal' working hours at another hospital. Successful investment schemes had been run attracting personnel to the organisation but ideally would like to reach a balanced position of staff working within the organisation consistently and able to do extra hours on the bank if they wished

- The Trust was very mindful and guided by NHS England in relation to whether it was appropriate and ethical to go abroad to recruit. The Spanish nurses were those that could not secure a job in Spain due to there not being sufficient positions, not because they were not competent. 2 of the Trust's experienced nurses had gone to Spain to interview the applicants and ensure they were fit to work in England and the Trust. Many of the nurses wanted to be able to secure jobs in the NHS and Rotherham's team had given assurance that the nurses were very impressive. They would start at the Hospital in the second week of February and would have a minimum of 2 weeks classroom induction to help them understand how the NHS worked and induct them into the process. The Trust was working with the Council to develop guides of local colloquialisms to help the nurses understand

- Every month the number of registered nursing vacancies were monitored and scrutinised at the Quality Committee. The Trust held between 30-50 registered nursing vacancies across the Trust per month and it knew that the local universities had an outturn twice a year so did its best to recruit new nurses to fill the vacancies. It had been identified that over the course of the next 6 months it would probably need to recruit 70 registered nurses to fill the vacancies and those that were likely to occur. A recruitment visit was to take place to Romania at the end of February as the Trust was led to believe from its recruitment agency that Spain would dry up in relation to surplus nurses shortly and it would be unethical to continue to recruit. It was hoped to recruit up to 30 nurses from Romania

- There was a NHS national staff survey which took place in the Autumn every year the results of which were anticipated in February/March. The Trust's own survey was also conducted in the Autumn and, whilst there was room for improvement, it had done quite well compared to other organisations. There needed to be continued

work with staff to ensure they were supported and had a good experience

- The Vision and Mission statements were reviewed annually. In terms of changes it was incumbent upon the Trust and others to work together and work through the Health and Wellbeing Board and outside that which all contributed to improving the health and wellbeing of Rotherham

- With regard to ex gratia payments i.e. small amounts of money claimed for compensation, the Trust took the stance that it was still public money and should not pay even small amounts without a full investigation. It was acknowledged that administratively it took time and cost for the investigation but it was still public money and if there were lessons to be learnt to avoid future costs that investigation should take place. The Ex Gratia Panel would consider whether an offer should be made and then would be reported to the Finance Committee and/or the Audit Committee.

- Patient litigation – the Trust contributed to the NHS Litigation Authority and was not out of line with other Trusts of its size in relation to litigation costs. It could be 6 years before the cost of a litigation was known. Rotherham's premiums to the Litigation Authority was what might be expected to see in a Trust of its size. Trusts without the 3 specialisms that Rotherham had - obstetrics, orthopaedic and A&E – may have lower premium and claims history as they were known as the 3 highest risk areas

Louise was thanked for her presentation.

Resolved:- (1) That the Trust attend Health Select Commission meetings twice a year to provide updates.

(2) That the Trust provide additional information about future plans for car parking on site.

79. THE ROTHERHAM FOUNDATION TRUST- HALF YEAR UPDATE ON QUALITY ACCOUNT

Tracey McErlain-Burns, Chief Nurse, gave a half yearly update on the Quality Account.

2014/15 Quality Objectives

- Safe – Harm Free Care
  - The aim across the NHS was to get a 95% harm free care position. The national average across all England, including hospitals those which did not necessarily provide Community Care was currently 94%. The Trust had set itself a stretched target of 96%
  - This time last year the Trust's position of harm free care was a little over 90%

- In November and October the Trust had exceeded 95%

- Safe – Mortality – Deliver a 4 point reduction in HSMR
  - It was believed that the Trust would be able to achieve the target and would be demonstrated at year end with a revision of the SHMI (Summary Hospital Level Mortality Indicator)
  - It would be a recommendation that the Priority be carried forward into 2015/16 as it was the original suggestion that it be a 3-5 years long term Strategy

Zero avoidable Pressure Ulcers Grade 204

- Primary focus on preventing avoidable pressure ulcers particularly in those patients living in their homes within the community
- Still some progress to make within the Community
- 94% rate in hospital

- Reliable – Achieve all national waiting time targets

A&E

- Quarter 3 target had not been reached (see Minute No. 78), therefore, the year end position in relation to the emergency 4 hours target could not be met

- Caring and Reliable – Friends and Family
  - Looked to increase the net promoter score for Maternity Services, Inpatients and A&E
  - The Test had been rolled out to all Services including Outpatients, Paediatrics and GPs
  - Current focus to drive the Test and get a representative view of Services, target 75%

2015/16

- The 2013 inpatient survey had been reviewed and would be repeated. The 2013 results along with the Friends and Family Test and complaints had generated a number of issues which had been considered by the Quality Assurance Committee. The Committee had recommended that the Trust look at improving the position and the number of patients whose condition acutely changed and the Trust needed to ensure that that acute change was picked up to prevent further deterioration whilst on the Wards

- Missed or delayed diagnosis. There was a national prerogative that the Trust ought to consider its rates of missed or delayed diagnosis. The Trust had signed up to the National Patient Safety website and made a pledge to improve patient safety and ensuring patients did not deteriorate in its care and did not delay or misdiagnose

- Discharge management and improving the care of patients with Dementia

- Complaints management – both Louise and Tracey managed the process very closely and read every complaint that was received with Louise signing all the responses. However, it was acknowledged that the process was not as effective as it could and there would be some quality improvement priorities set

Infection Control

- MRSA – there had been no cases during 2014/15. The Trust was getting better at preventing infection and increasingly knew how many people may come into contact with the Hospital Services who were carrying the bacteria without any ill effects

- When there had been examples of Norovirus in the Hospital it had been managed without rampant outbreak and contained within 1 or 2 Wards. This was a good marker of Infection prevention

- Clostridium Difficile – The Trust had been set a target of no more than 24 cases in 2014/15. There was currently the 24th case so it was likely that the Trust would exceed the target. The Chief Executive and Board had been advised and a meeting held with the Care Quality Commission and Monitor to make them aware. All cases were subject to a root access analysis which was then peer reviewed by Public Health England and the Clinical Commissioning Group to ensure the Trust had not overlooked anything. With the exception of 1 case they were suggesting that all of the cases were unavoidable and, therefore, if unavoidable it was difficult to know how the numbers could have been reduced

Discussion ensued with the following issues raised/clarified:-

- At the moment there were 25 vacancies across the Ward base but also vacancies in areas such as Outpatients and Endoscopy and approximately 50 Band 5 vacancies

- The vacancy level was higher as the Trust was looking at investing in development of Services such as a nurse leading the management of the Admission and Discharge of all patients from hospital

- Last year's recruitment campaign had been successful but approximately 6-10 nurses would leave on a monthly basis

- All of those nurses leaving were offered the opportunity of an interview with the Human Resources Director or Chief Nurse to understand the reasons for their resignation

- It was often found that nurses wanted to be in control of their rotas and when they worked which was why some choose to be agency nurses. Rotas were based around service needs first but with some flexibility for staff

- There would be approximately 3 nurses retiring a month. The age of a retiring nurse had reduced as many had protected their right to retire at 55 years of age

- The results of the national staff surveys and the national Inpatients and A&E surveys were public documents. It was not known when the results would be received but they were published by the Care Quality Commission

Tracey was thanked for her report.

Resolved:- That a year end report on the Quality Account be submitted to the April meeting.

80. SPECIAL SCHOOLS NURSING SERVICE

This item was deferred due to the report author being ill.

81. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 19th March, 2015, commencing at 9.30 a.m.

Quality Accounts 2014-15
Rotherham Health Select Commission
April 2015

Tracey McErlain-Burns, Chief Nurse
Hilary Fawcett, Quality Governance Lead

The focus of the Quality Account is on how we take assurance that the services we provide are safe, effective and enabling our patients, their families and carers to have a positive experience of care

CQC Registration

- The Trust is required to register with the Care Quality Commission and its current registration status is ‘fully compliant’ with no conditions on registration.

- The Trust was subject to a routine, announced inspection between 23rd and 27th February 2015. Draft report awaited

- Trust is currently on Band 4 on CQC Intelligent Monitoring Report (scale of 1-6 where band 1 represents highest level of risk, 6 lowest)

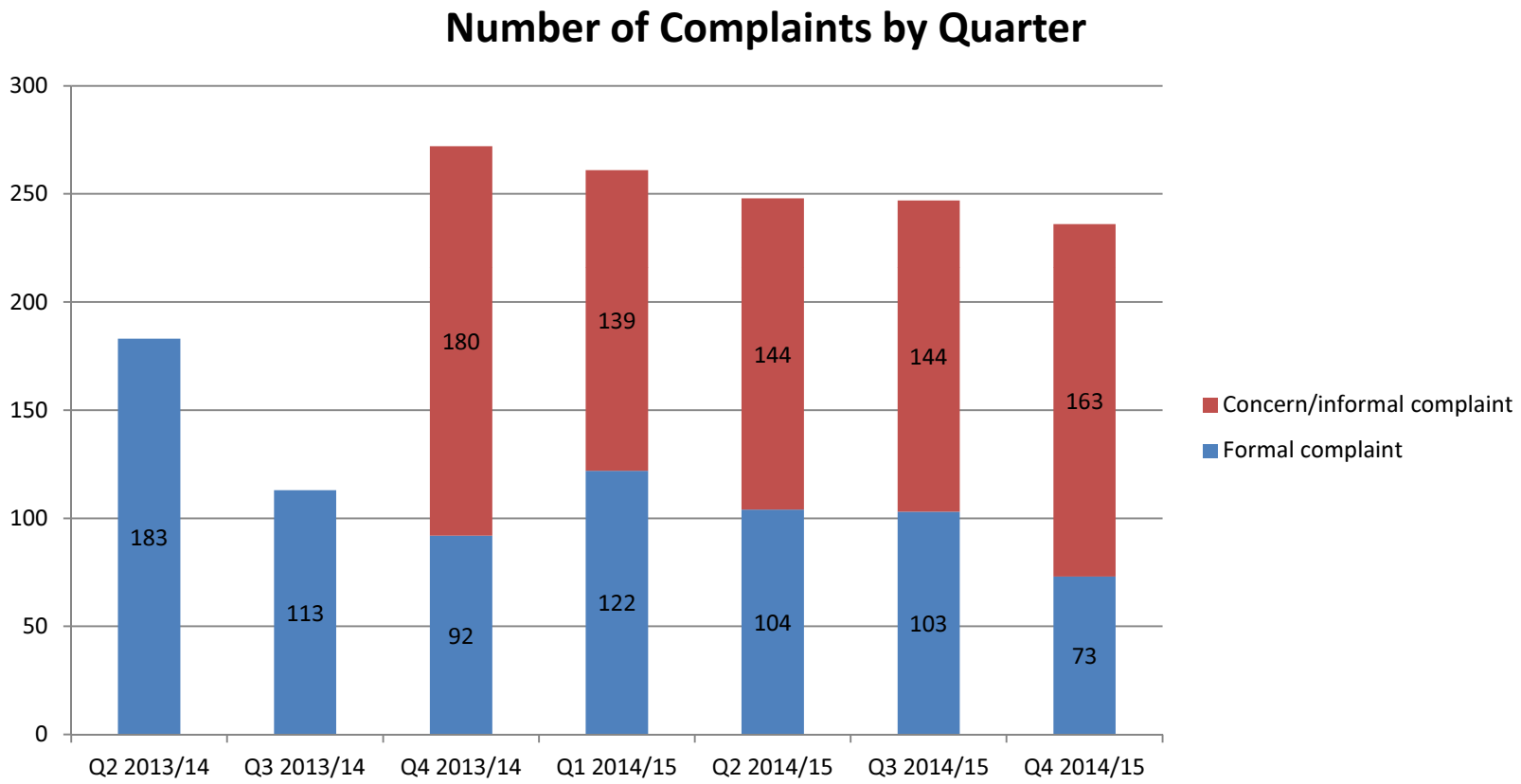
LOOKING BACK – Our quality improvement priorities for 2014-15

Priority	Description	Did we achieve this goal?
1	Mortality. To achieve a 4 point reduction in HSMR **Confirmation of figures awaited**	TBC
2	SAFE - Harm Free Care (HFC) Achieve Minimum 96% HFC avoidable pressure ulcers grade 2-4 Zero avoidable falls with harm	Almost achieved this goal
3	Achieve all national waiting times targets • Cancer · 2 week waits · 31 days · 62 days. • A&E • 18 weeks • 52 weeks target	1. yes No Yes No
4	Achieve improvement in all Friends and Family Test scores – all	No

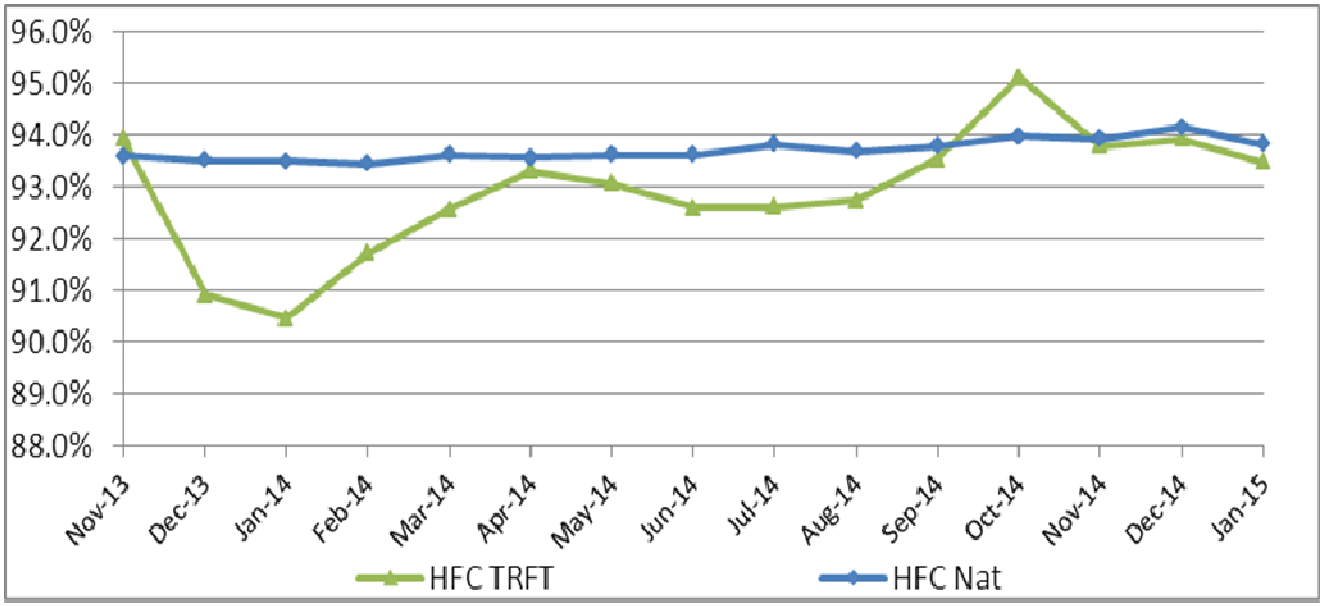
LOOKING FORWARD: TRFT Quality Objectives 2015/16

PRIORITY	DESCRIPTION
Clinical Effectiveness	1. Ensure maximum learning from unexpected deaths and reduction in mortality rates through review of all unexpected deaths, in line with Trust mortality review process 2. Reduction in delayed discharge of patients – SAFER patient care bundle
Patient Safety	1. SAFE - Harm Free Care (HFC) Continue to aim for minimum 96% HFC 2. Sign up to Safety campaign • Improve responsiveness to diagnostic test results to ensure avoidable harm caused by missed/delayed diagnosis • Improve processes designed to recognise and respond to signs of deterioration in condition of adult patients
Patient Experience	1. achieve improvement in the outcome of the national in-patient survey, specifically having a focus on reduction of noise at night 2. Achieve and maintain improvement relating to Friends & Family Test results, both in terms of positive score rates, and responsiveness 3. Improve care of patients with Dementia – ensure Trust colleagues undertake awareness training 4. Improve Trust responsiveness to complaints – 90% of responses with complainant by date agreed 5. Improve patient satisfaction with quality of complaints management process

Patient Experience



Harm Free Care



Infection Control

Incidence of Clostridium Difficile 2014-15

TRFT		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 Target = 22	Monthly Actual	2	3	3	2	2	1	3	3	3	3	5	2
	Monthly Plan	3	3	1	2	2	3	2	1	1	2	2	2
	YTD Actual	2	5	8	10	12	13	16	19	22	25	30	32
	YTD Plan	3	6	7	9	11	14	16	17	18	20	22	24

Patients at the heart of what we do, providing excellent clinical outcomes and a safe, first class service

Any Questions?

The Rotherham NHS
NHS Foundation Trust

This document forms the first draft of The Rotherham NHS Foundation Trust's Quality Report for 2014/15. This will be published as an integral part of the Trust's annual report at the end of May 2015, then will subsequently be published as the Quality Accounts by June 30th 2015.

In forwarding this to you for review we are seeking your comments on the content of the draft at this stage and will incorporate your written statement of response in the final published version. We thereby are meeting our statutory obligations to allow you a period of 30 days to review and comment on this document.

In order to meet statutory timeframes for preparation, audit and external review of the quality report we do have to send the report out before all final year end data and information has been collated and analysed, therefore we would like to draw the attention of reviewers to the fact that this draft document will be finalised prior to publication at the end of May and will have been fully updated to reflect the full year at that point.

Where data or information is not yet available for this reason, it has been indicated in the narrative.

Thank you

QUALITY REPORT 2014/15

DRAFT VERSION 3

Patients at the heart of what we do, providing excellent clinical outcomes and a safe, first class service.

TABLE OF CONTENTS

Vision, Mission & Values

Our Vision To ensure patients are at the heart of what we do, providing excellent clinical outcomes and a safe and first class experience

Our Mission To improve the Health and Wellbeing of the population we serve, building a healthier future together

Our six values safe, compassion, together, right first time, responsible and respect will underpin the way we work and define the culture we wish to build within the organisation

1.1 Chairman's Introduction (Not yet approved by the Chairman)

Welcome to The Rotherham NHS Foundation Trust's Quality Account for the period 2014/15. This is an important report describing the Trust's performance across a range of measures agreed with the local organisations representing patients and the public we serve, our commissioners (NHS Rotherham Clinical Commissioning Group), our Governors and staff at the end of 2014/15.

The Quality Account provides a description of our performance over the last year and sets out our priorities for quality improvement this year. As the Chairman of the Trust I am confident that the details provided in the account are a true and honest reflection of performance and the numerous achievements are a testament to the expertise, commitment and professionalism of our staff and volunteers who deliver, or support the delivery of, care to our patients.

During 2014/15 the Trust built on the two year plan it agreed with the Foundation Trust regulator, Monitor, during 2013/14 by undertaking a wide-ranging clinical speciality review. The results of the review will be used to secure the future of high quality care for the Rotherham community.

Shortly after I joined the Trust in February 2014 I had the pleasure of appointing Mrs Louise Barnett to the position of substantive Chief Executive from 1st April 2014. Since then we have substantively appointed to all the Executive Director positions on the Board of Directors with the exception of the Medical Director post to which the Trust is currently recruiting. The stability created by having substantive Executive Director colleagues in post has reaped many rewards during the year and has enabled the Trust to move on from a difficult period during 2013.

This annual Quality Account describes many achievements, specifically I want to recognise:

- ✓ In April 2014 we launched a new Alcohol Liaison Service designed to support adults who attend the hospital with alcohol related problems.
- ✓ The Trust was again announced as being a CHKS 40 Top Hospitals Award Winner for the 6th consecutive year in July 2014.
- ✓ That during the year the Trust launched *Governors' Surgeries*, an opportunity for patients, their relatives and staff to speak to our Governors and make their views known.
- ✓ That in July 2014 Monitor removed the breach associated with the Trust's Provider Licence in relation to the Electronic Patient Record meaning the Trust became only the second in the country to have achieved regulatory compliance in this manner.
- ✓ We were awarded a 'Park Mark' by the Police in August 2014 in recognition of the fact that our car parks have achieved the standard of the British Parking Association's *Safer Parking Scheme.*
- ✓ The plans for the new Emergency Centre were formally approved by the Board of Directors in September 2014.
- ✓ December 2014 saw the organisation being identified nationally by HealthWatch as a Trust that deals effectively and proactively with complaints and suggestions from visitors.
- ✓ In January 2015 Monitor also removed the Trust's Provider Licence breach in relation to governance meaning that only one breach of our Provider Licence remains in relation to financial planning.

Conversely it is important that I report that during the year one patient experienced a Never Event relating to the World Health Organisation's (WHO) surgical checklist.

There were 3breaches of information governance reported to the Information Commissioner's Office. The Trust was unable to meet its planned trajectory relating to Clostridium Difficile (C-diff) infection and did not meet the 4-hour emergency care target. Whilst the personal impact of these events upon individual patients and their relatives cannot be underestimated, I believe that our community should have confidence in the fact that we talk openly and honestly about these occurrences and their root causes and take robust and sustainable action to prevent their reoccurrence through learning. As an example of this practice, in January 2015 the Trust joined the *'Sign up to Safety'* campaign championed by NHS England, Monitor and the NHS Litigation Authority. The *Sign up to Safety* campaign aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.

From September 2014 onwards Louise and I have been sharing our business plan with colleagues through a series of *Moving Forward Together* briefing sessions. We have had the pleasure of meeting and hearing from over 400 colleagues across community and acute care settings.

The *Moving Forward Together* briefing has been formed from the Trust's five year strategic plan, delivered to Monitor. Through the briefing, colleagues are reminded of the Trust's operational structure, mission, vision and core values. Primarily, *Moving Forward Together* outlines the Trust's five strategic objectives and priorities and explains how all colleagues can work together to deliver excellent care for patients.

Looking forward it is clear that the NHS faces unprecedented challenges caused by rising demand from an aging population and a contraction in health spend nationally. The Trust is no different to any other NHS Trusts in terms of the challenges it faces. However our commitment to listen to feedback from our patients, their relatives, our Governors, Members and the local community; our drive to make the organisation a place where staff are proud to work and recommend its care services to others and the support from local GPs and the Clinical Commissioning Group mean we are well placed to build on the improvements described in this Quality Account to continue to provide high quality care, based on clinical need, free at the point of delivery to our local population.

1.2 Message from the Chief Executive (not yet approved by the CEO)

It is a privilege to continue working with Trust colleagues, Governors, health and social care partners and the local community to achieve the ambitions described in this annual Quality Account for our patients and the population of Rotherham.

As Chief Executive I am proud of the level of commitment demonstrated by my colleagues to delivering high quality care to our patients whilst also ensuring that we continually improve the quality of care we deliver for our patients and listen and act on the patient feedback that we receive. This has contributed to the progress made in the quality of care delivered since the publication of the last Quality Account.

Two of our key achievements during 2014/15 have been the reduction in avoidable pressure ulcers and the improvement in the number of our patients who experience harm free care.
During 2014/15 our goal was to eliminate avoidable hospital acquired pressure ulcers grades 2, 3 and 4 and to eliminate community acquired pressure ulcers grades 2, 3 and 4. I am able to report that during the year there was a steady decline in the number of avoidable pressure ulcers occurring in both in-patient areas and patients cared for at

home by TRFT community staff. Whilst we have not yet achieved our target of zero avoidable pressure ulcers, good progress has been made and we will continue to focus closely on this issue during 2015/16.
In terms of harm free care our target for 2014/15 was for 96% of our patients to experience harm free care. At the time of writing the latest data (for January 2015) shows that 93.42% of our patients experienced harm free care. Whilst this means that we did not achieve our challenging target it does show that more of our patients experience harm free care than the national rate of 93.36%

Last year the CQC changed their arrangements for reporting on Trust risk profiles, introducing 6 bandings: bands 1 to 6, with 1 identifying those organisations the CQC considers to be most at risk of failing to meet these standards and 6 identifying those organisations considered by the CQC to be the least at risk of failing to meet the CQC's essential standards of quality and safety. The Trust ends the year as it began it, in a band 4 position and will be taking steps to further improve quality with the aim of maintaining or improving the band 4 position in year.

Achieving the 4 hour waiting time in A&E has proved very difficult during 2014/15. Despite the enormous effort of all our staff the achievement of the year-end target of 95% of patients spending 4 hours or less in A&E was not possible. However during the year we have taken a number of actions to ensure the sustainable achievement of this target going forward not least of which was the decision to build a new Emergency Department which will open in the summer of 2017.

We did not achieve our annual target of 24 cases or fewer of Clostridium Difficile (C Diff, a hospital acquired infection) which proved challenging despite in depth analysis of each case, and stringent infection control measures and training. This is an area in which the Trust is looking to improve next year.

Child Sexual Exploitation (CSE) was a significant issue during 2014/15 within Rotherham. In August 2014 the report from the independent inquiry commissioned by the Council and led by Professor Alexis Jay was published. The 'Jay Report' conservatively estimated that 1,400 children had been sexually abused in Rotherham between 1997 and 2013.

Also in August 2014 the Education Secretary announced that Ofsted would undertake an early inspection of child protection services in Rotherham. The inspection report, published in November 2014, found that widespread or serious failures at the Council were exposing young people to the risk of harm and rated RMBC's Children's Services as 'inadequate'.

In September 2014 the Local Government Secretary announced that Rotherham Metropolitan Borough Council would be the subject of an independent inspection led by Louise Casey, head of the Government's Troubled Families Programme. The 'Casey Report', published in February 2015, assessed that RMBC was 'not fit for purpose' which resulted in the Local Government Secretary handing over the control of the Council to a team of five government commissioners who will run the council until March 2019.

In October 2014 the Department of Education appointed a Children's Social Care Commissioner to oversee children and young people's services in Rotherham. Sir Malcolm Newsam has established a Children and Young Peoples Improvement Board which meets on a regular basis and with which the Trust has actively engaged.

Throughout this period, TRFT as an organisation and in collaboration with our wider healthcare partners and Rotherham partnership organisations, has reflected on the potential implications of these CSE events, to ensure appropriate support is provided to victims; that colleagues are also supported where necessary and that services are fully equipped to meet any current and future needs. Furthermore, alongside the process of reviewing the recommendations within the report, we have established further learning which we can have and will continue to use to enhance our approach going forward.

I am very pleased to have the full support of our Governors, Healthwatch Rotherham, the Clinical Commissioning Group and the Rotherham Health Select Committee for endorsing the quality priorities contained within this Quality Account.

Louise Barnett
Chief Executive Officer
May 2015

PART 2

QUALITY NARRATIVE

Since April 2010, all NHS Foundation Trusts have been required to publish an annual Quality Account as part of the move to ensure an open and transparent approach in making public information about the quality of the services they provide. This report therefore forms the Quality Accounts for 2014-15, on the quality of healthcare provided by The Rotherham NHS Foundation Trust (TRFT) and patients, members of the public and our Trust colleagues are invited to use this report to evaluate the quality of care we provide

The focus of this Quality Account is on how we take assurance that the services we provide are safe, effective and they enable our patients, their families and carers to have a positive experience of care. This section of the Account outlines some of those processes and the results.

The Board of Directors has ultimate accountability for quality, including the safety of services provided. The Quality Assurance Committee is a Board committee with responsibility for seeking assurance that the Trust is providing the highest possible quality of care. This role of this committee is to seek assurance that the Trust is managing risks to quality, has the capability to ensure the delivery of high quality services, is promoting a culture of openness and transparency and has the right structures and processes in place to ensure this can be successfully achieved. The Committee holds managers and clinicians to account for performance across a range of quality and safety indicators, monitoring and tracking progress through measurement, identifying and challenging early warning signs that may emerge.

The committee is led by Mr Mark Edgell, a Non-Executive Director of the Board supported by Ms Tracey McErlain-Burns, Chief Nurse who is the executive lead for quality and safety.

Since the publication of last year's Quality Accounts, the Trust's commitment to keeping the focus on quality improvement has been further strengthened by the establishment of the Operational Quality, Safety and Experience Group which is chaired by the Chief Nurse. This group reports to the Quality Assurance Committee and Trust Management Committee, escalating concerns regarding operational delivery and capability. The group is attended by student nurses and junior clinical colleagues in recognition of the good practice recommended by Sir Bruce Keogh following the reviews he led into 14 Trusts where concerns about mortality rates had been raised[1] and their perspective and contribution has been greatly valued.

[1] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Each year following a consultation process, the Trust selects priorities for quality improvement and progress against these targets has been closely monitored over the year. A report on progress made over the last year is provided in this section of the Quality Accounts. The outcome of this year's consultation process is also included, which resulted in identification of the priorities for improvement for the coming year. A more detailed picture of what we have done well, as well as areas where the Trust intends to maintain focus to achieve further improvement, is included in part 3.

Readers are asked to note that the figures reported are correct at the time of reporting (March 2015) and the report will be updated as year-end data becomes available, and prior to publication at the end of June 2015. A number of sections are therefore not yet complete pending release of this data but where this has been indicated on the document where appropriate.

2.1 LOOKING BACK: Progress made since publication of 2014/15 Quality Accounts

Quality improvement priorities for 2014/15

During the year we have been monitoring progress against the targets we set ourselves after consultation with key stakeholders and staff. The priorities for 2013/14 and outcome are summarised in table 1:

Table1

Priority	Description	Did we achieve this goal?
1	Mortality. To achieve a 4 point reduction in HSMR **Confirmation of figures awaited**	TBC
2	1. SAFE - Harm Free Care (HFC) • Minimum 96% HFC • avoidable pressure ulcers grade 2-4 • Zero avoidable falls with harm	Almost achieved this goal
3	Achieve all national waiting times targets • Cancer · 2 week waits · 31 days · 62 days. • A&E • 18 weeks • 52 weeks target	1. yes No Yes No
4	Achieve improvement in all Friends and Family Test scores	No

Priority 1: Achieve a 4 point reduction in Hospital Standardised Mortality Rate (HSMR) data awaited

Did we achieve this goal?
The year-end position and validation of data is awaited prior to confirming the outcome of this priority. The outcome will be confirmed once available.

The HSMR can be briefly described as the actual number of deaths occurring in a hospital, compared to the number of those deaths which could be expected to happen. Nationally, an HSMR of 100 is expected and TRFT has consistently been below this level over 2014/15. This means that fewer deaths have occurred than would be expected at other comparable Trusts nationally.

TRFT set itself a target to reduce HSMR by 4 points below baseline.
Table 2

(to be added)

There has been a gradual and continuing improvement in mortality rates at the Trust over the year and there is an expectation that this will continue to improve over the coming year

Mortality rates and measurements are an important part of assessing how a hospital performs and these statistics have received increased attention following the Francis, Berwick and Keogh Reports, all of which confirm that there are many different issues that impact on mortality and no single method for reducing it. Mortality rates do not provide the whole picture but they are a useful measurement to use alongside many others when rating a hospital's overall performance.

The Trust remains committed to scrutinising mortality rates and ensuring robust processes lead to further reduction in preventable deaths and is in a position now to extend this goal beyond statistical reduction in HSMR. Focus on mortality rates as a priority for quality improvement will continue over 2015/16 to ensure this important work is continues, extending in depth through the mortality review process. The detail is included in part 2.2: Looking forward

Priority 2: Safe Harm Free Care

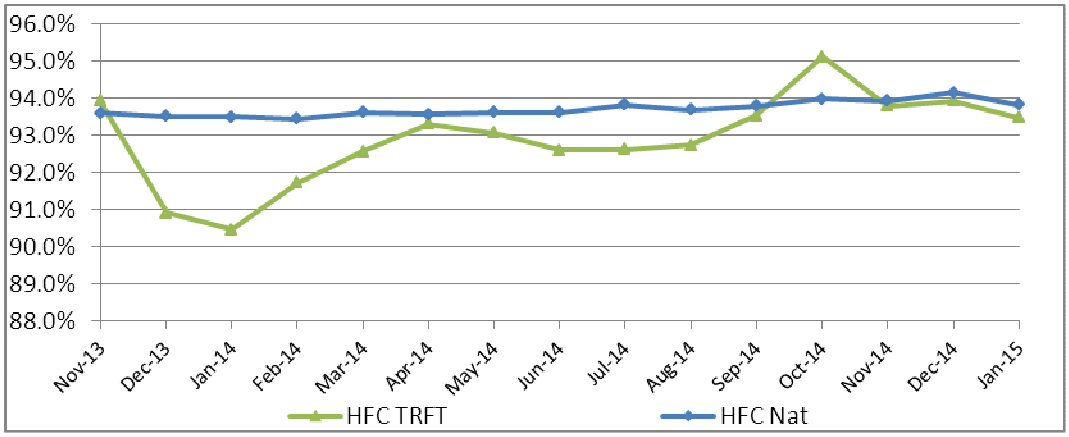
Our aim was to achieve 96% harm free care for our patients. With a particular focus on the prevention of all avoidable falls and all avoidable pressure ulcers graded 2-4 in in-patient areas

Did we achieve this goal?
No. Further improvement is required in order to consistently achieve this target

While considerable progress has been made over 2014/15, unfortunately we have not yet consistently achieved this ambitious target. At the time of reporting (January 2015 figures) the Trust has achieved 93.42% harm free care, against a national rate of

93.36%. (table 3)The data gained through this process allows us to monitor performance and progress locally, as well as benchmarking performance nationally.

Table 3



To monitor patient harm, the Trust carries out a monthly audit using a tool called the Safety Thermometer. This is part of a national patient safety programme and is an improvement tool for measuring, monitoring and analysing patient harm and harm free care. From April 2012 we have used the Safety Thermometer on all wards and in the Community Nursing Service every month, following the national guidance. The Safety Thermometer looks at four key harms that can affect patients when they are admitted to hospital:

- Pressure ulcers
- Falls
- Catheter associated urinary tract infections
- Venous thromboembolism (blood clots which form in the veins)

We aim to prevent each of these occurring in order however over 2014/15 our prime focus was the prevention of pressure ulcers and falls.

In analysing the outcome of Safety Thermometer it is important to note that unlike many of the Trusts nationally against which TRFT is measuring itself, TRFT is an integrated acute and community organisation. This has an important impact on the outcome of the audit for a number of reasons. For example, the nature of community care means that it is not possible for patients to be observed and monitored in the same way as an in-patient, in order to reduce the risk of falls or development of pressure damage. The incidence of pressure ulcers occurring in community based patients therefore tends to be somewhat higher than in-patient areas. The performance against this target has been analysed further to look at the outcomes for community and hospital patients separately. However our commitment to achieving the goal of 96% Harm Free Care remains. Looking at the figures in this separated manner helps analysis of where a further focus for improvement might be and provides the following picture:

Table 4

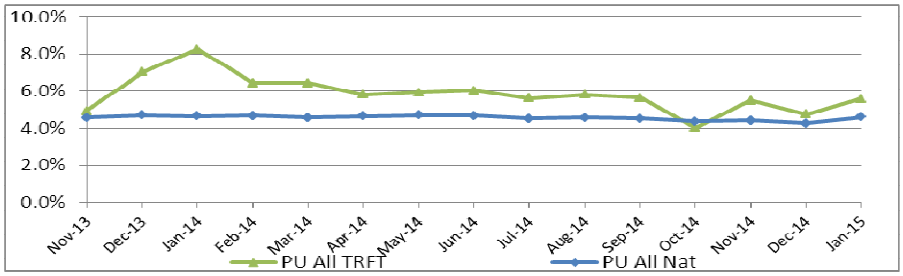
Graph indicating community & acute position separately to be added when data available

The Safety Thermometer looks at four key harms that can affect patients when they are in hospital. These are pressure ulcers, falls which result in harm, venous thrombo-embolism and catheter-associated urinary tract infection. Over the previous twelve months our focus has predominantly been on pressure ulcers and falls with the outcome reported below. In the coming year we will focus on all four of these harms with goals and how we will achieve this set out in section 2.2, Looking forward.

1. Pressure ulcers

The goal is to eliminate the incidence of avoidable hospital acquired pressure ulcers grade 2,3 and 4 and to eliminate the incidence of community acquired pressure ulcers grade 2,3 and 4 (patients on a Community Matron caseload, or being actively managed by a District Nurse and being seen on at least a weekly basis.)

Table 5

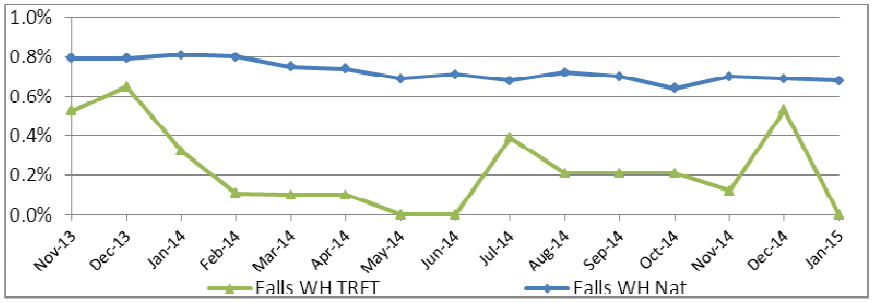


Over 2014/15 there has been a steady decline in the number of avoidable pressure ulcers occurring in both in-patient areas and patients cared for at home by TRFT community staff but while we are pleased with the progress made, the target of zero avoidable pressure ulcers has not yet been reached. The focus will remain on achieving this target, consolidating and building on this improvement. Please see Section 2.2 Looking Forward for further details of the approach which will be taken, specifically describing the Stop the Pressure campaign which has been implemented to achieve this goal.

2. Falls

The goal is to eliminate the incidence of patients falling when this could have been prevented and experiencing harm as a result

Table 6



The Trust has maintained its position in relation to the number of falls which have occurred and the number of falls resulting in harm.

The Trust Falls Group has agreed that continuing work to reduce the number of falls will be undertaken with the areas who have reported the highest number of falls which will

more detailed analysis. The Trust has recently purchased 30 ultra-low beds which are due to be delivered in March 2015. The Medical devices Management Group (MDMG) have also approved the purchase of 35 falls alarms and 25 Falls Guards. This additional equipment will support reduction on the number of falls and help provide a safer environment for those at risk of falling. Please see Section 2.2 Looking Forward for further details of the approach which will be taken

Priority 3: Achieve national waiting time targets
Our aim was to:

3.1 Achieve all cancer waiting targets
Did we achieve this goal? Yes

Performance against all cancer waiting time standards has been good throughout the year. This is based on figures for December due to national reporting timescales being 6 weeks after month end. The report will be updated prior to final publication with the most up to date figures but there are currently no concerns about maintaining this performance to year end.

3.2 Achieve A&E 4 hour waiting targets

Did we achieve this? No
The current position is 93.45% (target 95%). This will be updated to provide final year end data.

In line with the picture of pressures on Emergency Departments (ED) which has emerged across the country, performance against the 4 hour operational standard has been challenging. The Trust did not achieve the 95% 4 hour operational standard for Q3 at 90.43% and Q4 performance remains difficult at 92.62% (at 9 March 2015). The Trust has seen a significant increase in acuity of patient attendances at ED which is reflected in the increased non-elective admission rate. Many of these admissions have been frail elderly patients with complex care needs. As a result, the discharge rates have been low and have struggled to keep pace with the admission rate. Length of stay has therefore also subsequently increased as many patients are requiring complex discharge planning. The Trust has opened additional surge beds to manage this increased demand for bed capacity.

In order to manage this very challenging situation, the Trust has initiated and implemented a number of actions. A Site Co-ordination room has been set up to manage the situation and from the end of December and over the first 2 weeks of January a Silver Command structure has been implemented to closely manage all aspects of the demand for urgent care – this has included a very clear recovery plan. Some of the key actions being undertaken include; management of complex long stay patients, revised ward-based MDT reviews twice daily, co-ordination of admissions and discharges at a detailed level, effective co-ordination of all the external capacity available to the Trust. New ways of working have been introduced that will provide sustainability to being able to manage what is a very difficult situation.

As a result of these actions, the Trust has started to see an improvement in ED performance, however the challenges described will mean that the Trust can no longer achieve the target in quarter 4, which will mean two consecutive quarters in which this target was not met.

3.3 Achieve 18 week wait target

Did we achieve this goal ? Yes

We are pleased to report that targets for percentage of patients receiving treatment within 18 weeks from the point of referral have been consistently met throughout the year.

Within one specialty, Trauma and Orthopaedics, an improvement programme is underway as this target has not consistently been met, however while the focus will be on ensuring improvement in this single area, the target for the Trust overall has been achieved.

The Board will continue to monitor performance against targets via the monthly Integrated Performance Report

3.4 Achieve 52 week referral to treatment target
Did we achieve this goal? No

Unfortunately an issue came to light relating to waiting list management which was not in line with best practice, unfortunately causing a number of breaches of this target in the latter end of this year. The identification of this issue triggered an immediate and robust response, including a review of all patients on this pathway and external support was obtained from NHS England and the NHS Intensive support Team to help with the recovery plan, which had an urgent timeframe to be completed in mid-March.

It is regrettable that 6 patients (at the time of reporting) were found to have been affected by this issue. The clinical situation of each of these patients was reviewed and it was determined that while none had suffered any adverse impact on their health, this was acknowledged to have been a very poor experience for the patients concerned.

The recovery plan is now fully implemented and steps have been taken to ensure there is no further recurrence.

Priority 4: Achieve improvement in all Friends and Family Test scores
(to be updated with year end data when available)
Our aim was to achieve:

4.1 A&E - net promoter score of 75 (national average: 54)
The position at the time of reporting is **51** (year to end of February 2015 figures)
The position at the same time last year was **53**

4.2 In patient areas - net promoter score of 83 (national average: 72)
The position at the time of reporting is **72** (year to end of February 2015 figures)
The position at the same time last year was **72**

4.3 Maternity - net promoter score of 83 (national average: 82)
The position at the time of reporting is **81** (year to end of February 2015 figures)
The position at the same time last year was **77**

4.4 achieve 40% response rate for A&E, maternity and in patients combined (national average: 18.49%)

The position at the time of reporting is **25.45%** (year to end of February 2015 figures)
The position at the same time last year was **15.91%**

Did we achieve this? No. Further improvement is required to achieve this goal

The target has almost been achieved in the maternity department, however overall the Trust has not yet achieved its goals relating to Net Promoter Score and response rate and therefore improving the outcome of the Friends and Family Test has been carried forward as an improvement priority for 2015/16, with further details about how we will achieve this set out in part 2.2 'Looking Forward'. However although the stretched target we set ourselves for improvement have not been reached, we are in line with the national average for in-patient areas and are close to the national average in the Maternity setting and in the A&E department. We will continue to aim to meet and exceed these standards over the coming year.

In addition to these areas, the Friends and Family Test has now been extended to the out- patients department since October 2014 and to all community services since December 2014. This will result in the provision of further feedback providing a broader picture of the experience of our patients.

Please see part 2.2: Looking Forward and part 3, Other Information for further details. This section also provides additional explanation of the process, the questions asked and how the Net Promoter Score is reached.

2.2 LOOKING FORWARD: QUALITY IMPROVEMENT PRIORITIES FOR 2015/16

This section of the Quality Account is concerned with the priorities for improvement over the course of 2015/16

The priorities have been agreed following consultation with Trust Members, Trust Governors, Trust colleagues, the Quality Assurance Committee and corporate groups, Rotherham Health Select Committee and the Board of Directors. The decision has also taken account of the outcome of patient surveys, complaints and incidents as well as review of progress against the goals set for 2014/15

The agreed priorities for quality improvement are summarised in table 7 below with further detail provided over the following pages. We believe these priorities reflect the views of those who engaged with the consultation process and are also in accordance with Trust strategic objectives to provide safe and effective care by reducing the risk of harm, to own and enhance patient experience and to deliver effective care systematically and consistently.

Table 7: Quality Improvement Priorities for 2015/16

Priority	Description	Exec lead	Operational lead
Clinical Effectiveness	1. 100% of unpredicted deaths of patients in hospital will be reviewed in line with the Mortality Review Process	Medical Director	Associate Medical Director: Quality & Standards in Medical Care
Clinical Effectiveness	2. Over 2015/16, the number of patients with a length of stay equal to, or greater than 14 days will be reduced: • Over Quarter 1&2 to fewer than 100 patients at any given time averaged over the Quarter • Over Quarter 3&4 to fewer than 80 patients at any given time averaged over the Quarter **Current base line position** is 117 at the time of reporting	Chief Operating Officer	Director of Operations
Patient Safety	1. SAFE - Harm Free Care (HFC) Achieve minimum 96% HFC, with the following percentage reduction from the 2014/15 baseline: • 70% reduction in avoidable pressure ulcers grade 2-4 (this will achieve 96% HFC overall) • 70% reduction avoidable falls with significant harm • reduction Trust attributable VTE episodes – baseline for improvement to be established April 2015 • reduction Trust attributable catheter associated UTIs – baseline for improvement to be established over April 2015 **Current base line position** (January figures) 2014/15 is 93.42% which will be updated to the year-end figure when available.	Chief Nurse	Associate Director, Patient Safety and Risk
Patient Safety	Sign up to Safety 1. By December 2017 TRFT will reduce avoidable harm caused by missed or delayed diagnosis by 50% from the December 2014 baseline Goal for 2015/6 : 15% reduction in reported incidents **Current baseline position TBA:** 2. By December 2017 reduce avoidable harm caused by failure to recognise and manage the adult deteriorating patient by 50% from the December 2014 baseline Goal for 2015/6 : 15% reduction in reported incidents: **Current base line position TBA:**	Medical Director	Associate Medical Director: Governance and Patient Safety

Patient Experience	1. Increase percentage of in patients who were not disturbed at night during their admission : • by staff to >85% Current Baseline*: 80% • by other patients > 60% Current Baseline*: 55% (*in-patient survey result) 2. Achieve & maintain minimum 95% positive score Friends & Family Test (F&FT) – in patient areas : **Current Baseline: 95.95** Achieve and maintain minimum 87% positive score Friends & Family Test (F&FT) – A&E Department: **Current baseline: 84.67%** 3. Achieve 40% F&FT response rate – in-patient areas **Current base line 30.43**	Chief Nurse	Deputy Chief Nurse
	4. Increase the number of colleagues who have undertaken training in dementia awareness by 30%, with reduction of the number of complaints about our care of frail & elderly patients, including those with dementia, by at least 30% in 2015/16. **The baseline position at year end 2014/15 is anticipated as 1000 colleagues trained in dementia awareness.** Base line of complaints relating to care of elderly and frail patients to be established over Q1. Achieve 90% positive result from carers' survey **Current baseline 85% positive**	Chief Nurse	Assistant Chief Nurse, Vulnerabilities
Patient Experience	5. Achieve 90% of complaints response times on the date agreed with the patient. **Current baseline position**: 23% response rate - 25 days target during quarter 3 6. Achieve 20% patient satisfaction rate with Trust complaint & concerns management processes above the base line to be established over quarter 1, 2015/16 (implementation of new survey commences 01 April 2015)	Chief Nurse	Deputy Chief Nurse

CLINICAL EFECTIVENESS

Priority 1:
100% of unpredicted deaths of patients in hospital will be reviewed in line with the Mortality Review Process

Executive Lead: The Board sponsor for this area of improvement is the Medical Director

Implementation Lead: Associate Medical Director, Standards of Medical Care

Current position and why this is important:
The real need for review of hospital mortality and quality of care has been highlighted by high profile reports such as those written by Robert Francis QC[2], Sir Bruce Keogh and Professor Don Berwick[3] which strongly presented the need to ensure the focus is not solely on mortality statistics but that such statistics are viewed as a 'smoke signal', triggering the need to in-depth analysis of the quality of care. Unexpected in-hospital mortality is rare, occurring in approximately 2% of in patients nationally and studies have shown that mortality is only preventable in 5% of these cases

It is incumbent upon health professionals to identify those deaths which may have been preventable, improving quality of care through a process of continual learning

What will we do to achieve this?
A mortality review programme has been introduced at the Trust designed to achieve this goal. The review process will complement the scrutiny of mortality data and will enhance opportunities for local learning.

The principal method of reviewing quality of care retrospectively is the review of case notes and this has been introduced in each clinical department with an overview from the Trust Mortality Steering Group

An evidence based method of review has been incorporated into this process which introduces a standardised process across the Trust.

How will progress be monitored?
This work will be overseen by the Trust Mortality Review Steering Group, chaired by the Medical Director and reporting to the Clinical Effectiveness and Research Group. This group is in turn monitored by the Quality Assurance Committee. Each Clinical Directorate will be responsible for implementing the process, led locally through the Directorate Clinical Effectiveness Lead

Table 8

Domain	HSCIC Ref	Indicator name	Latest & previous reporting periods	TRFT value	TRFT previous value	Acute Trust average	Acute Trust previous average	TRFT highest value	Acute Trust previous highest value	TRFT lowest value	Acute Trust previous lowest value
Domain 1 – Preventing people from dying prematurely	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Priority 2:
Over 2015/16, the number of patients with a length of stay equal to, or greater than 14 days will be reduced:

- Over Quarter 1&2 to fewer than 100 patients at any given time averaged over the Quarter

[2] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013

[3] Review into Patient Safety , Don Berwick, August 2013

- Over Quarter 3&4 to fewer than 80 patients at any given time averaged over the Quarter

Executive Lead: The Board sponsor for this improvement area is the Chief Operating Officer

Implementation Lead: Director of Operations

Current Position and why this is important:
The goal is to reduce the number of occasions when a patient has to stay in hospital longer than necessary due to delays in discharge. The Trust wants to improve the experience of patients by ensuring they are able to return to their home as soon as they are well enough medically to be discharged from the hospital and avoid unnecessary waiting. Patients will benefit from improved care co-ordination which ensures they receive their care in a timely manner and in the right environment.

What will we do to achieve this?
The Trust is implementing the SAFER Patient Care Bundle. This is a combined set of actions designed to improve patient flow and prevent unnecessary waiting for patients. With the SAFER patient care bundle routinely implemented, the journey of our patients following admission and their experience will be improved. The SAFER acronym describes this set of actions:

S – Senior review; all patients will have a consultant review before 11am
A – All patients will have a planned discharge date that the patient will be made aware of, based on when they will be medically suitable for discharge
F – Flow of patients will commence at the earliest opportunity (by 10am) from assessment units to inpatient wards
E – Early discharge, 35%of our patients will be discharged from their ward before midday. Medication to be taken home should be prescribed and with the pharmacy by 3pm the day prior to discharge.
R – Review, a weekly systematic review of patients with extended length of stay (more than 14 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the Trust

How will progress be monitored?
One of the measures of success of this initiative will be the number of patients who stay in hospital for fourteen days or more and the Trust will be looking for a reduction in this figure over the coming year with targets set as described above. The base line position is 117 at the time of reporting.

This will be led by the Operational Team and reported to Board on a monthly basis via the Integrated Quality Report.

PATIENT SAFETY

Priority 1
SAFE - Harm Free Care (HFC)
Achieve minimum 96% HFC, with the following percentage reduction from the 2014/15 baseline:

- 70% reduction in avoidable pressure ulcers grade 2-4
- 70% reduction avoidable falls with harm

- 70% reduction Trust attributable VTE episodes
- 70% reduction Trust attributable catheter associated UTIs

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Associate Director, Patient Safety and Risk

Current Position and why this is important:
It is a fundamental right of patients receiving care at the Trust that they should expect to come to no harm and this is therefore an important priority for quality improvement.

Falls and pressure ulcers contribute to a person's morbidity and mortality. They cause significant suffering and lead to a loss of confidence in the service. The Trust is maintaining a focus on this and closely monitoring the outcome of this work. The current position is set out in part 2.1 along with further detail about the Harm Free Care and Safety Thermometer programme which also focuses on eliminating the incidence of patients developing venous thrombo-embolism (blood clots in the veins) and of patients developing urinary tract infections associated with urinary catheter use.

What will we do to achieve this?

Pressure Ulcers

- TRFT has implemented the 'Stop the Pressure' campaign as part of its commitment to deliver harm free care.
- This will support clinical areas in achieving the Trust ambition to eliminate avoidable pressure damage.
- This 12 month programme commenced in September 2014, with staff development sessions delivered by the Tissue Viability Lead Nurse supported by the Assistant Chief Nurse.
- The focus is primarily on clinical areas which had the highest incidence of pressure ulcers and provides training, support and encouragement to teams to take action to eliminate avoidable pressure damage in their area.
- A programme of audit is undertaken and as improvement is embedded, recognition is awarded to those areas where 50 or more consecutive days without the occurrence of pressure damage are achieved.

Falls reduction

- The Falls Group has agreed for the Trust to participate in the National Audit of Inpatient Falls and Fragility Audit Programme (FFFAP) from the Royal College of Physicians
- Falls Champions are to be identified on all wards
- Review of falls assessments and documentation to ensure these remains compliant with NICE guidance.
- Introduction of therapy assessment to support robust risk assessment for falls by members of the multidisciplinary team
- Focus of falls reduction through checks and challenge of all clinical areas as part of quality and safety walkabouts by senior nursing staff and the Trusts patient safety team.

Catheter associated UTIs

- The aim will be to reduce overall the number of occasions where an indwelling urinary catheter is in use

- We will continue to analyse the data to develop a clear picture of how many times indwelling catheters are used, with a goal of ensuring this is minimised to occasions where this is clinically essential
- A review of current policies and procedures related to the management of incontinence and catheterisation will be undertaken to ensure they reflect best practice.
- Care packages will be developed which provide the best possible care of patients who are in need of an indwelling catheter which covers initial insertion and ongoing care, including regular planned monitoring.
- Continue education and training will be provided for staff, patients, relatives and carers on catheter management.
- The information available for staff, patients and families on catheter management will be reviewed

Reduction in Trust attributed VTE
Continued improvement has been evident over the year with over 98% of all our in-patients being risk assessed for VTE as part of routine admission processes across all specialties. However we want to ensure this improvement is embedded and consistently achieved, therefore this quality improvement priority will be carried forward into the coming year. Further detail of how we will continue to work towards maintaining this standard is included in section 2.2, Looking Forward.

- Root cause analysis (RCA) will continue to be undertaken for all VTE episodes within 72 hours of admission. This is an in-depth level of investigation that seeks to identify the exact cause of an event, and what steps can be taken to prevent recurrence. The learning from these RCA will be fed back to the Directorates to form part of their clinical learning and quality improvement.
- Further audits to ensure quality measures including retrospective audits to check appropriate thromboprophylaxis (the measures taken to support blood flow through the veins of the legs and prevent formation of clots) has been prescribed and administered.
- Review of risk assessment processes is to be undertaken for fracture clinics to identify high risk patients.

We will continue to measure the incidence of HFC using the NHS Safety Thermometer, and publish the results in the Quality and Performance Report to the Board of Directors and on the Open and Honest Care website

How will progress be monitored?
Each quarter the Associate Director of Patient Safety and Risk will submit a written report covering the actions taken to achieve these targets.

In addition, progress against this target will be reported on a monthly basis to the Patient Safety Group and monitoring of VTE prevention work will be undertaken through the Trust's anticoagulation group.

Priority 2:
Sign up to Safety

1. **By December 2017 TRFT will reduce avoidable harm caused by missed or delayed diagnosis by 50% from the December 2014 baseline**

Goal for 2015/16: 15% reduction from base line

2. **By December 2017 reduce avoidable harm caused by failure to recognise and manage the adult deteriorating patient by 50% from the December 2014 baseline**

   Goal for 2015/16: 15% reduction from baseline

Executive Lead: The Board sponsor is the Medical Director
Implementation Lead: Associate Medical Director, Patient Safety

Current Position and why this is important:
TRFT is supporting NHS England's sign up to Safety campaign and thereby the goal to reduce avoidable harm by 50%, saving 6,000 lives over a three year period. This national campaign requires NHS staff to put safety first, to continually learn, to be open and honest, to work collaboratively, to share learning and to support staff to enable personal and professional reflection, promote learning and reduce stress. This is an important goal for the Trust which is fully committed to delivering consistently safe care and taking action to reduce harm

What will we do to achieve this?
The Trust has submitted its proposal to NHS England which describes a three year Safety Improvement Plan (SIP). This builds on the Trust Patient Safety and Patient Experience Strategies, and demonstrates the Trust's commitment to significantly reduce harm to patients whose condition is deteriorating or where diagnosis is missed or delayed.

Central to ensuring that diagnosis is neither missed nor delayed is the avoidance of administrative errors and ensuring robust procedures are in place for handling information in consultants' offices and in clinical departments. We will be aiming for the introduction of standardised clinical administration systems between and within clinical teams. This will increase patient safety because safer practice will be embedded in relation to requesting, verifying, communicating and acting upon diagnostic test results.

Failure to recognise , respond, and treat deterioration can result in avoidable patient harm, ultimately death and improvement in this area forms the second priority in the Trust's Safety Improvement Plan. The plan will focus on ensuring processes are in place which ensure measurement and recording of vital signs, recognition and escalation when there are signs of deterioration, effective handover and communication between teams. There will be a specific focus on recognition and initiation of treatment of patients developing acute kidney damage and sepsis.

How will progress be monitored?
The Safety Improvement Group will identify the base line against which improvement can be measured. The Trust uses the Datix risk management system and this system will allow the collection and reporting of data on the number of missed or delayed diagnoses and the incidence of patients who deteriorate.

Responsibility for delivering the Safety Improvement Plan sits with the executive team. Operational management will be through the Patient Safety Group, led by the Associate Medical Director of Patient Safety, supported by the Associate Director of Patient Safety and Risk. The Patient Safety Group will report on progress to the Quality Assurance

Committee on a quarterly basis, enabling assurance to be provided to the Board of Directors.

PATIENT EXPERIENCE

Priority 1:
Increase percentage of in patients who were not disturbed at night during their admission :

- by staff to >85%
  current baseline*: 80%
- by other patients > 60%
  current baseline*: 55%
  (*in-patient survey result)

Executive Lead: The Board sponsor is the Chief Nurse
Implementation Lead : Deputy Chief nurse

Current position and why this is important:
We believe that patient recovery and their overall experience of care are enhanced by maintaining a relaxed and restful environment. This is of particular importance at night. At a time when patients are experiencing the stress of hospital admission and unfamiliarity, sleep could be difficult and our goal is to ensure the atmosphere is as conducive to rest as possible.

Results of the national in-patient survey undertaken in 2014 report that 20% of our patients were disturbed at night by noise from hospital staff (national average 21%) and 45% of patients were disturbed by noise from other patients (national average 39%) By creating a more peaceful and quiet environment for all patients we hope to see these figures reduced in the 2015 survey.

What will we do to achieve this?
Following initial work within the Directorate of Surgery, a number of practical measures have been designed to reduce noise levels during the night and enhance rest, for example promoting the availability of milky drinks for patients at night, considering use of telephones which don't have ring tones which will disturb sleeping patients at night, bins on wards with a 'silent close' function. This programme will be rolled out across all in patient areas will all in-patient areas required to ensure they support the need to develop a calm atmosphere and environment at night

We are carrying out monthly patient surveys in which we repeat those questions from the national survey where we want to see improvement, including the questions about noise at night. This will enable us to monitor progress and identify whether the steps we are taking are supporting achievement of this goal.

How will progress be monitored?
The results of the local survey and action plans will be monitored at the Patient Experience Group which reports to the Operational quality, Safety and experience Group, which is in turn monitored by the Quality Assurance Committee

Priority 2

- **Achieve 95% positive score Friends & Family Test (F&FT) – in patient areas**

- **Achieve 87% positive score F&FT – A&E Department**
- **Achieve 40% F&FT response rate – in-patient areas**

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Deputy Chief Nurse

Current position and why this is important:

The current position is detailed in part 2.1, Looking Back and shows that we have not yet reached the targets we set ourselves for 2014/15. As an important indicator of our patients' experience of the Trust and how we can improve quality of care, we will continue to seek improvement.

In the coming year, in line with the national direction, the focus will move from the Net Promoter Score, which only takes into account the response of patients who are 'extremely likely' to recommend the Trust to their friends and family, to the new positive score, which also reflects responses of patients who say they would be 'likely' to recommend the Trust. This will provide a rounder picture of satisfaction levels and accounts for the higher target of 95% which has been set

What will we do to achieve this?
The Friends and Family Test Group continue to meet on a weekly basis to steer progress across the Trust and monitor results. The group is considering a range of approaches designed to increase response rates but satisfaction levels indicated by the positive score, will be impacted on the full range of activities taking place across to improve the experience of our patients, including all our quality improvement priorities for the coming year. This group provides reports on progress to the Patient Experience Group each month. Clinical Directorates will receive reports on the outcome on a monthly basis and are expected to investigate any negative comments submitted, taking action to improve care where appropriate

How will progress be monitored?
The outcome of the Friends and Family Test is reported on a monthly basis to the Patient Experience Group, which reports to the Operational Quality, Safety and Experience Group, which is in turn monitored by the Quality Assurance Committee

Priority 3:
Increase the number of colleagues who have undertaken training in dementia awareness by 30%, with reduction of the number of complaints about our care of frail & elderly patients, including those with dementia, by at least 30% in 2015/16.

We will also seek to achieve 90% positive outcome from the carers survey which asks a series of questions of the carers of patients with dementia (see part 3: Other Information).

The baseline position at year-end 2014/15 is anticipated as 965 colleagues trained in dementia awareness.

Base line of complaints relating to care of elderly and frail patients to be established over Q1.

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Assistant Chief Nurse: Vulnerabilities

Current Position and why this is important:
A measure of quality of care is how well the most vulnerable patients are cared for and the Trust wants to ensure all colleagues, whether clinical or non-clinical, as a minimum will have undertaken basic dementia awareness training. In part 3, further information is provided about the roll-out of dementia training which has made excellent progess over 2014/15, with the first target for year-end almost met.

What will we do to achieve this?
The Trust has invested in 10 Dementia Champions becoming gold level (tier 3) trainers in dementia care, with a further 10 champions adding to this by summer 2015. They, alongside the Dementia Care Lead Nurse, will be delivering a minimum of 5 dementia awareness training sessions per month including mandatory and Induction sessions over the next year.
Additional sessions with more in-depth learning will be facilitated through the year, these are modules based on a holistic model of care. It is also planned that a review of the effectiveness of developing an e-learning dementia care package will be scheduled.

How will progress be monitored?
The plan is aimed at achieving the second tranche of colleagues becoming dementia aware in line with the government's target of all NHS staff being trained in dementia awareness by 2018. (initial statement May 2014, updated Prime Minister's Challenge on Dementia 2020, February 2015)

The Trust records the training on individual staff members Electronic Staff Record and reports training figures on dementia awareness quarterly, via Health Education Yorkshire and the Humber, providing a benchmark of local and national levels of compliance.

The Dementia Care Lead Nurse also presently leads a dementia care pathway group, which reports quarterly to the Trust's Patient Experience Group, monitored in turn by the Quality Assurance Committee

Priority 4:

- **Achieve 95% of complaints response times on the date agreed with the patient.**

- **Achieve 20% patient satisfaction rate with Trust complaint & concerns management processes above the base line established over quarter 1, 2015/16**

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Deputy Chief Nurse

Current Position and why this is important:
Staff at The Rotherham NHS Foundation Trust always try to do their best for those who use its services but we recognise that sometimes expectations may not be met and patients may wish to submit a complaints about their experience of care at the Trust. When complaints are received we want to be able to investigate and respond in a timely manner and importantly, ensure we learn from what patients tell us so that quality of

care can be improved. In recognition of the fact that we acknowledge our complaints response letters have not always been sent out in a timely manner, we are committing to address this and ensure that we meet the standard we have set that at least 90% of response letters will be sent in accordance with the timeframe agreed with the patient.

In addition our patient satisfaction survey used once a complaint has been closed has been revised to a format designed to provide real evaluation of the quality of the Trust's response from the patient's perspective. This survey will seek information about how satisfied people who make a formal complaint are about how the Trust has responded. A baseline measure of this will be established over quarter 1, following which we will aim to increase satisfaction, initially by 20% above this base line.

What will we do to achieve this?
The complaints management policy and process have been fully revised and led by the Patient Experience and Complaints Manager who took up her post in December 2014, training and support has been provided to support colleagues in their understanding of the policy. A comprehensive improvement plan has been developed which is described in further detail in part 3: Other Information

How will progress be monitored?
Progress against this priority will be monitored at the Patient Experience Group where performance regarding complaints management will be reported. This group reports to the Operational quality, Safety and Experience Group, which is in turn monitored by the Quality Assurance Committee

All quality improvement priorities
A suite of reports will be developed relating to each of the above quality improvement priorities which will be submitted each quarter to the Quality Assurance Committee and thereafter to the CCG Contract Quality meeting.

2.4 STATEMENTS OF ASSURANCE FROM THE BOARD

REVIEW OF SERVICES AND INCOME GENERATED

This section will be updated when year-end data becomes available (extract is from Quality Accounts, 2013/14)

During 2014/15 The Rotherham NHS Foundation Trust provided and / or subcontracted 65 services, both community and acute services.
The Rotherham NHS Foundation Trust has reviewed all the data available to them on the quality of the care in all 65 of those relevant health services.
The income generated by the relevant health services reviewed in 2014/15 represents **85%** of the total income generated from the provision of relevant health services by the Rotherham NHS Foundation Trust for 2014/15

CLINICAL AUDIT ACTIVITY

During 2014/15, 38 national clinical audits and 3 national confidential enquiries covered NHS services that The Rotherham NHS Foundation Trust (TRFT) provides. During that period TRFT participated in 89% of national clinical audits and 100% of national confidential enquiries of the national clinical audit and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that TRFT was eligible to participate in during April 2014 to March 2015 are as follows (see table 9 below).

Table 9

	Number of audits relevant to services provided by The Rotherham NHS Foundation Trust	Percentage of audits participated in
National Clinical Audits	38	89% (34/38)
National Confidential Enquiries		
National Confidential Enquiries into Patient Outcome and Death (NCEPOD)	3	100%
Confidential Enquiries into Maternal and Child Health	1	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	0	Not applicable

Total number of audits 2014-15

The National Clinical Audits and National Confidential Enquiries that TRFT participated in, and for which data collection was completed during 2014/15, are listed below in table 10 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 10

Title	Eligible	Participation	% Cases submitted	Report published 2013 (calendar year)	Report Reviewed	Action (s) to improve quality of care
Acute						
Adult Community Acquired Pneumonia	Yes	Yes	Data collection ongoing until 31 May 2015	No	Not applicable	No applicable
Case Mix Programme (CMP)	Yes	Yes	100%	Yes	Yes	No actions required.
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	61.9% April – September 2014			
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100%	No	Not applicable	Not applicable
National Emergency Laparotomy Audit (NELA)	Yes	Yes	50%	Yes	Yes	Implement acute abdomen/high risk laparotomy pathway and consider including a review of mortality and morbidity for emergency laparotomy

						at the bi-monthly General Surgery Clinical Effectiveness and Clinical Governance meeting.
National Joint Registry (NJR)	Yes	Yes	93.7%	Yes	Yes	
Non-Invasive Ventilation - adults	Yes	Did not take place in 2014/5	Not applicable	Not applicable	Not applicable	Not applicable
Pleural Procedure	Yes	Yes	100%	Yes	Yes	No actions
Blood and Transplant						
National Comparative Audit of Blood Transfusion programme:-						
Patient information and consent	Yes	Yes	25%	Yes	Yes	Discuss results at Hospital Transfusion Committee meeting. To be included as part of Hospital Transfusion Team audit plan 2016/17. Include as part of annual transfusion ICP documentation audit to check whether a patient has been informed of indication for transfusion, risks, benefits and alternatives. Update current material to include for retrospective patient information where consent unable to be obtained. To overcome language barriers to better inform patients, include in current policy to use Big Word service and obtain NHSBT leaflets where available
Survey of red cell use	Yes	Yes	100%	Yes	No – to be discussed at the end of March meeting	Not applicable
Cancer						
Bowel cancer (NBOCAP)	Yes	Yes	100%	Yes	Yes	Ensure all applicable cases are submitted to the audit (reported as 91% for 2012-13) - liaise with CHKS lead to determine cases identified through Hospital Episode Statistics. Improve the recording of radiotherapy data – review processes to capture this internally, rather than through the treatment

						centre at Sheffield.
Head and neck oncology (DAHNO)	Yes	Yes	100%	Yes	Yes	Review process for entering treatment data by liaising with DAHNO coordinators at Sheffield, Chesterfield and Doncaster to ensure all surgery, chemotherapy and radiotherapy records are submitted
Lung cancer (NLCA)	Yes	Yes	100%	Yes	Yes	Meeting to finalise action plan on 11.3.15
National Prostate Cancer Audit	Yes	Yes	100%	Yes	Yes	Recruit clinical nurse specialist.
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%	Yes	Yes	Awaiting action plan
Heart						
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100%	Yes	Yes	No actions
Cardiac Rhythm Management (CRM)	Yes	Yes	?	Yes	Yes	No actions
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Coronary Angioplasty/National Audit of PCI	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
National Adult Cardiac Surgery Audit	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%	Yes	Yes	No actions required.
National Heart Failure Audit	Yes	Yes	Data has been submitted for ? patients since April 2014 to the present	No	Not applicable	Not applicable
National Vascular Registry	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Pulmonary Hypertension (Pulmonary Hypertension Audit)	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

Long term conditions						
Chronic Kidney Disease in primary care	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Diabetes (Adult) – Inpatient audit	Yes	Yes	100%	Yes	Yes	Awaiting action plan from Fiona Smith
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	No	Not applicable	Not applicable
Inflammatory Bowel Disease (IBD) programme:-						
Ulcerative colitis	Yes	Yes	100%	Yes	Yes	Awaiting action plan from Dr Miles/Dr Yousif
Biological Therapies	Yes	Yes	100%	No	Not applicable	
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes	100%	Yes	Yes	Awaiting action plan from Dr Miles
Renal replacement therapy (Renal Registry)	No					
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	97%	No	Not applicable	Not applicable
Mental Health						
Mental health (care in emergency departments)	Yes	Yes	100%	No	Not applicable	Not applicable
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	Not applicable				

Detailed audit participation 2014-15

Prescribing Observatory for Mental Health (POMH)	No	Not applicable				
Older People						
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	The falls audit did not take place	Not applicable	Not applicable	Not applicable	No applicable

Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes – National Hip Fracture Database	100%	Yes	Yes	Awaiting action plan
National Audit of Dementia	Yes	No – this is a pilot audit during 2015 and it was agreed at the dementia care pathway meeting not to participate	Not applicable	Not applicable	Not applicable	Not applicable
Older people (care in emergency departments)	Yes	Yes	100%	No	Not applicable	Not applicable
Sentinel Stroke National Audit Programme (SSNAP):- Clinical Audit	Yes	Yes	Information not yet available – figures will be based on Oct – Dec 14 submissions and report is due late March 2015	Not applicable	Not applicable	Not applicable
Sentinel Stroke National Audit Programme (SSNAP):- Organisational audit	Yes	Yes	Not applicable	Yes	Yes	The actions from this will be incorporated into the overall SSNAP action plan
Other						
Elective surgery (National PROMs Programme)	Yes	Yes	78.5% (participation rate to September 2014)	Yes	Yes	Brief nursing staff to ensure importance of maintaining participation of the PROMs questionnaire is clear and is an on-going initiative. Review nursing documentation to include a question to prompt the nurse to offer the patient a PROMs questionnaire. Support to complete the questionnaire is to be offered where possible.
National Audit of Intermediate Care	Yes	Did not take part	Not applicable	Not applicable	Not applicable	Not applicable
TBC						
British Society for Clinical Neurophysiology						

(BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	No	Not applicable				
Women's & Children's Health						
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	100%	No	Not applicable	
Fitting child (care in emergency departments)	Yes	Yes	100%	No	Not applicable	Not applicable
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes		No	No	Not applicable
Neonatal Intensive and Special Care (NNAP)	Yes	Yes		Yes	No, to be discussed in March CE meeting	
Paediatric Intensive Care Audit Network (PICANet)	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

The reports of 19 National Clinical Audits were reviewed by the provider in 2014/15 and TRFT intends to take the actions to improve the quality of the healthcare provided as listed in the table above.

Review of Local Clinical Audits

The report of 149 local clinical audits were reviewed by the provider in 2014/15 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table 11)

Table 11

Department	Audit Title	Reviewed	Action to Improve Quality of Care
A&E	Seizure Management (NASH)	Yes	Results to be communicated to Consultants, Middle Grades, Senior Nursing staff and SHOs, specifically, the need to document ECG. Results to be emailed to all appropriate staff, updates to be provided in the newsletter circulated to staff and results to be displayed on the noticeboard in the A&E department.
A&E	Management of head injury in the emergency department	Yes	A poster to be produced and displayed in the department to highlight the main objectives in the management of head injury. An update to be provided on head injury management on Sharepoint. Updated information to be provided in teaching sessions on management of head injury and information displayed on the noticeboard in the department.
A&E	Disposal of infants <3 months old from A&E	Yes	To highlight and continue working in line with the policy that all patients under 3 months old should be reviewed by an A&E Consultant or Paediatric Registrar. To continue implementation of the policy regarding senior review of patients aged under 3 months. Awareness of the policy to be raised through induction.
A&E	A&E Documentation audit	Yes	To provide education and remind staff via Nursing Staff and Doctors teaching sessions on the need to prescribe oxygen. Nursing staff, reception staff and doctors to be reminded of the importance of documenting the telephone number for emergency contact.
A&E	Investigation of Pulmonary Embolism	Yes	The PERC tool to be introduced to A&E once ratified. The current pulmonary embolism guideline on Sharpoint to be updated. Education to be provided to senior and junior clinical staff on the use of the PERC tool through a poster and teaching sessions.
A&E	Patient Group Direction Audit for 1% Lignocaine	Yes	No actions required
Anaesthetics	Hip Fracture Anaesthesia Sprint Audit Project 2013 (National Hip Fracture Database)	Yes	Feedback the results to the Orthopaedic Surgeons at an upcoming Clinical Effectiveness meeting.
Anaesthetics	Review of Cardiac arrests and resuscitation calls over 12 months (NCEPOD Time to Intervene)	Yes	Carry out a separate review into clinical observations. Meet with the Medical Director and Clinical Director for Medicine to discuss ways of addressing issues relating to reluctance to consider and complete Do Not Attempt Cardio Pulmonary Resuscitation forms. Continue to monitor performance for pre-cardiac arrest care.
Anaesthetics	Daycase Interscalene Blocks	Yes	Check what information is given by pre-operatively by nurses and the Day Surgery Unit to ensure patients receive appropriate information regarding pain control. Discuss the 'To Take Out' regime with the Acute Pain Lead and consider the development of a guideline.

Anaesthetics	Audit of anaesthetic practice and influence of anaesthetic delays to discharge (breast)	Yes	Determine day case rates and make staff aware of the best practice tariff for surgery . Encourage the use of Apfel scoring and appropriate anti-emetics by sharing findings with the Anaesthetic department and developing a guideline. Inform the Day Surgery Unit to stop prescribing co-codamol and to prescribe paracetamol and codeine separately. Monitor the impact of stopping co-codamol through a patient questionnaire and review patient satisfaction of day case surgery through the patient focus group.
Anaesthetics	Reaudit of peri-operative hypothermia in main theatres and day surgery 2013	Yes	Develop rolling programme for monitoring patient temperatures. Remind all Anaesthetists of the guidance from NICE regarding frequency of intra-op temperature documentation and the need to document warming techniques. Review guideline and liaise with estates department to organise data collection on ambient temperatures on clinical areas.
Anaesthetics	Availability of anaesthetic emergency guidelines in anaesthetic areas	Yes	Raise awareness of the Anaesthetic guidelines folder by adding this to the trainee induction programme
Anaesthetics	Audit of documentation of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Decisions	Yes	Make the new version of the Do Not Attempt Cardio Pulmonary Resuscitation Form to all clinical areas and continue to include DNACPR discussions in resuscitation training.
Anaesthetics	Audit of fractured NOF following introduction of fascia iliaca block on wards	Yes	Include the Emergency Department pathway in the next audit and consider modifying the fracture neck of femur pathway to include fascia iliaca compartment block if the patient hasn't already received this
Anaesthetics	Audit of documentation of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Decisions	Yes	Ensure complete documentation on DNACPR forms - circulate report to all clinical leads/matrons/ ward managers/patient safety/head nurses. Circulate the current DNACPR form to all areas to ensure the correct version is used. Chair of Resuscitation committee to contact all Consultants to emphasise the importance of complete documentation and correct version of form being used. Training event to be arranged for Consultants in June 2015 by Trust Solicitor. Investigate the possibility of amending the regional DNACPR form to better meet TRFT needs as previous audits (with TRFT form) demonstrated much better results. Contact junior doctors and advise them they may not sign DNACPR forms.
Anaesthetics	Emergency Equipment Audit	Yes	Ensure all clinical areas check resuscitation equipment daily as per guidance in red 'Daily Emergency Equipment Checks' folder, and sign to say the equipment is checked and ready for use in an emergency - circulate report to all Matrons, Ward Managers, Associate Director of Patient Safety and Risk for information/action. Ensure improvement is seen in areas with low compliance - re-audit in March 2015 when the results have been disseminated. Escalate to Associate Director of Patient Safety and Risk if there are still concerns regarding performance.
Anaesthetics	Potential Donor Audit (NHS Blood and Transplant Audit)	Yes	No actions required
Anaesthetics	Surgical Safety Checklist - An Audit of Practice in Rotherham	Yes	No actions required
Anaesthetics	Timely anaesthetic involvement in the care of high risk and critically ill women	Yes	No actions required

Anaesthetics Orthopaedics	Enhanced recovery - Orthopaedic hip and knee spinal without diamorphine	Yes	Provide training on addressing post-operative pain before operations through the Hip and Knee school. Circulate the hip and knee guidelines and make available in Theatre Admissions Unit. Provide more structured information about Nonsteroidal anti-inflammatory drug (NSAID) prescribing. Source funding for acupins.
Anaesthetics Trust Wide	Annual suction audit	Yes	Ensure all wards and departments are familiar with the requirements for emergency equipment checks by producing standardised guidance and issuing this to all wards. Ensure areas for improvement are picked up by individual wards and departments by circulating results to Assistant Chief Nurses and Head of Patient Safety.
Anaesthetics Trust Wide	MRX Weekly operational check audit	Yes	Inform Senior nurses within the Accident and Emergency department and the Stroke Unit of the importance of performing a weekly MRX check. Re-audit in May 2014 to assess whether improvements have been made.
Anaesthetics Trust Wide	Audit of emergency equipment checks	Yes	Inform senior nurses and staff from the Accident and Emergency department, Planned Investigations Unit, Community Health Centre and Medical Physics of the importance of daily emergency equipment checks and documentation of these checks. Replace old folders. Re-audit in May 2014 to assess if improvement has been made.
Community Adult Services	An audit of clinical record keeping for comprehensive dental treatment under general anaesthesia at Doncaster Royal Infirmary - Second Cycle	Yes	The audit form will be used throughout the Community Dental Service, the form will be made accessible on the S drive and will also be emailed to the Rotherham and Barnsley dental teams. The audit will be discussed at the local clinical governance meeting.
Community Adult Services	Consent 2014	Yes	The giving of leaflets/information sheets to the patient/parent/carer will be documented on the Consent form in the appropriate place. Special requirements, such as the need for an interpreter or the patient requiring a hoist, will be noted on the Consent form. Interpreters who have been invovled in the consent process will sign and date the consent form. For procedures carried out after the date of the initial consent this will be reconfirmed by a signature of the treating dentist in the appropriate section of the consent form. For patients/parents/carers given a copy of a consent form at the initial visit a contact number will be recorded on the consent form to enable contact with the responsible dentist if any questions or concerns arise. The audit and its recommendations will be presented/disseminated at a staff meeting for discussion.
Community Adult Services	Audit of consistency of paperwork completed on client discharge from the community integration service	Yes	Findings to be presented at a team meeting to raise awareness of inconsistencies and demonstrate importance of completing discharge paperwork. To meet with the Occupational Therapy Manager to discuss the report and the impact staffing levels is having upon the service in terms of discharge paperwork. A discharge checklist to be introduced and discussed with staff which will be kept in each client's file so that this can be used during the discharge review to act as a prompt sheet for staff to ensure discharge paperwork is completed.
Community Adult Services	Audit of PGD - the administration of seasonal influenza vaccine	Yes	Training programme to be developed to assess that staff are competent to use the Patient Group Direction (PGD) in light of recent changes.
Community Adult Services	An Audit of Liverpool Care Pathway and end of life care	Yes	No actions required

Community Adult Services	Reaudit of Symptomatic Lower Urinary Tract Infection	Yes	No actions required
CYP Service	British Thoracic Society: Paediatric Pneumonia - 2012	Yes	Raise awareness of the Rotherham guidelines for Pneumonia to ensure appropriate use of blood tests, chest x-rays and antibiotics. Ensure guidance is easily available on the intranet for junior doctors to access by liaising with the intranet lead. Participate in the next national audit and collect data on whether an initial chest x-ray was performed.
CYP Service	RCPCH: Diabetes (Paediatric) - 2011-12	Yes	Secure additional Diatetic input to Implement Best Practice Tariff: 'Invest to Save'. Improve clinic waiting times, by introducing staggered appointments, Change clinic invite letter, to manage expectations in clinic. Seek charitable funding to purchase and secure digital information sources of educational material for patients to read whilst waiting in clinic.
CYP Service	British Thoracic Society: Paediatric asthma 2013	Yes	Ensure the type of device used during the admission is documented on the Kardex and discuss frequency of omissions weekly at Thursday lunch clinic teaching sessions. Improve use of the discharge planning pack by implementing it on the wards and highlight to new doctors at induction session. Discuss xrays reviewed at Radiology weekly meetings. Disseminate aduit results to GPs
CYP Service	Pathways for a diagnosis of an Autism Spectrum Condition	Yes	Assess how many staff and what grades of staff are required to meet 3 month waiting time for assessment target and identify negative impact of failure to do so on the child and/or the family. To standardise the pathway and use of the Wood's lamp as an assessment tool for all children by all Paediatricians, by acquiring a more robust Woods lamp model, and also a blind for the door to ensure the room at Kimberworth Place is sufficiently darkened. Appoint a Key Worker with the remit to do some Autism Spectrum Condition follow up clinics as part of this post and share registrar follow-up clinics equally between Consultants to increase the number of Consultant follow up clinics and Registrar clinics. All Consultants to indicate on any new referral to Child Development Centre if child could be seen in Child Development Centre for follow up rather than new appointment time slot.
CYP Service	Epilepsy Audit	Yes	Review and update local guideline in line with APLS. Provide further training on drawing up phenytoin for A&E nursing staff. Review training re. parental involvement in administering first line drug. Revise audit data collection sheet to capture ambulance timing and arrival at A&E, and re-audit.
CYP Service	Reaudit of NICE Neonatal Jaundice Guidelines	Yes	Formulate a jaundice checklist for newborns. Include teaching for SHOs on jaundice early in post, including summary of the NICE guidelines. Provide all parents of newborns with the NICE jaundice information leaflet and inform midwives to document that it is given. Establish checklist for identifying risk factors and further investigations required after starting phototherapy.
CYP Service	Audit of Hepatitis B - 2011 births	Yes	No actions required
CYP Service	CRMC/UCMC Follow up audit - CYP Service	Yes	No actions required
CYP Service	Audit of Drug Monitoring for Gentamycin	Yes	No actions required

CYP Service Safeguarding	Audit of looked after children and Leaving Healthcare Summary (Safeguarding)	Yes	Discuss outcome of audit with Clinical Service Managers to ensure that completion of 'My Health Care Summary' process is embedded into practise. Deliver training to ensure clinical staff are aware of the local guidance and processes
CYP Service Safeguarding	Re-audit of Health Assessments for Looked After Children (Safeguarding)	Yes	To continue to offer 'A Child's Journey' bi- monthly training sessions initially then quarterly for new practitioners, to provide knowledge of the documentation and processes for looked after children and young people. Quality assure all review health assessments and address uncompleted information with the individual practitioner.
Dermatology	Consent 2014	Yes	Disseminate the audit findings at the next clinical governance meeting in November 2014 and highlight the continuation of achievement of high standards.
Dermatology	Audit of nurse led Botox service for Axillary HyperHidrosis	Yes	No actions required
Endoscopy	ERCP audit	Yes	No actions required
Endoscopy	Colonoscopy Completion Rate	Yes	No actions required
Endoscopy General Surgery	Patient Group Direction for Klean Prep and Picolax: Bowel Cancer Screening Programme	Yes	No actions required
Endoscopy General Surgery Integrated Medicine	Colonoscopy completion rate	Yes	No actions required
Endoscopy Integrated Medicine General Surgery	Consent audit	Yes	Feedback to staff when presenting the audit to ensure appropriate information booklets are given and that patients are informed during the consent process of the type of anaesthesia to be used. Emphasise the importance of recording this information on the consent form.
Endoscopy Integrated Medicine General Surgery	Gastroscopy Audit - Oesophago-gastro-duodenoscopy (January - June 2014)	Yes	Ensure endoscopists complete all aspects of the required documentation by updating the InfoFlex system to include the question 'Has duodenum part 2 been reached?'
Endoscopy Integrated Medicine General Surgery	Number of procedures	Yes	No actions required
Endoscopy Integrated Medicine General Surgery	Number of procedures	Yes	No actions required
Endoscopy Integrated Medicine General Surgery	Gastroscopy Audit - Oesophago-gastro-duodenoscopy (July - December 2014)	Yes	No actions required

ENT	Consent 2014 - ENT	Yes	Remind all staff at the Clinical Effectiveness meeting of the need to document when information leaflets have been provided to patients. Consider providing additional consent training for junior medical staff by liaising with the lead at Doncaster to establish what training is already provided and prepare an update if required.
ENT	Thyroid Fine-needle aspiration (FNA) Re-Audit	Yes	Consultant to be trained in slide preparation by specialist cytopathologist at ultrasound guided fine need aspiration (FNA) course. Re-audit to take place after slide technique training.
ENT	Third cycle audit of Fine Needle Aspiration -c adequacy rates	Yes	No actions required
General Surgery	Documentation Audit 2013 (General Surgery)	Yes	Encourage recording of name and patient identifier on both sides of continuation sheets by liaising with the Clinical Records Group to ensure the documentation is updated. Present the audit to new Foundation Year 1 doctors to raise awareness of the standards and incorporate the standards into the induction presentation.
General Surgery	Documentation 2014	Yes	Incorporate practice standards into the junior doctor induction booklet.
General Surgery	Readmissions after General Surgery - Regional Project (Clinical Effectiveness Workstream)	Yes	No actions required
Genito-urinary Medicine	PEPSE audit (HIV) - Comparing current practice to BASHH Recommendations	Yes	Revise PEPSE (Post Exposure Prophylaxis after Sexual Exposure) proforma and remind staff to use this, to ensure all relevant information is captured; Include medication for side effects in PEP (post exposure prophlaxis) starter packs; Liaise with all GU Med Consultants to ensure patients are referred to Health Advisors and ask Health Advisors to ensure all patients have a recall for final blood tests; make staff aware that gay men should be offered the opportunity to see the Health Advisor for Health Promotion.
Genito-urinary Medicine	Re-audit of GP referrals to GUM clinic	Yes	Feedback results of Audit to GPs at Protected Learning Event, and discuss to confirm the CQUIN for letter response times to GP referrals has been set and that this is being met; Confirm whether GPs would like to continue using referral proforma. Discuss with staff a prompt box on the results sheet of patient proforma to remind staff to gain consent from patients to write back to GP and confirm GP address.
Genito-urinary Medicine	Assessment of the rationale for Hepatitis C testing in the Genito-Urinary Medicine Clinic, and adherence to the criteria stated by Public Health England	Yes	Update the clinic hepatitis C testing guidance, and supply copies of Hepatitis C testing leaflets to all clinic rooms.

Genito-urinary Medicine	Management of Gonorrhoea in accordance with National guidance	Yes	Patients identified with gonorrhoea should be offered written information about STIs and their prevention, add tickbox to proforma to document if offered but declined. Positive NAATs from extra genital sites to be confirmed by supplementary testing that uses a different nucleic acid target. Discuss and disseminate at Clinical Governance to stop performing Urethral culture in symptomatic women as a screen. Only perform ur culture in women: 1. Contact of GC 2. If had hysterectomy 3. GC positive on asymptomatic screen and to do prior to treatment. Disseminate to nurses and support workers to pull notes if laboratory calls to say they have a positive GC culture, and double check microscopy slides to see if GC was found or not found.
Genito-urinary Medicine	BHIVA 2013 National Audit of HIV Partner Notification	Yes	No actions required
Genito-urinary Medicine	Gonorrhoea and Chlamydia Audit (2013) - treatment and partner notification	Yes	No actions required
Genito-urinary Medicine Safeguarding	Audit of patients attending clinic following Sexual Assult in accordance with BASHH guidance (Safeguarding)	Yes	Draft proforma to prompt for all standards for assessemnt following Sexual Assult, and discuss implementation at Clinical Governance meeting. Make all staff aware of BASHH guidelines at Clinical Governance meeting. Re-audit when form in use
Haematology	Consent 2014	Yes	The audit findings will be presented at a local Haematology governance meeting. Consent will be included when teaching SpR how to use the marrow biopsy kit. Information leaflets will be available in clinic and on the ward.
Haematology	Audit of 30 day mortality following SACT 2013 (systemic Anti-cancer therapy) Round 5	Yes	To ensure pre-chemo assessments are as robust as possible, the pre-chemo telephone clinic assessment will be re-ratfied.
Integrated Medicine	Cardiac Arrhythmia (Cardiac Rhythm Management)	Yes	Increase CRT and ICD implantation rate within the North Trent Cardiac Network by continuing to improve the identification of candidates for CRT and ICD implantation through providing an edication session for primary care doctors about devices and by providing reminders for secondary care physicians in grand round and Consultant Physicians forum.
Integrated Medicine	BTS Adult Community Acquired Pneumonia 2012-13	Yes	To improve documentation and increase awareness amongst medical staff of the importance of recording CURB 65 scores in patients with community acquired pnemonia via Foundation Teaching sessions.

Integrated Medicine	NHS IC: Diabetes (Adult) (2012)	Yes	The complexity of diabetes, the potential for serious diabetes treatment-related harm and the adverse effects of poor diabetes management on outcomes to be addressed. Audit findings to be disseminated to senior nursing staff at Senior Nursing and Midwifery forum, to medical staff through the Clinical Effectiveness Lead for Integrated Medicine, discuss insulin errors and management with pharmacy and patient safety staff and implement Hypoglycaemia boxes on the wards with training package rolled out in the new year. The use of diabetes UK leaflets on the wards to be considered, so people with diabetes know what inpatient care to expect to help inform and deliver improvements. Improvement on the appropriate use, effectiveness and safety of insulin infusions to be addressed with Pharmacy and Patient Safety. Foot care pathways before, during and after any episode of hospital care to be improved. Foot assessment sticker to be implemented and discussions to be held at a clinical meeting.
Integrated Medicine	Emergency Use of Oxygen (2013)	Yes	To improve accuracy of oxygen prescribing, review the oxygen prescribing sheets using examples acquired from other Trusts where possible.
Integrated Medicine	Heart failure	Yes	Continue to participate in the audit and submit data for at least 20 patients discharged with a primary diagnosis of heart failure. The heart failure pathway to be streamlined to ensure all patients regardless of admission ward have access to recommended medication in line with NICE guidelines and that treatment is managed by specialist staff. Referral rates to CNS to be improved, as well as access to cardiology wards and services. A heart failure management plan to be devised by CNS and submitted for approval in accordance with NICE quality standards for chronic heart failure. When discharged patients to be given contact numbers of community cardioogy services. Appointment date or date of visits to be made prior to discharge. Contact numbers for hospital based CNS to be given to patients prior to discharge.
Integrated Medicine	Pneumonia Mortality Review, CQC response (Clinical Effectiveness Work Stream)	Yes	Respiratory Consultant to review all primary diagnoses of Pneumonia on a monthly basis to ensure accuracy of data. Liaise with the Clinical Commissioning Group and local public health group to implement the British Thoracic Society pneumonia care bundle. To improve documentation and increase awareness of the importance of recording CURB 65 scores in patients with community acquired pneumonia amongst medical staff through foundation teaching sessions
Integrated Medicine	To assess if stroke risk in patients seen with Atrial fibrillation is being identified and treated (unless CI) as per European Society of Cardiology guidelines update 2012	Yes	Teaching session to be arranged to cover formal risk scoring of stroke risk by CHADsVASc score in patients in persistent atrial fibrillation and to cover formal risk scoring calcualtors available. To await introduction of new anticoagulation charts which will have provision of stroke risk assessment. To include the re-audit to the audit plan for 2015/16 and carry out in 6 months time.
Integrated Medicine	Management of Acute Kidney injury	Yes	The Trust Acute Kidney Injury pathway to be updated to reflect the latest clinical guidelines. The updated pathway to be disseminated to trainee doctors in the form of posters on MAU and A&E. The pathway will be uploaded onto the intranet under guidelines and will also be included in the RFT acute medical emergencies book. Patients with Acute Kidney Injury not responding to initial therapy should, after senior review, have ultrasound scans within 24 hours. Discussions will take place between directorates about how to deliver service change effectively. A senior review of all patients with actute kidney injury should take place within 12 hours of development, this update will be incorporated into the pathway.

Integrated Medicine	Audit of DEXA scanning (Osteoporosis - referrals with a known vertebral fracture will be referred to Bone Health Clinic)	Yes	To educate and increase awareness amongst clinical staff about the need for all patients with vertebral fractures to be referred for a DXA scan. This will be carried out via Grand round/PG lecture. Service development discussions to take place with the CCG regarding a Fracture Liaison Service.
Integrated Medicine	Audit of TB services across Rotherham	Yes	Patients identified as a contact of TB will be sent a patient satisfaction questionnaire. Documentation (templates) currenlty in use in the contact clinic will be reviewed, a new template will be created to support future audits and to improve record keeping. The TB nursing service will be reviewed in relation to succession planning and options will be identified to support the TB Specialist Nurse to provide a continuous service. The contact tracing audit will be added to the list of potential audit projects for 2015/16 as a re-audit.
Integrated Medicine	30 day stroke mortality	Yes	To educate junior doctors and nurses in other wards about the early referral of stroke patients to the stroke team, this will be done through induction meetings and further training. To have discussions with the hospital management team regarding the provision of two free beds in the stroke unit to facilitate the timely transfer of patients. Education to be provided to the stroke nurses regarding timely swallow assessment and clear documentation within the notes. Discussions to be had with the Radiology department in respect of providing early CT scans.
Integrated Medicine	Consent 2014	Yes	A larger sample of notes to be audited next time this audit is undertaken and to include within the sample patients who need consent form 4. Capacity assessment to be documented and measured at the next audit. All wards to have information leaflets available for common procedures like ODG and colonoscopy.
Integrated Medicine	CRMC/UCMC Follow ups - Gastroenterology	Yes	No actions required
Integrated Medicine	Septic bundle re-audit (Sepsis six)	Yes	No actions required
Integrated Medicine	Audit of management of encephalitis	Yes	No actions required
Integrated Medicine	Reaudit of management of status epilepticus	Yes	No actions required
Integrated Medicine	Ward B1 (Medical Assessment Unit) performance indicators (Clinical Effectiveness Workstream)	Yes	No actions required
Integrated Medicine	Re-audit of antipsychotic use in the elderly	Yes	No actions required
Integrated Medicine	Acute Stroke Mortality	Yes	No actions required
Lab Med	Parenteral Nutrition Review 2013	Yes	No actions required
O&G	PGD for Emergency Hormonal Contraception - Levonorgestrel (PGD99v2)	Yes	Ensure access to appropriate annual Reproductive Sexual Health knowledge Update for all Sexual Assault Nurse Examiners
O&G	Audit of response time and attendance at SARC for forensic examinations.	Yes	Amend the Forensic Proforma which will prompt SANEs to document when compliance has not been met or give a reason why

O&G	Audit of Caesarean Section against NICE Quality Standards	Yes	Email/educate midwives and put notices in antenatal area that women should be offered VBAC following up to 2 Caesarean sections. Also send memo to community midwives to remind them that women can still have vaginal birth after 2 C/Ss. Add prompt on record for booking of elected C/S to record when discussed with consultant at >39 weeks, and remind trainees at induction of the coding page on reasons for CS <39 weeks. Inform trainees at induction to record in C/S notes when post-operative instructions and information given. Also Inform trainees to clip the letter explaining reasons for C/S to the info leaflet: "Choices of birth after Caearean Section". Add topic to the list of re-audits for 2015/16 plan.
O&G	Cardiotocography (CTG)/Fetal Blood Sampling in Labour	Yes	Feedback the following to all during labour ward handover: Documentation, Maternal vital signs, Documentation on CTG. Feedback to Coordinators' meeting hrly review of CTG and documentation. Feedback results to doctors at CTG meetings Complete proposal forms to register quarterly re-audits.
O&G	New-born Feeding	Yes	Double check readmissions against list from Clinical Effectiveness and retrospectively generate an IR1 for all readmissions to ensure all readmissions are reported on Datix. Update staff at annual mandatory training, that all babies to be weighed on readmission, and provide individual feedback where applicable. Provide training to CYP doctors that all babies should have bloods taken to check U&Es on readmission. Update staff at annual mandatory training, and provide individual feedback where applicable to: improve general documentation of infant feeding assessments and problems; that both breast fed and bottle fed babies should be observed feeding on readmission, and discussion re technique documented; Breastfeeding assessment to be completed on Day 3-4 to help identify problems early and allow feeding plan to be implemented before readmission becomes required; to use sticker to document discussion when supplements to breastfeeding commenced. Review audit tool before commencing data collection for re-audit, to ensure all the standards are reflected in the data.
O&G	Surgical management of ectopic pregnancy	Yes	Feed back to trainees on induction in August, and draft a memo to say: Methotrexate to be offered to all eligible women: (B HCG <1500, consider in B HGC 1500 – 5000). Ensure clear documentation of time of procedure. Do not offer routine B HGC F/up test post-op. routine salpingectomy; Offer Urine pregnancy test at 3 weeks post op. Feedback individual cases of negative laparoscopy to sonographers, and contact ICE administrator and radiographers to establish best method of feedback via PACS/ICE. Re-audit mid 2016 (sample June 2014 - 2016)

O&G	Category 1 & 2 Caesarean Section audit	Yes	Place notices in theatre on LW, and remind everyone at LW handover meeting, that it is the operating surgeon's responsibility to ensure completion of WHO checklist on Labour Ward is done. Determine an achievable standard to achieve for the WHO safety checklist completion. Put reminder into caesarean section Operation notes in labour birth notes to improve the consultant notification in case of categoary 1 and 2 caesareans Disseminated an audit summary to Labour Ward staff to ensure they know where improvements have occurred, and also disseminate audit to anaesthetic department who were unable to attend the audit presentation. Discuss at audit meeting to set date for reaudit, and include new WHO standard.
O&G	Audit of Documentation	Yes	To send individual results to Consultants regarding the areas of their medical documentation that did not meet the standard, with the aim of improving documentation. To Produce a guidance document on the methods used for the audit, so that this can be followed in future rounds of the audit to ensure that results are comparable. Develop a crib sheet to remind medical staff of the expected documentation standards. Redesign the care pathway to include reminders for patient demographics on each page.
O&G	Cervical loop biopsy as a single piece	Yes	Send reminder email to Histopathology Hospital Based Programme Co-ordinator and colposcopists involved that the number of specimen pieces should be recorded on histology request form, and to record reasons for fragmented specimens in case notes. Re-audit in 2015/16.
O&G	Management of patients seen in triage with spontaneous rupture of membranes (SROM)	Yes	Add to Labour Ward lessons to staff:- Encourage staff to use the telephone advice record, and Staff to use the reviewed patient information leaflet for discussion and advice on timing of delivery and to ensure the discussion is documented.
O&G	Heavy menstrual bleeding	Yes	To send letters to GPs to raise awareness of pathway for Heavy Menstrual Bleeding and availability of dedicated 1-stop Menorrhagia clinic, and to incorporate protocols for management of HMB, and continue to audit against peers.
O&G	The management of Group B Streptococcus in pregnancy/postnatal	Yes	Design and print stickers for antenatal documentation of Group B Strep. Discuss requirement with Dr Macfarlane to establish whether there is a need for paediatric alert for previous GBS, and a need for 12 hour follow up for well babies with previous GBS. Design sticker for 4 week GBS diary. Update guideline to reflect changes
O&G	Audit of Vaginal Birth after Caesarean Section (VBAC)	Yes	Raise awareness in Antenatal clinic by presenting audit to ensure consultant involvement in decision making for VBAC vs ERCS is recorded and audited in next audit. Ensure this issue is audited in next audit as part of NICE Quality standards requirements. Draw awareness to stickers VBAC v s ERCS at induction of new doctors. Raise awareness of need to ensure consultant decision to use oxytocin in previous CS patients to augment labour, at the Band 7 meeting. Increase frequency of observations during IOL. Re-audit 2015-16
O&G	Body Mass Index >= 40 in pregnancy	Yes	To present data to midwives and place reminders in Greenoaks so that they are aware of significant improvements made. Improve referral to 36 week appointment with Healthcare Assistant and documentation about intended weight Management post delivery by raising awareness in Greenoaks. Review capacity of Anaesthetic High BMI clinic. Feedback audit results and most up to date BMI figures to Public Health dept as follow up to meeting on 9th July 2014.

O&G	Audit on detection and management of mental health illness in pregnancy	Yes	Revise Antenatal information leaflet. Speak to community midwives, regarding provision of information and possibly carrying spare copies to improve distribution of Antenatal Information leaflet. Include in the mandatory teaching to improve 3rd trimester risk assessment. Revise care plan to improve documentation of care plan in hand held notes
O&G	Cardiotacography (CTG) and Fetal Blood Sampling (FBS) in labour	Yes	Feed back the learning points at handover on Labour Ward and display audit results on Labour Ward notice board. Discuss appropriate classification of CTG at CTG meetings and mandatory teaching.
O&G	Readmissions to the postnatal ward within 30 days (Clinical Effectiveness Workstream)	Yes	Arrange Infection control training for theatre staff to reduce infection rate. Ensure midwives advise and educate patients on postnatal ward for self-care and recognition of symptoms and to continue in community. Discuss provision of Community support and perineal trauma clinic in joint consultant meeting. Register Service Evaluation project to review threshold for admission with endometritis. Print SIRS diagnosis criteria in Post natal records. Update database and add new fields to collect extra audit criteria. Use most accurate data for monthly dashboard, from January 2015. Feedback to midwives to promote completion of VTE Risk assessment and Datix forms for suspected VTEs. Revise study day for community midwives to include key postnatal scenarios. Present ongoing re-audit in 6 months.
O&G	Continuous audit of forensic record keeping standards	Yes	No actions required
OMFS	Documentation of sensory loss with fractured mandible - re-audit	Yes	Highlight the importance of recording sensory loss to new-starter Senior House Officers through a teaching session and re-audit during 2015-16.
OMFS	Consent 2014	Yes	Deliver a teaching session for Senior House Officers on retrobulbar haemorrhage and discuss the eye observation protocol with nursing management.
OMFS	Assessing Maxillofacial note keeping using Crabel scoring	Yes	Ensure all new staff are aware of documentation requirements by circulating the standards to all staff at the next Clinical Effectiveness and Governance meeting.
OMFS	Audit of the Appropriateness and Quality of Referral Letters	Yes	Develop new referral proforma and discuss with the Local Area Team for dentistry to ensure this is implemented. Deliver lecture to educate local dental practitioners on referral criteria and the 'ideal' letter.
OMFS	Audit of inpatient medical documentation	Yes	No actions required
OMFS	Management of fractured mandibular condyles - do we meet national guidelines?	Yes	No actions required
OMFS	Do we follow guidelines for the management of dog bite wounds?	Yes	No actions required
OMFS	Time to treatment for mandible fractures	Yes	No actions required
OMFS	Response times to A&E for OMFS	Yes	No actions required

Ophthalmology	Patient Group Direction Audit - Eye Drops for Ophthalmic Surgery	Yes	Ensure staff document that the medication has been given under a Patient Group Direction and consider changing the treatment chart in the new integrated care pathway (ICP) to accommodate this means of drug administration. Distribute copies of the PGD to staff and ensure each member of staff is assessed for each PGD by producing a training and assessment pack.
Ophthalmology	Audit of Outcomes of Cataract Surgery	Yes	Ensure that complications, pre and post-operative refraction and target of refraction are documented in theatre in the patients notes, electronic eye log and theatre note book by performing regular checks. Ensure all cases are followed up on the ward 1 week post-operatively by nurse practitioners and have refraction data recorded in the eye log book.
Ophthalmology	Re-audit of Retinopathy of Prematurity Screening	Yes	Amend proforma to include a section on whether an information leaflet has been given to the patient. Contact Special Care Baby Unit to ensure referrals are made/forecast earlier (by one week) to ensure all babies are seen in time. Re-audit performance to ensure standards are maintained.
Ophthalmology	Reaudit of Outcomes of Cataract Surgery	Yes	Ensure complications are fully documented in the theatre book by emailing all surgeons reminding them that this should take place. Liaise with ward B6 nurses to ensure all patients are recorded within the log book and are offered a one week follow up appointment.
Ophthalmology	Lid Basal cell carcinoma clearance margin	Yes	Establish local standard for clear margins (to be set at 90%) and re-audit performance during 2015. Refine audit database to ensure data collection is appropriate.
Ophthalmology	Consent 2014	Yes	Email all staff to remind them to re-confirm consent forms with the date and signature of a health professional and ensure contact details are provided.
Ophthalmology	Reaudit of clinic discharges in first appointment patients	Yes	Ensure discharge guidelines are adhered to by reminding all colleagues to follow the discharge guidelines at the Ophthalmology Clinical Effectiveness meeting and inform all new staff of the standards when joining the trust.
Ophthalmology	Documentation 2014 - Ophthalmology	Yes	Inform colleague not adhering to the standard of using black ink. Consider the use of stamps to improve the level of detail recorded for each medical entry - liaise with Governance facilitator regarding the feasibility of this. Remind all colleagues of the required standards at the Ophthalmology Clinical Effectiveness meeting. Liaise with nursing staff to ensure pages are placed in chronological order.
Ophthalmology	Patient Group Direction Audit - Tropicamide 1% eye drops	Yes	No actions required
Ophthalmology	The outcome of Eylea treatment in Age Related Macular Degeneration	Yes	No actions required
Orthopaedics	Audit of World Health Organisation (WHO) Surgical checklist in Orthopaedics	Yes	Make staff aware of the deficit in completing the World Health Organisation Surgical checklist by placing a poster in theatres. Re-audit performance.
Orthopaedics	Audit on Podiatry Notekeeping	Yes	Update the initial assessment documentation sent to patients to include all relevant patient information (ethnic group, occupation, emergency contact name and emergency contact number). Consider adjusting the SystmOne patient record template to ensure all elements of the assessment and care plan are recorded consistently.

Orthopaedics	Re-audit of WHO Surgical Checklist in Orthopaedics	Yes	Share findings with World Health Organisation (WHO) task and finish group.
Orthopaedics	Blood glucose monitoring in neck of femur fracture admissions	Yes	No actions required
Orthopaedics	Audit for fracture clinic patients referrals and services	Yes	No actions required
Palliative Care	National Care of the Dying Audit-Hospitals (NCDAH) - Round 4	Yes	End of life working group to be established to undertake/oversee the evolving work plan
Palliative Care	Audit of End of Life Care Pathway (SNAP)	Yes	No actions required
Radiology	Computed Tomography Head Accident and Emergency timings	Yes	The weekly rota will be reviewed to allow for availability of a second "reporter" on weekday afternoons to asssit with the workload. CT staff will be reminded to inform the reporting radiologist as soon as the scan is completed so as to report in a timely manner. Reporters will also be reminded of the importance of reporting A&E CT head scans in a timely manner. The above will be discussed at the department Clinical Effectiveness meeting. A re-audit of reporting times will be registered with the Clinical Effectiveness department and undertaken in February 2015.
Radiology	Diagnostic Reference levels in Plain film	Yes	Dose reference levels to continue to be monitored as part of current practice. The senior radiographer to investigate and review the persistent increase in dose levels in room 1 for lumbar spine films. The findings will be presented at the radiation protection and the department clinical effectiveness meetings. To include the audit on the 2016 audit plan.
Radiology	Diagnostic Reference levels in Nuclear medicine	Yes	To ensure that all patient doses are within the 10% discrepancy allowance. All details to be recorded both on the request card and on RIS. This will be discussed with and staff reminded at a staff training meeting. A re-audit to be undertaken as part of the 2015/16 audit programme.
Radiology	Request card details and patient checks (Ionising Radiation (Medical Exposure) Regulations 2000) audit	Yes	All staff to be reminded via staff training meeting regarding 28 day rule and breast feeding status and that the information should be recorded on the RIS QDoc system, regarding request justification and ARSAC details, to ensure staff record justification on the request card itself and that all details to be recorded on QDoc system and request cards to be scanned. To include the re-audit on the audit plan for 2015/16.
Radiology	Reaudit of NICE guidance CG144 (June 2012) on Venous Thromboembolic Diseases	Yes	Present audit findingss at a medical audit meeting to discuss the 'N/A' dimer results. Re-audit to be undertaken as part of the 2015/16 audit plan.
Radiology	Diagnostic Reference levels in Computed Tomography Scans	Yes	Continue to Monitor and ensure doses are in line with NRPB levels. CT head doses to be reviewed to ascertain the cause of high doses. Further training in progress.
Radiology	Patient Group Direction Chlorphenamine	Yes	No actions required
Radiology	Audit of side effect profile of Regadenoson for cardiac stressing	Yes	No actions required

Rheumatology	Documentation 2014 - Rheumatology	Yes	Remind all staff at the Rheumatology Clinical Effectiveness meeting to print their name and designation for all entries in case notes. Carry out a spot check in April 2015 to assess improvement.
Rheumatology Integrated Medicine Haematology	Audit of Prophylactic treatments of Osteoporosis for patients on steroids (within Rheumatology, Haematology and Medicine)	Yes	Produce a Prednisolone consent form/checklist to ensure patients receiving oral glucocorticoids for 3 months or longer receive the appropriate treatment, general advice and Bone Mineral Density scans as required to prevent and manage osteoporosis. Ensure patients receive educational material for Osteoporosis - discuss with Osteoporosis Specialist Nurse and check leaflets are available in the information centre in the hospital reception.
Safeguarding CYP Service	Safeguarding section 11 self audit	Yes	Source provision of relevant training to TRFT Board members. Discussion with Patient Safety and Experience Lead on mechanism to enable children and young people to raise concerns regarding any RFT service that they access. Feedback Ratification of threshold descriptors to performance and quality subgroup. Chief Nurse to provide a quarterly report to the RFT Board which provides information from Governance Manager C&YPS regarding any complaints or incidents which include a safeguarding children concern. Engage with the youth council to establish young peoples involvement with the TRFT board of governors. A new corporate template for Job descriptions now issued to new recruits with a section detailing safeguarding responsibilities for children and adults , and Director of Human Resources to issue all existing employees with an addition to their current Job description outlining their safeguarding responsibilities. Extend specialist safeguarding supervision in C&YPS to include caseload holders in the Complex Care Team. Include the Matron and Ward Managers in the supervision training plan. Ensure all trained staff attend supervision as procedure. Discuss with lead members within the Surgical clinical services unit, to review servivces for children and young people attending the hospital for elective surgery, both on the children's ward and day surgery unit. Provide Safeguarding leaflet to all TRFT staff at corporate induction. Communicate the need to review internal processes and confirm criteria for referral to LADO, to be reflected in the Disciplinary Procedure. Work closely with Human resources and the Chief Nurse to establish a baseline of current CRB checks and review of current roles subject to CRB checking. Agree and implement Early Help Thresholds across all services to support early intervention and referral to the right services, to be launched by RMBC. Review and update the RCHS Policy for Sharing Children and Young People's Health Records using SystmOne, to include both EPR and paper records across health services.
Safeguarding CYP Service	Audit of SystmOne child health records to determine timeliness of flagging of records following discussion at MARAC	Yes	Ensure there is a standardised pathway in place to add and remove a flag to a child's SystmOne electronic health record following discussion at MARAC, and ensure that pathway not only meets with TRFT and MARAC Protocols but leaves audit trail. Review transfer of flag from pregnant mother's record to newborn following delivery. Review Special Alert Policy to ensure it makes reference to required timescale for applying MARAC flag. Make enquiry with with Information and Performance Team regarding flagging of MEDITECH records for children discussed at MARAC.

Therapy Services & Dietetics	Audit of compliance by Orthopaedic Physiotherapy Practitioners to the Injection Patient Group Direction within Therapy Services	Yes	Meeting to be held to feedback the audit results to all Orthopaedic Physiotherapy Practitioners and highlight where the audit failings were. An injection checklist for documentation to be circulated and discussed with the Orthopaedic Physiotherapy Practitioners. Expiry date checker to be put up in the drug cupboard. All Orthopaedic Physiotherapy Practitioners to receive written feedback in respect of the results following the audit.
Trust wide	Emergency Admissions (CQUINs)- Over 80s	Yes	No actions required
Trust wide	Emergency Readmissions Audit 13/14	Yes	No actions required
Urology	Reaudit of Stent Registry use	Yes	Ensure all stents inserted are recorded on the registry - determine compliance by Consultant and discuss with individual Consultants if required.
Urology	Consent 2014	Yes	Discuss completion of the 'type of anaesthesia' section with Anaesthetics and replenish stock of patient leaflets in Outpatients and Endoscopy.
Urology	Outcomes of Pyeloplasty surgery	Yes	Monitor outcomes of Pyeloplasty surgery prospectively and inform all staff that if surgery is taking 2 hours longer than expected, a second Consultant should be contacted.
Urology	BAUS: British Association of Urological Surgeons - Nephrectomies 2013	Yes	Implement the enhanced recovery programme to provide additional information to patients and nurses - review and update documentation and roll out across pre-assessment and ward staff. Ensure operating time is accurately recording by reminding all staff at the Clinical Effectiveness & Governance meeting.

PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving relevant health services provided or subcontracted by the Rotherham NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 403 compared to 569 in 2013/14.

Table 12 shows the number of active studies underway, table 13 shows numbers of Rotherham patients recruited to portfolio studies where the Trust is hosting a study, the total number was 403 patients. Table 14 also shows the number of studies currently undergoing approval within the Trust.

Table 12: Active Studies

Study Type	Number of Studies
Commercial	**9**
Portfolio (in PIC registered)	**84**
Own Account	**1**
Other Non-portfolio	**7**

Table 13 : Recruitment

Study Type	Patient Recruits
Hosted Portfolio Study	403
PIC Registered Portfolio Study (Cancer Research Network)	N/A

Table 14 Studies currently undergoing approval

Study Type	Number of studies
Commercial	2
Portfolio (inc PIC registered)	15
Own Account	0

Nb.These figures present the picture at the end of quarter 3 and will be updated to reflect year-end prior to final publication.

GOALS AGREED WITH COMMISSIONERS: CQUIN FRAMEWORK

To be updated for 2014/15 when available

A proportion of Trust income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between TRFT and any person or body that entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework (CQUIN). Further details of the agreed goals for 2014/15 will be made available electronically when finalised, on the Trust website and will be included in the finance report presented to the Board of Directors and the Council of Governors

(web link to be added when available)

The link to the CQUIN schedule for 2015/16 will be added to the report once available following agreement with Commissioners. The value of income dependent on achieving CQUIN goals for the year 2014/15 was XXX this represents XX% of the Rotherham CCG contract, compared with £Xm the previous year.

Tables presenting progress against CQUIN goals for 2014/15 will be included at appendix X, and presenting forward plans for 2015/16 at appendix X

CQC REGISTRATION AND PERIODIC REVIEWS / SPECIALIST REVIEWS

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'fully compliant'. The Rotherham NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The Rotherham NHS Foundation Trust during 2014/15.

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

However, the Trust was subject to a routine, announced inspection between 23rd and 27th February 2015. 65 CQC Inspectors reviewed services across the eight acute and four community 'core services' as follows:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical Care
- Maternity & Gynae
- Services for children and young people
- End of life care
- Outpatients & diagnostic imaging
- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- Community end of life care.

The draft inspection report from the CQC is due in April 2015. The Trust will have a short window within which to check the report for factual accuracy. A 'Quality Summit' will be held in May / June 2015 which will involve the Trust, the CQC, Monitor and the Trust's health and social care partners (e.g. Rotherham Clinical Commissioning Group and Rotherham Metropolitan Borough Council). The purpose of the Quality Summit is to agree a plan of action and recommendations based on the CQC's inspection report and to challenge whether the Trust's quality improvement plans are adequate or not. It is also designed to decide whether support should be provided to the Trust from other stakeholders (e.g. commissioners) to help the Trust to achieve any required improvements.

Once published a full copy of the CQC report will be able to be accessed at www.cqc.org.uk

In addition to the announced inspection of the Trust's acute and community services, during the same week in February 2015 the CQC also undertook a review of services for children looked after and safeguarding in Rotherham. This was a joint review involving the Trust; NHS England; Rotherham, Doncaster and South Humber NHS Foundation Trust and Rotherham Clinical Commissioning Group. The draft inspection report is due in late March and the Trust will have a short window within which to check the report for factual accuracy. The action plan from the review was created contemporaneously and its implementation is being managed via the Joint Adults and Children Safeguarding Operational Group and assurance is provided by this group to the Joint Adults and Children Safeguarding Professionals Group chaired by the Trust's Chief Nurse.

At the end of March 2014 the Trust received an alert from the CQC notifying the Trust that the CQC's analysis had indicated significantly high mortality rates for patients admitted as an emergency with a primary diagnosis of pneumonia. This was fully investigated and it was found that there are a number of factors which contribute to pneumonia rates in the Rotherham community including high risk occupations, heavy

rates of smoking and air pollution. However the investigation also concluded that the issue of coding was a significant factor in the apparent discrepancies regarding the Trust's outlier status and that the implementation of the British Thoracic Society Pneumonia Care Bundle was associated with improved outcomes for patients.

The Trust implemented an action plan to address its outlier status for pneumonia mortality and in July 2014 the CQC notified the organisation that it was satisfied that it did not need to undertake any additional enquiries relating to this issue. The Trust continues to closely monitor its position via an audit of all patients diagnosed with pneumonia.

During 2014/15 the Trust has continued to progress its action plan from 2012 to ensure that its mortality rates for patients admitted with septicaemia (except in labour) remain within the expected range.

The Trust is required to report any breaches of the Ionising Radiation Regulations to the CQC and in year six such breaches were reported (three the previous year).

May 2014	**Unnecessary thoracic and lumbar spine examination**
August 2014	**Incorrect examination (cardiac CT instead of Mesenteric CT angiogram)**
September 2014	**Incorrect teeth examination**
November 2014	**Incorrect section of the jaw exposed when taking a sectional orthopantomogram**
February 2015	**Unnecessary shoulder examination**
February 2015	**Incorrect patient referred for head CT examination**

Each incident has been investigated and all have been escalated through to the Diagnostics and Support divisional governance meeting and onto the Trust's Operational Quality, Safety & Experience Group in order to provide assurance as to the quality of the investigation and the robustness of the remedial actions taken. Since the 2013/14 Quality Report the basis for reporting breaches of the Ionising Radiation Regulations to the CQC has been lowered: previously reports were made on the basis of the radiation dose received by the patient and only incidents over a certain dose were deemed to be reportable to the CQC. This threshold has now been removed meaning that all breaches of the Ionising Radiation Regulations must be reported to the CQC which accounts for the increase in incidents reported by the Trust during 2014/15.

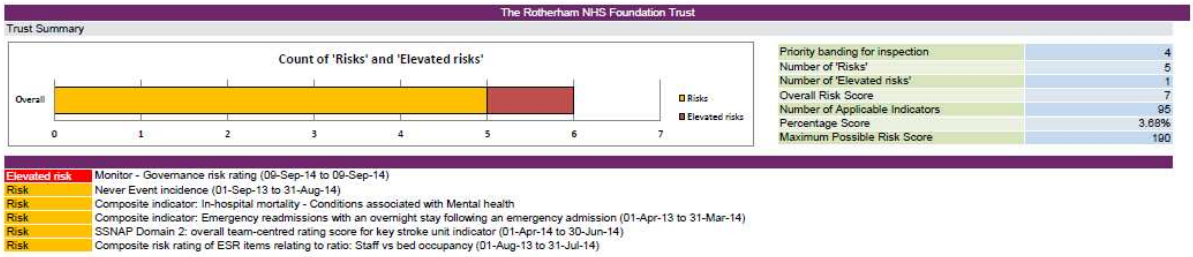
Each incident has been investigated and in March 2014 the Quality Assurance Committee reviewed progress against the action plans agreed with the clinical lead for radiology in order to be assured that internal process failures are not likely to be repeated. That assurance was obtained and the committee members were satisfied that each of the three patients involved had been notified of the incident and all staff involved have been reminded of their personal accountability for compliance with Trust policy and procedure.

During 2013/14 the CQC changed the way it assesses the risk of healthcare providers being in breach of standards. In October 2013 the first 'Intelligent Monitoring' reports were introduced. These reports are published 3 times a year and provide the public and the Trust with the CQC's assessment as to the likelihood of the organisation failing to meet one of the CQC's essential standards of quality and safety.

Each report assigns the Trust to a 'priority banding for inspection'. There are 6 bands, 1 being the band representing the highest risk of the Trust failing to meet the CQC's standards and 6 being the band representing the lowest risk of breaching the standards. In the first two Intelligent Monitoring reports (October 2013 and March 2014) the Trust was assigned a band 4 position with a risk score of 7 in both reports. In the July 2014 report the Trust's position dropped to band 2 with a risk score of 12 due to 8 identified risks of which 4 were elevated risks as follows:

- Emergency readmissions with an overnight stay following an emergency admission
- Overall team-centred rating score for key stroke unit indicator
- Monitor - Governance risk rating
- Provider complaints

Following the implementation of a robust action plan, the Trust recovered its band 4 position in the December 2014 Intelligent Monitoring report with a risk score of 7 due to 6 risks, one of which was an elevated risk relating to the fact that the Trust is in breach of its Provider Licence with the Foundation Trust regulator: Monitor as detailed in the image below:



All of the Trust's Intelligent Monitoring reports are available on the CQC website. The next Intelligent Monitoring report for the Trust will be published in May 2015.

Throughout the course of the year the Trust has maintained contact with the CQC through regular conversations and correspondence with the Trust's Lead CQC Inspector and quarterly Engagement Meetings. No changes to the Trust's CQC registration have been required during 2014/15. A full copy of the Trust's registration certificate can be viewed at http://www.cqc.org.uk/provider/RFR/registration-info or by requesting a copy from the Company Secretary at the address below:

The Company Secretary
General Management Department
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Compliance with CQC standards is monitored internally through a sequence of service-level and Trust-level self-assessments and quarterly presentation to the Interim Medical Director and Chief Nurse reporting ultimately to the Quality Assurance Committee and the Board of Directors.

The standard most often self-assessed as at risk during 2014/15 was standard 13 – safe staffing levels which the Board and Quality Assurance Committee have reviewed monthly since October 2013 and more latterly with reports comparing actual staffing on adult in-patient wards against plan.

The average percentage fill rates for the 6 months to the end of February 2015 were as follows:

- Registered Nurse day shift: 94.5%
- Health Care Support Worker day shift: 103.9%
- Registered Nurse night shift: 98.5%
- Health Care Support Worker night shift: 109.6%

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SERIOUS INCIDENTS AND HER MAJESTY'S CORONER INQUESTS
Section to be updated when year-end data available

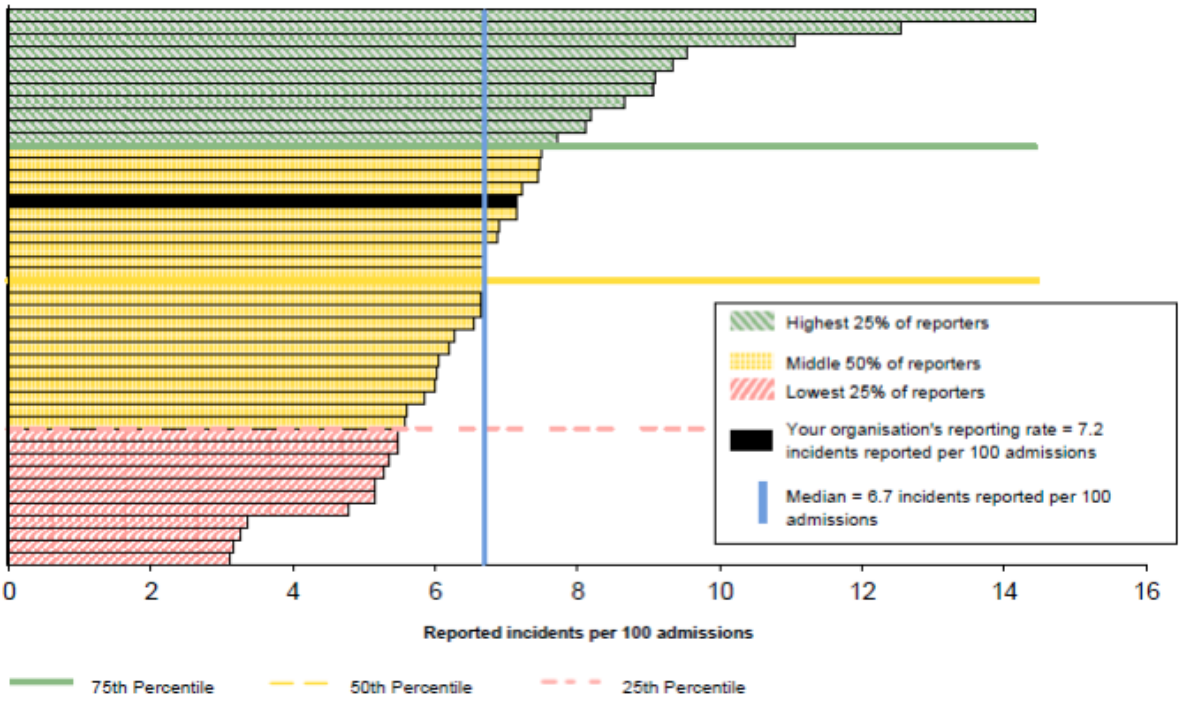
The Trust is reporting an increase in the number of serious incidents this year. The total number reported in 2013/14 was 23 and in 2014/15 was 41. This increase is due to the Trust aspirations to prevent harm. This requires zero tolerance and expectation of openness, candour and honesty in line with the Francis report recommendations. Every serious incident is investigated by a senior and experienced clinician not directly involved in the patient's care, and every report is presented to the Quality Assurance Committee, the Clinical Commissioning Group and is shared with the patient directly affected, unless they state that they do not wish to receive a copy of the report.

Inevitably each investigation identifies learning and action to be taken and assurance that those actions arising from incidents in 2014/15 have been undertaken will be sought through clinical audit in 2015.

To be updated when NRLS data published
In terms of benchmarking, the most recent published data by the National Reporting & Learning System reflects TRFT incident reporting to be above the Medium Acute Trust average per 100 admissions at 7.2 against 6. 7. In the previous reporting period, October 20122- March 2012, the Trust reporting rate was 6.9 per 100 admissions against a static median of 6.7.

In terms of severity the TRFT results are significantly better for % of incidents resulting in moderate/severe harm or death - with 1.6% against the medium acute average of 7%.

Table 15 (to be replaced - updated version due for release end March 2015)



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The total number of reported incidents of all types in 2014/15 was 10.458 compared to 9477 reported in 2013/14.[4] This increase is also indicative of a positive safety culture where staff are encouraged to adopt an open approach to reporting concerns and seeking to improve quality.

The Coroner and Justice Act 2009 created the role of Chief Coroner who came into post in September 2012. After engagement with Her Majesty's Coroners and other relevant groups new rules were drafted enabling secondary legislation to came into force in July 2013. This has resulted in new inquest rules, the Coroner having the power to require evidence and the introduction of a new criminal offence if information is not disclosed. This is a major change and extension of the recommendations identified in the Robert Francis QC Report issued in February 2013 that there should be a statutory "duty of candour" to ensure that any harm to patients is reported and is therefore relevant to all staff involved in an inquest. The Trust has taken a number of steps to ensure that the duty of candour is embedded into practice, including a full review of the Trust's policy for reporting concerns (whistleblowing policy) and action has been taken to ensure there are several routes through which colleagues are able to report concerns

The Trust has been issued with no inquest Rule 43 (letter) of the Coroners Rules 1984, as amended by the Coroners (Amendment) Rules 2008, over the course of 2014/15

DATA QUALITY 2014/15 to be updated with year-end data

The Rotherham NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data (up to and including November 2014). The percentage of records in the published data which included the patient's valid NHS

[4] This data is extracted from Datix, the Trust incident reporting system

number was 99.7% for admitted patient care, 99.7% for outpatient care and 87.8% for accident and emergency care (1st April 2014 – 30th November 2014 data only).

This compares with 99% having a valid NHS number for admitted care, 99.1% for out-patient care and 85.8% for accident and emergency April 2013 to March 2014

The percentage of records which included the patient's valid General Medical Practice Code was 99.8% for admitted patient care, 99.8% for outpatient care and 98.6% for accident and emergency care (April 2014 – November 2014 data only). At the time of publication of this report, the Health & Social Care Information Centre have not yet published full year comparative date in respect of SUS datasets for 2014/15. These percentages compare to 99.7% GP registration code for admitted care, 99.8% for out-patient care and 98.2% for accident and emergency care April 2013 to March 2014 .

Table 15

Areas selected for focussed improvement activity									
			Baseline Period	Baseline Value	Year end target	Qtr1	Qtr2	YTD November 2014
Improving Data Quality	IDQ_1	Data Quality Index (CHKS Live)	FY2013-14	95.9	Increase	96.3	96.6	96.0
	IDQ_2	Blank, invalid or unacceptable primary diagnosis (CHKS Live)	FY2013-14	0.6%	Decrease	0.3%	0.3%	0.43%
	IDQ_3	Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)	FY2013-14	9.4%	Decrease	9.4%	9.1%	9.0%
	IDQ_4	Sign and symptom as primary diagnosis (R codes) as second episode (CHKS Live)	FY2013-14	16.8%	Decrease	15.7%	16.4%	15.9%
	IDQ_5	SUS Data Quality - Admitted Patient Care: NHS number validity	FY2013-14	99.0%	Increase	99.5%	99.6%	99.7%
	IDQ_6	SUS Data Quality - Admitted Patient Care: Postcode validity	FY2013-14	99.8%	Increase	99.8%	99.7%	99.7%
	IDQ_7	SUS Data Quality - Outpatients: NHS number validity	FY2013-14	99.1%	Increase	99.6%	99.7%	99.8%
	IDQ_8	SUS Data Quality - Outpatients: Postcode validity	FY2013-14	99.9%	Increase	99.8%	99.9%	99.9%
	IDQ_9	SUS Data Quality - Accident and Emergency: NHS number validit	FY2013-14	85.8%	Increase	87.8%	87.8%	88.1%
	IDQ_10	SUS Data Quality - Accident and Emergency: Postcode validity	FY2013-14	99.4%	Increase	99.3%	99.3%	99.2%

Data Quality Index (HRG4 based)

The Trust has achieved improvement but is still focussing on further improvement in order to ensure this target is reached, this being to reach our index score against 2013-14 for data quality 95.9. Currently the Trust value for 2014-15 is 96.0 against HES peer value of 95.4. At the time of report publication data beyond November 2014 is not available therefore not all episodes are included, it is likely that these will drive up the year end figure once refreshed hence the full year index score will improve.

Blank, invalid or unacceptable primary diagnosis rates (HRG 4 based)

The Trust has achieved considerable improvement against this target for 2014-15 and work is continuing to ensure the target is fully met. March data is not yet available for inclusion at this stage. The rate for the Trust of 0.43% blank primary diagnoses against 1.43% for HES peers at year to date remains favourable. As per the Data Quality Index, this rate is likely to improve significantly as further outstanding episodes are coded.

Average diagnoses per coded episode

Trust performance in respect of this indicator has improved, achieving 4.1 compared to same period last year at 3.4 diagnoses per coded episode. Our performance against HES peers is lower than the 4.6 national average. It is anticipated that outcomes from the data quality and death certification improvement programmes will further positively influence this situation in the coming year.

Information Governance
TRFT Information Governance Toolkit Assessment Report overall score for 2014/15 was 62%. The Trust is disappointed that this year, self-assessment against the Information Governance Toolkit (IGT) has led to the decision to reduce from level 2 to level 1.

This is because whilst there is evidence against many of the standards that the Trust is compliant, there are some areas where further improvement is required or processes in development and not yet fully embedded. The Trust commissioned a process of internal audit of IGT evidence which supported this stance.

There is also insufficient evidence to re-assess the Trust as having achieved standards required of level 2 against Information Governance Training. It is a requirement that Trust staff undertake annual IG training with a target of 95% uptake. We have not been able to demonstrate that this is the case.

The overall score for 2014/15 is presented in table 16. In 2013/14 the overall score was 66%

Table 16

	Overall Score	**Grade**
Information Governance Management	60%	1
Confidentiality and Data Protection Assurance	66%	1
Information Security Assurance	60%	1
Clinical Information Assurance	66%	1
Secondary Use Assurance	62%	1
Corporate Information Assurance	55%	1
Overall	**62%**	**1**

A strong focus will be placed on regaining level 2 status on the IGT next year, with an action plan being developed under the leadership of the Senior Information Risk Officer and Information Governance and Security Manager. Progress will be monitored at the IG Steering Group, which in turn will be overseen by a sub-committee of the Trust Board

It is regrettable that despite all actions taken to increase the uptake of Information Governance training and to embed the new policy relating to the safe management of post, the Trust reported 3 serious incidents involving person identifiable information being sent to a member of the public in error. These incidents are automatically brought to the attention of the Information Commissioner through the on-line incident reporting tool. Processes for monitoring and audit have been put in place to evaluate how effective these measures have been and additional training and awareness sessions

are to take place for all admin and clerical staff. Additional in-depth Information Governance awareness sessions via the Select and Connect programme are also taking place for senior members of staff.

Clinical Coding

TRFT was subject to the Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission and the error rates (%) reported for that period for diagnosis and treatment coding were:

- Primary diagnosis 12%
- Secondary diagnosis 19.7%
- Primary procedure 0.9%
- Secondary procedure 8.4%

In respect of clinical coding audits, the results should not be extrapolated further than the actual sample audited. TRFT's Clinical Coding Department has undergone the annual PbR audit in Feb 2015. 200 sets of case notes, 100 from Ophthalmology and 100 from Paediatrics for the period 2013 – 2014 were selected.

TRFT will be taking the following actions to improve clinical coding data quality:

- Continue carrying out regular internal audits across specialties using the devised new internal audit methodology, which heavily depends on data analysis.
- Continue using intelligence to flag up potential coding and data quality errors and generate regularly reports to monitor coding and data quality, using the ever expanding locally designed clinical coding indicators.
- Continue engaging clinicians cross specialties and create coder/clinicians two way communications through coding/documentation review sessions.
- Continue in-house coding training sessions organised with the consultants.
- Exploring possibilities of letting clinicians validate their own data, extending from the mortality data validation to morbidity data section.

These actions are expected to enable and deliver significant improvements in all aspects of data quality.

Department of Health Mandatory Core Indicators for Acute Trusts

The Department of Health asks all trusts to include in their Quality Accounts information on a core set of indicators, using a standard format. This data is made available to by the Health and Social Care Information Centre and in providing this information the most up to date data available to us has been used and is shown in table 18, providing comparison with peer acute trusts.

In the following table 19, a rationale for these figures is provided

Table 18 – table to be updated when year end data available

Domain	HSCIC Ref	Indicator name	Latest & previous reporting periods	TRFT value	TRFT previous value	Acute Trust average	Acute Trust previous average	Acute Trust highest value	Acute Trust previous highest value	Acute Trust lowest value	Acute Trust previous lowest value
Domain 1 - Preventing people from dying prematurely	P01544	Summary Hospital Mortality Indicator – Value	Oct 12_ Sept 13	1.08	1.08	1.0	1.0	1.12	1.21	0.88	0.68
	P01544	Summary Hospital Mortality Indicator – Banding	Oct 12_ Sept 13	2 ("As expec ted")	2 ("As exp ecte d")	2.06 (n=141)	2.07 (n=142)	1 ("Highe r than expecte d")	1 ("Highe r than expecte d")	3 ("Lower than expecte d")	3 ("Low er than expec ted")
	P01544	SHMI: Percentage of patient deaths with palliative care coding at *diagnosis* level	Apr2012-Mar2013/ Oct 12_ Sept 13	29.80 %	27.6 0%	13.59%	18.75%	44.90%	43.28%	0.00%	0.20 %
Domain 3 - Helping people to recover from episodes of ill health or following injury	P01551	Patient Reported Outcome Measure: Groin hernia surgery (EQ-5D Index) - health gain	Apr2012-Mar2013 Apr 13 - Sept 13	0.123	0.10 6	0.086	0.085	0.138	0.157	0.019	0.015
	P01551	Patient Reported Outcome Measure: Varicose vein surgery (EQ-5D Index) - health gain	Apr2012-Mar2013 Apr 13 - Sept 13	*	*	0.861	0.080	0.163	0.271	0.102	- 0.089
	P01551	Patient Reported Outcome Measure: Primary hip replacement surgery (EQ-5D Index) - health gain	Apr2012-Mar2013 Apr 13 - Sept 13	0.445	0.54	0.447	0.429	0.792	0.791	0.223	0.207
	P01551	Patient Reported Outcome	Apr2012-Mar2013 Apr 13 -	*	0.34 3	0.585	0.321	0.585	0.621	0.255	0.111

		Measure: Primary knee replacement surgery (EQ-5D Index) - health gain	Sept 13								
	P00911	Readmissions within 28 days (same trust) 0-15 years old (Standardised % - medium acute for comparison)	April 2011-Mar2012/ April2010-Mar2011	9.05%	10.29%	9.98%	9.73%	13.88%	14.35%	4.86%	5.18%
	P01552 (P00904)	Readmissions within 28 days (same trust) 16 & over (Standardised % - medium acute for comparison)	April 2011-Mar2012/ April2010-Mar2011	13.39%	12.79%	11.26%	11.17%	13.50%	13.00%	9.05%	7.68%
Domain 4 - Ensuring people have a positive experience of care	P01553 (P01391)	CQUIN: Responsiveness to patients personal needs	Sept2012 - Jan2013/ Sept 2011-Jan2012	67.6	69.9	68.1	67.4	84.4	85.0	57.4	56.5
	P01554	Staff who would recommend the Trust to their family or friends (Acute Trusts for comparison)	National Staff Surveys 2013 & 2012	51.2	50.6	64.5	61.7	88.5	85.7	39.6	35.3
Domain 5 - Treating and Caring for People and a Safe Environment and Protecting Then From Avoidable Harm	P01556	Percentage of patients admitted to hospital and risk assessed for VTE	Qtr 3 2012/13 - Qtr 3 2013/14	97.6%	92.0%	95.8%	94.1%	100.0%	100.0%	74.9%	84.6%
	P01557	Rate per 100,000 bed days of cases of C. Difficile amongst patients aged 2 or over	Apr2012-Mar2013/ Apr2011-Mar2012	11.8	19.1	17.3	22.2	30.8	58.2	0	0
	P01558 (P01394)	Patient safety incidents: rate per 100 admissions	Apr 2013 – Sept 2013 Oct2012-Mar2013/	8.31	7.9	7.6	Median 6.7	14.49	16.7	3.54	1.7

		(medium acute for comparison)									
	P01558 (P01395)	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	Apr2013 – Sept2013 Oct2012-Mar2013/	0%	0.09 %	0.67%	0.63%	3.1%	4.7%	0%	0.05 %

NB: * Reflects that adjusted health gain has been suppressed due to fewer than 30 modelled records being available

Table 18: Department of Health Mandatory Core Indicators for Acute Trusts: rationale for performance over 2013-14

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
The value and banding of the Summary Hospital Level mortality Indicator (SHMI) for TRFT	The Trust has continued to see incremental improvements with regard to SHMI, this is reflected greater in more contemporaneous data where the HSMR is used The Trust remains banded as 2 ('as expected')	The Trust has implemented a mortality review process, detailed as a quality improvement priority for 2015/16 in Section2. Review of mortality statistics will be incorporated into this process designed to analyse every unexpected in-patient death and ensure learning is identified and shared across the Trust.
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level	The Trust has a Consultant led Specialist Palliative Care Team who assess patients and identify those patients deemed to be receiving specialist palliative care. The Trust only includes those patients who are receiving care from this team	Monitoring via Trust Mortality Steering Group and Clinical Effectiveness and Research Group

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
Patient Reported Outcome Measures (PROMS) for · Groin hernia surgery · Varicose vein surgery · Hip replacement surgery · Knee replacement surgery	The data is considered to be accurate based on number of returns received and data accessed via HSCIC The Trust performs minimal numbers of varicose vein procedures therefore it is not possible to draw conclusions about the impact on patient experience from the data	Patient Reported Outcome Measures (PROMS) are a series of measures recorded by patients, pre and post operatively which measure how quality of life and health outcomes have improved. PROMS report slightly higher than national average on hip and knee operations and slightly lower on groin operations. This indicates no cause for concern and suggests that patients are experiencing improved quality of life following their operations. Routine monitoring to be maintained
Percentage of patients aged · 0-15 · 16 or over Readmitted to hospital within 28 days of discharge	TRFT 28 day readmissions have decreased against previous for 0-15 year olds and rate is lower than acute trust average. Re-admission rates have increased slightly for patients16 years or over and are higher than acute Trust average.	Continuing monitoring of this indicator via quality reports to the Quality Assurance committee

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
Trust's responsiveness to the personal needs of its patients	The Trust's position is drawn from the outcome of the five key patient experience questions included in the national in-patient survey as an indicator of patient experience. **CQC published data awaited**	Please see Part3: Quality Commentary for further details The Patient Experience, Engagement and Involvement strategy sets out the implementation plan for improvement in this area A monthly questionnaire is conducted in in-patient areas, focusing on those areas where improvement is require By the end of 2014/15, all clinical areas where appropriate, including children and young people's services, are participating in the Friends and Family Test which provides further information about the experience of patients and provides further opportunity for improvement. Final published CQC report is awaited, following which a full review of existing scheduled actions will be revised. Monitoring via Patient Experience Group to ensure appropriateness
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism	Figures published by HSCIC The Trust has again achieved and exceeded national target and improved on the year end position of 2013/14	The Trust will continue to be vigilant in monitoring this standard to ensure continuing improvement. The Trust's determination to maintain this standard is reflected in the selection of achievement of 96% harm free care as a quality improvement priority for 2015/16, which includes targets for this indicator. Further details in section 2.

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
Rate per 100,000 bed days of cases of C difficile infection	Figures published by HSCIC. Trust processes in data collection underwent external audit last year	Please see Part 3, Quality Commentary, for full details Robust infection prevention & control processes led by specialist team. Each case investigated in depth in order to identify the root cause - learning is identified and shared with goal of preventing recurrence. Infection Prevention & control Team undertake series of audits, inspections to ensure policy compliance. Continued monitoring via the Infection Prevention and Control Committee
Number and rate of patient safety incidents Number and rate of patient safety incidents that resulted in severe harm or death	National data awaited – April 2015 Based on published data by the National Reporting & Learning System. Last year TRFT incident reporting was above the Medium Acute Trust average per 100 admissions at 8.31 against an acute trust average of 7.6. (To be checked) In terms of severity the TRFT results for this period were significantly better for % of incidents resulting in moderate/severe harm or death - with 1.6% against the medium acute average of 7%. – updated position to be reviewed when updated information made available	Please see Part 2.4 for further details. Continuing monitoring, with a continuing goal to achieve internal target to increase rate of incident, reporting as a measure of a positive safety culture Monitoring via Patient Safety Group and Operational Quality, Safety and Experience Group Overseen by the Quality Assurance Committee

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
Friends and Family Test, question 12d 'if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	Department of Health's independent survey of staff opinion of each NHS Trust.	Please see Part 3: Quality Commentary for full details Staff engagement focus groups will be led by the Human Resources Department, providing staff with the chance to talk about the factors that influence their perception of the Trust as a place they would recommend for care or a place to work.

PART 3

OTHER INFORMATION – QUALITY COMMENTARY

This section of the report presents further information relating to the quality of services we provide. The information describes the Trust's performance against National Priorities and Core Indicators, as well as measures agreed locally as part of our Quality Account last year.

The Trust's performance is also measured against the standards set out in Monitor's Risk Assessment Framework which are covered in section 2, pages 52-54
Commentary is provided on non-mandatory improvement programmes including:

- Patient Experience and Engagement Strategy
- Eliminating mixed-sex accommodation
- Complaints
- The Friends and Family Test
- Safeguarding
- Dementia Care
- Healthcare associated infections (HCAI)
- Mortality, both HSMR and Standard Hospital Mortality Index (SHMI)
- Meeting Cancer waiting times
- Staff sickness absence
- Staff personal development / appraisal reviews
- NHS in-patient survey

PATIENT EXPERIENCE AND ENGAGEMENT STRATEGY

The Trust has continued to progress in achieving the objectives set out in the Patient Experience and Engagement Strategy to cover the period April 2014 – 2017. Progress

against strategy objectives are detailed within this section under headings of Complaints, In-patient survey, Friends and Family Test all of which are included in the strategy action plan.

Specific objectives have been set relating to improving performance against the national in-patient survey. Four specific priorities have been set where Trust performance is below aspirations with a year on year improvement target. These measures have been developed as a direct result of the findings from the National In-Patient Survey. These areas are:
1. Elimination of Mixed Sex accommodation in admissions areas
2. Effective discharge planning- minimise waiting and improve information
3. Reducing Noise at night from staff / environment
4. Being offered a choice of food and providing access to snacks
Progress in each of these areas will be monitored and led by the Trust's Patient Experience Group.

The reader is referred to part 2.2 Looking Forward, for further information about how the trust is focusing on achieving improvement in these areas.

Elimination of mixed-sex accommodation

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Deputy Chief Nurse

Current Position and why this is important:
TBC

How will progress be monitored?

Progress against this quality improvement priority is monitored operationally at the Operational Quality, Safety and Experience Group which is chaired by the Chief Nurse. This group reports to Quality Assurance Committee on a quarterly basis, through which assurance of progress will be provided to the Board.

COMPLAINTS
A full review of the Trust complaints policy and processes has been undertaken which has taken into account the recommendations of the 'Francis Report' and the Parliamentary and Health Service Ombudsman best practice guidelines. In summary the revised process has implemented:

- The reintroduction of a PALS function to develop a fast responsive approach to complaints handling.
- Personal contact with the person making a complaint to establish their concerns and what it is they are looking for by way of outcome.
- Written acknowledgement of all complaints via the Chief Nurse office, within three days.
- A standardised response time of 25 working days and no extension beyond 10 days without the prior approval of the person making the complaint, and the Chief Nurse or Deputy Chief Nurse.

- A lead for complaints within each division and the principle of “Investigate Once, Investigate Well".
- The requirement to report to Board on the number of complaints upheld and the number not upheld in addition to other performance measures.
- The requirement to identify learning from complaints.
- The development of a revised data set which will include monitoring against KPIs listed above and more detailed directorate level data.
- The introduction of a satisfaction survey on completion of the complaint process in line with Patient Association recommendations.
- The inclusion of patient stories at the Board of Directors meetings monthly

A programme of training across the Trust is designed to support staff in delivering their responsibilities relating to the management of complaints and concerns, including ensuring effective governance arrangements are in place for learning from this valuable source of patient feedback.

Table 19 – final report will show figures for full year

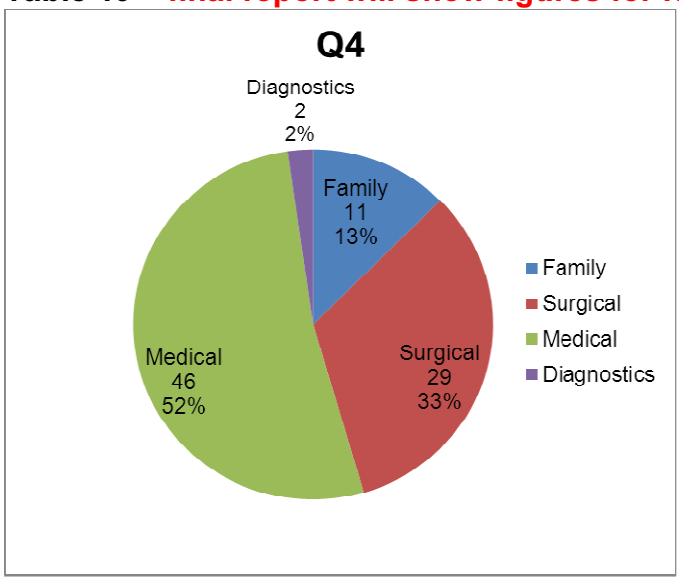
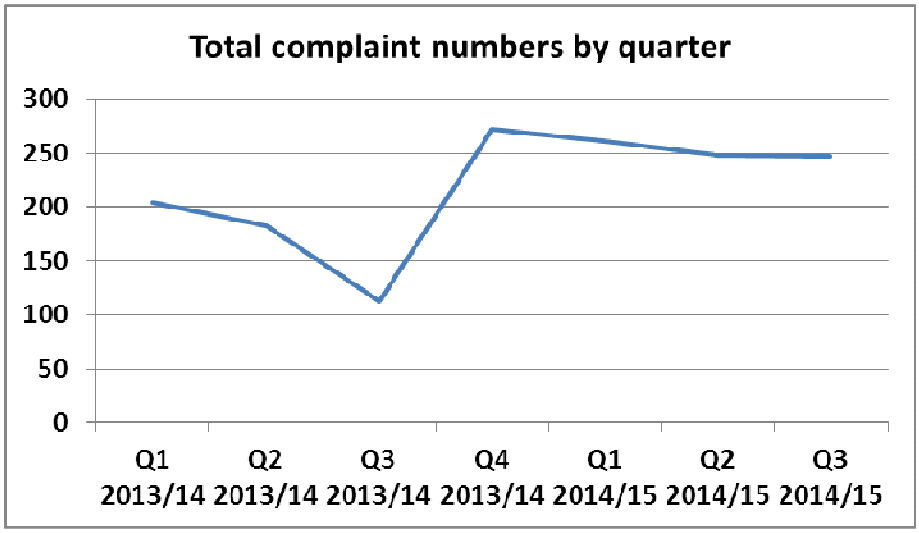


Table 20



FRIENDS AND FAMILY TEST

Ensuring that our patients have a good experience in our care is one of our key priorities. To achieve this, we remain committed to ensuring we listen to patients and act upon what we hear. The Trust takes very seriously its responsibility to respond to the recommendations of the Francis Report which only too clearly sets out the consequences of failing to listen to the concerns of patients, their relatives and carers. The Friends and Family test is one of the ways in which we seek the views of our patients about their recent experience of the care they have received. This asks patients:

'How likely is it that you would recommend this service to friends and family?'

('This service' may include: this ward, community service, this emergency department, this outpatient clinic; or this maternity service)

Response can be:

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Extremely unlikely
- Don't know

Based on their responses, patients are categorised into one of three groups:

- Promoters (extremely likely to recommend),
- Passives (likely to recommend),
- Detractors (neither likely nor unlikely to recommend, unlikely to recommend, extremely unlikely to recommend or don't know).

***The Net Promoter Score**

Working out how many patients recommend a service involves subtracting the percentage of Detractors from the percentage of Promoters and this gives a Net Promoter score (NPS). This score can be as low as -100 (where everybody is a detractor/no one recommends the service) or as high as +100 (where everybody is a promoter/everyone recommends the service):

From 1st April 2013 data collection and reporting became mandatory for all acute providers. There is an expectation that all providers reach a minimum 15% response

rate from in-patient areas and A&E attendances; 15% being required for any of the results to have statistical meaning. Since October 2013 data on the FFT response rate and Net Promoter Score for Maternity Services has been reported. Like the inpatient and A&E areas, maternity services are expected to return a response rate of 15%. In Q4 (January to March 2014) the Trust was expected to achieve a combined in-patient and A&E response rate of 20 % in order to achieve the national CQUIN, and this important flagship measure of patient experience has again been successfully achieved.

Table 21 (figures to January 2015)

FRIENDS AND FAMILY SCORECARD 2014/15 Source of Data: Unify2 Data Collection - FFT_AE and FFT_IP																
Inpatient response rates																
Trust name	April	May	June	Qtr 1	July	Aug	Sept	Qtr 2	Oct	Nov	Dec	Qtr 3	Jan	Feb	March	Qtr 4
England (including Independent Sector Providers)	34.9%	35.9%	38.0%	**36.3%**	38.2%	36.9%	36.6%	**37.2%**	37.6%	37.1%	33.6%	**36.1%**	36.1%			
South Yorkshire and Bassetlaw Area Team	32.1%	29.3%	32.3%	**31.2%**	31.5%	26.4%	36.5%	**31.5%**	30.2%	27.8%	32.9%	**30.3%**	32.6%			
Barnsley Hospital NHS Foundation Trust	28.5%	41.6%	38.2%	**36.3%**	33.4%	31.8%	40.5%	**35.2%**	31.5%	40.3%	33.0%	**34.9%**	38.2%			
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	28.7%	21.3%	20.1%	**23.3%**	25.4%	19.4%	24.4%	**23.1%**	27.1%	25.6%	30.4%	**27.7%**	30.7%			
Sheffield Teaching Hospitals NHS Foundation Trust	36.4%	29.8%	36.7%	**34.2%**	33.9%	26.7%	41.7%	**34.1%**	31.2%	25.0%	36.6%	**30.9%**	33.9%			
The Rotherham NHS Foundation Trust	**28.8%**	**28.4%**	**32.9%**	**30.0%**	**31.9%**	**32.5%**	**37.4%**	**33.9%**	**31.3%**	**30.6%**	**24.1%**	**28.7%**	**25.2%**	**32.0%**		
A&E response rates																
Trust name	April	May	June	Qtr 1	July	Aug	Sept	Qtr 2	Oct	Nov	Dec	Qtr 3	Jan	Feb	March	Qtr 4
England (including Independent Sector Providers)	18.6%	19.1%	20.8%	**19.5%**	20.2%	20.0%	19.5%	**19.9%**	19.6%	18.7%	18.1%	**18.8%**	20.1%			
South Yorkshire and Bassetlaw Area Team	19.5%	21.8%	16.1%	**19.2%**	14.6%	15.7%	14.5%	**14.9%**	16.6%	16.1%	17.3%	**16.7%**	17.7%			
Barnsley Hospital NHS Foundation Trust	14.7%	26.7%	27.9%	**23.1%**	22.4%	24.0%	24.7%	**23.7%**	23.8%	25.1%	27.7%	**25.5%**	26.6%			
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	16.5%	16.1%	2.6%	**11.7%**	4.8%	4.5%	2.4%	**3.9%**	5.1%	3.8%	3.8%	**4.2%**	5.7%			
Sheffield Teaching Hospitals NHS Foundation Trust	23.6%	27.3%	24.9%	**25.2%**	22.6%	22.2%	21.4%	**22.1%**	20.6%	19.0%	18.7%	**19.4%**	20.2%			
The Rotherham NHS Foundation Trust	**22.0%**	**20.6%**	**20.1%**	**20.9%**	**15.7%**	**20.8%**	**18.6%**	**18.4%**	**25.1%**	**26.8%**	**32.4%**	**28.1%**	**29.8%**	**30.6%**		

A number of additional measures to support real time response to the feedback received from the Friends and Family test have been put in place including the introduction of a ward based dashboard that records the Friends and Family score by ward and the implementation of a web based alert system that informs ward sisters and matron when a negative comment has been received.

DEMENTIA CARE

Considerable progress has been made to improve the care and experience of patients who have dementia and their carers, under the leadership of the Dementia Lead Nurse.

In 2014/15, three CQUIN[5] targets have been set; dementia screening, carer engagement/ training and leadership of staff

Dementia and Delirium Screening Process.

[5] Commissioning for Quality and Innovation

The national Dementia Screening programme has been in place since April 2012. At TRFT an electronic system has been developed which can record all 4 elements of the screening process and support processes for screening for delirium, an acute illness that can be debilitating for anyone but especially those people with memory problems. This electronic screening tool was formally launched in January 2015 and will support clinicians in carrying out this important work.

The CQUIN asks us to evidence that we are **FAIR- F**ind **A**ssess **I**nvestigate and **R**efer patients with dementia.

Effective screening processes enable the following:

- With the goal of adding to the quality of the patient experience, screening highlights a need to offer patients and carers support through the Trust's Forget-me-not scheme.
- Increase in the numbers of referrals for a dementia diagnosis (The local Rotherham diagnosis rate has risen to over 70% in December 2014)
- The Trust has consistently managed to screen the initial parts of the FAIR process at over 90% in the last 12 months, this electronic version should build on that success- 92.3% for the year to date (Nov figures)
- The screening gives a live reporting system (simple dashboard) so now the TRFT can identify those people who are within the criteria for assessment (over 65 years of age and within hospital for non- elective admission for more than 72 hours) by location/ ward
- The report shows details of all 4 elements of FAIR, thus providing clear evidence that best practice in line with NICE guidelines and standards is being followed.
- The information specifically provides evidence that those patients shown by assessment to require referral to their GP are appropriately referred, for follow-up 3 months of discharge following a period of acute illness. This will greatly enhance people's access to diagnosis and supports all work nationally in supporting people to a timely diagnosis.
- Targeted training has been offered to junior doctors, and ward staff.

2. Carer engagement

The Trust launched its own Forget me not scheme in May 2014, the aim is to support staff in recognising those people who are identified as having higher needs due to cognitive problems, caused by illness, memory problems, frailty or delirium.

The Forget me not scheme emblem of the blue flower may be visible on the wards, on staff uniforms when awareness training around good practice has been received, the scheme provides a pathway for people to access support, and incorporates working with carers to understand a person's life story in the "This Is me" document.

The carer leaflets also highlight the local support that is available. All services listed are part of the Rotherham Dementia Action Alliance, who is forging ahead in finding ways to improve the quality of life of local people.

The scheme has been rolled out through the wards, led by the local dementia champions. In the 9 months since the scheme has been running there has been an increased awareness of needs and support levels of both patients and carers. The Forget me not scheme is supported by increased staff training in dementia awareness.

The Trust collects the data from the carers of people living with dementia regarding their experiences. These are reported on a quarterly basis and we are pleased to report positive results from this (analysis to to 31st December 2014)

Over 80% of carers responding positively to the following four questions:

1. Did the ward staff seek your advice and guidance in the best approaches to caring for and supporting your relative/ friend whilst they were in hospital? 82.7% said yes

2. Were you given the opportunity to be involved in delivering care for your relative/ friend? 86.21% said yes

3. Were you included in the process of planning for your relative/ friend to be discharged from hospital? 82.7% said yes.

4. And finally, over 90% of carers were likely to recommend our wards to family and friends if they needed similar care or treatment

Our long term goal is to improve our partnership approach to care, learn how people perceive our services, and how we can improve them, and continue to have meaningful engagement with carers and those people who are living with dementia who use our services.

A Trust Community Health Meeting held in Rawmarsh on the 4th February2015, was aimed to meet this long term goal. The open event was an opportunity to meet the Council of Governors, attend a workshop based on dementia and delirium and offered the chance to learn about local services that are available from both Trust staff and the Rotherham Alzheimer's Society. Finally the Trust's Chairman spoke to those attending about the future strategy for the Trust.

- We have attended the Alzheimer's Society local memory cafés, where we have been able to support people with information and connections locally as well as receiving invaluable feedback, including positive reports on services and comments on areas where we can improve our care standards. This came this from both carers and the people living with dementia who use our services.

TRFT responses have included:

- Additions to training information, after request for staff specifically to see the person and not the illness and guidance as to how to approach people who are experiencing dementia to prevent patronising approaches.
- Delirium: From the memory café feedback it was clear that carers have dealt with delirium but not always felt that hospital staff have understood the condition. This has resulted in the delivery of delirium training for TRFT staff.
- We continue to work with colleagues with concerns and complaints looking for ways of learning and quality improvement to be shared.

- Carers were very positive that their feedback is now part of the training of junior doctors on this important topic.
- Outcomes from these feedback and learning events to date appear to be positive. Issues raised are taken to the Dementia Champions and the Dementia Care pathway group and local leaders

3. Training

A range of approaches are being utilised including:

- Bespoke sessions for teams and small groups of staff have been offered and taken up. Feedback has been positive
- Investment and development of the Dementia Champions training roles – 10 colleagues completed gold level training in November 2014 who will lead future training workshops. A further session has been booked for 10 more colleagues(spring 2015)
- Bespoke training sessions commenced for all the Facilities teams- including security guards, porters, and kitchen staff, with a departmental goal of training 300 staff this financial year.) Feedback has been positive.
- September 2014 saw Dementia Awareness becoming part of the Trust induction for all new staff. Feedback has been positive
- In April 2015, the Dementia Awareness training becomes mandatory for all colleagues working within the Trust, in line with government targets of ensuring all NHS staff are trained in dementia awareness by 2018.
- We have now trained over 700 (February 2015) colleagues in dementia awareness this year, encouraging them to engage openly with people living with dementia and their carers, working in partnership.

Other developments:

Mental Capacity Act 2005.

We participated in the development and delivery of mental capacity Training with special reference to the legalities of the Deprivation of Liberties (DoLs)

Dementia Friendly Environments

The trust is embarking on a project to improve and enhance the environment for people living with dementia within the hospital. Following training in Kings Fund Enhancing Dementia care, Phase one is prioritising 6 ward areas, with changes to the colour, signage, and the provision of focal points anticipated. We plan to have a display board area within C floor corridor (main entrance) for consideration.

Finally, the Patient Experience Groups is actively exploring how the Trust can respond to the national drive to improve arrangements for carers when the person they care for is admitted to hospital. John's Campaign[6] is campaigning for the right of carers to have unrestricted rights to remain with the person they care for at all times if they choose.

SAFEGUARDING VULNERABLE SERVICE USERS

[6] http://www.johnscampaign.org.uk/howyoucanhelp.html

The Trust continues to be an active partner in the Rotherham Local Safeguarding Children Board (LSCB) and the Local Safeguarding Adult Board (LSAB).

The LSCB has welcomed a number of reviews of the multiagency focus on Child Sexual Exploitation (CSE).

A number of changes have been made within Local Authority (RMBC). Following Professor Alexis Jay's Report[7] into child sexual exploitation in Rotherham and Louise Casey's best value inspection Report published in February 2015[8].

To facilitate robust engagement by the Trust with the Rotherham Child Sexual Exploitation (CSE) Strategy, a new CSE three year Strategy has been developed. This provides a refresh, a fresh start for Rotherham and the Multi-agency partnership response to CSE. The LSCB in conjunction with the Safer Rotherham Partnership and the Rotherham Health and Wellbeing Board makes a promise to relentlessly pursue improvements in front line services, directed by a strategic action plan that focuses unequivocally on positive outcomes for children and young people.

The Trust has further reviewed and developed the integration of the Safeguarding Team that brought together the previously separately managed Safeguarding Vulnerable Adults Team with the Safeguarding Children and Young People's Team recognising that both teams are often working with and supporting the same vulnerable families.

As a result of that review, Safeguarding Adults Service will be the Adult Vulnerabilities Team which will consist of a Named Nurse for Adult Safeguarding, a Nurse Advisor, a Lead Nurse for Learning Disabilities (a new post funded by the CCG) and a Lead Nurse for Dementia. Together this team will lead on all safeguarding adult matters including the Mental Health Act and Deprivation of Liberty Safeguards.

Within the Safeguarding Children Service the Child Sexual Exploitation (CSE) Specialist Nurse and the Paediatric Liaison Nurse that were previously managed within Family Health, has been aligned to the Safeguarding Team and will provide increased resilience and support.

The TRFT Safeguarding Vulnerable Service Users Strategy has been developed and embedded in the organisation and key performance indicators against which performance is monitored are in place and reported to the Quality Assurance Committee quarterly.

A number of reviews have been commissioned and reports published in relation to Child Sexual Exploitation (CSE) in particular within Local Authority (RMBC). Following Professor Alexis Jay's Report into child sexual exploitation in Rotherham and Louise Casey's best value inspection Report published in February, which found widespread

[7] Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)

[8] Report of inspection of Rotherham metropolitan borough council: February 2014

failings across the council's culture and services. A full review and analysis of the Reports have been undertaken in relation to our own systems and processes.

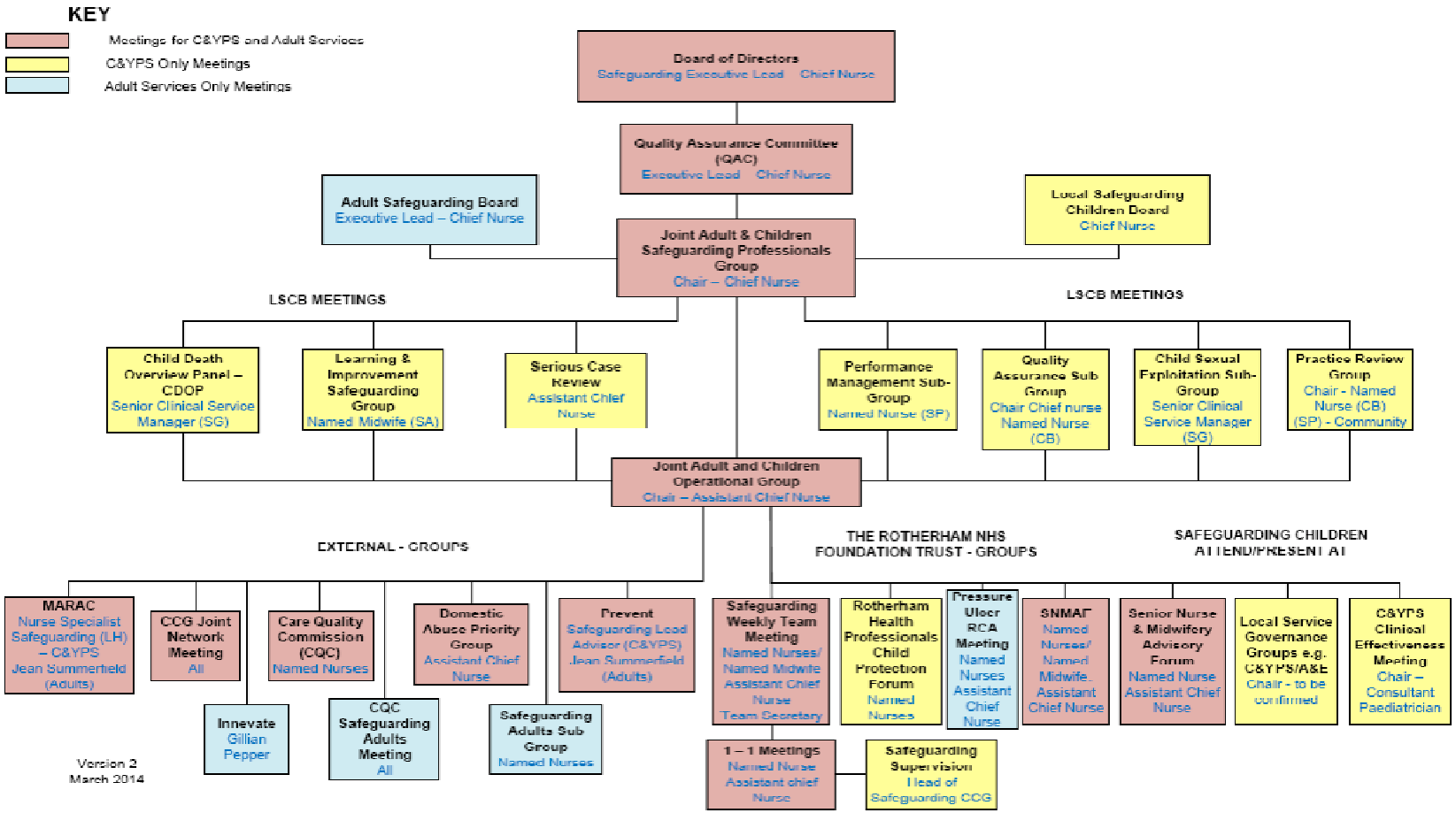
From these reviews ongoing and further improvements have been made in relation to TRFT processes regarding prevention of CSE. This includes awareness raising and training of Trust colleagues, supporting them in their understanding and awareness of how to raise concerns.

CSE is a standing agenda item on TRFT Safeguarding Groups.

The organisational structure for safeguarding is shown below.

The Rotherham NHS
NHS Foundation Trust

Joint Safeguarding Children and Adult Services – Organisational Governance Structure



HEALTHCARE ASSOCIATED INFECTIONS

Will be update to include year-end data when available

The Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in June 2014. The 2014/15 annual report will be written in April 2015. Throughout the year detailed updates on the incidence of healthcare associated infections have been provided to the Infection Prevention and Control and Decontamination Committee which reports to the Operational Quality Safety and Experience Committee. The Chief Nurse is the Executive lead for Infection Prevention and Control and meets regularly with the DIPC.

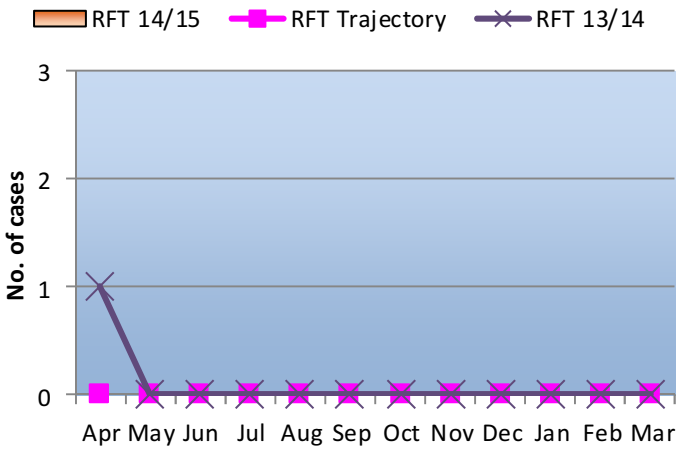
To date there have been zero cases of hospital acquired MRSA bacteraemia against a zero preventable cases trajectory. The Trust has been MRSA bacteraemia free for 21 months and indeed the case reported 22 months ago was from a blood culture contaminated sample and not a clinical infection.

To date there has been one CCG community acquired case of MRSA bacteraemia which was investigated using the national toolkit and reviewed at a post infection review meeting led by the CCG where it was agreed that this was not attributable to any TRFT care provision.

New national guidance on MRSA screening has been reviewed by the IPC team and the decision to continue to screen for MRSA has been supported by the Infection Prevention and Control and Decontamination Committee which will support the strategy plans for ongoing zero preventable cases.

Table 22 below shows the 13/14 and 14/15 information year to date

Table 22



Throughout the year the Infection Prevention and Control Committee has maintained a focus on blood culture contamination rates. The national average is 3%, i.e. 3% of samples taken are contaminated, usually with flora or bacteria on the skin. The Trust has marginally exceeded the 3% month-on-month. Actions plans to reduce contamination risk are in progress in the Emergency Department (ED) where the highest percentage of blood culture sampling is under taken, the whole of the ED team

are working to reduce contaminated samples with the collaboration being led by one of the ED consultants.

Table 23

(Details from the Infection Prevention KPI report April 2014).	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Blood culture contamination Target is to have less than 3% every month	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
Blood culture contamination actual % age	3.37 %	4.14 %	3.32 %	4.38 %	4.35 %	5.11 %	3.84 %	5.34 %	5.0 %	5.6 %	TBC	TBC

MRSA and C-difficile are both alert organisms subject to annual improvement targets. The MRSA target for 2014/15 is Zero preventable cases which has been achieved to date and the C-difficile trajectory was 24 cases. The C diff trajectory has been breached during January 2015.

Table 24

RFT		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14 Target = 22	Monthly Actual	2	3	3	2	2	1	3	3	3	3	5	2
	Monthly Plan	3	3	1	2	2	3	2	1	1	2	2	2
	YTD Actual	2	5	8	10	12	13	16	19	22	25	30	32
	YTD Plan	3	6	7	9	11	14	16	17	18	20	22	24

All cases of hospital acquired C diff are reviewed in depth by the IPC team. Shared ownership of completion of the RCA investigation with the clinical directorates commenced at the beginning of the period but this has not been continued due to the time delay involved with multiple people involved in the collection of information so is being investigated by the IPC team with any enquiries into other care aspects being referred to the relevant team when identified. e.g. to the vascular access team if there is any query regarding line care, the continence team if there is any query regarding urinary catheter care or to the patient safety team if there is any query regarding falls, pressure ulcers and prolonged length of stay, antimicrobial subgroup if there are any queries regarding antimicrobial prescribing (this is not an exhaustive list). A meeting with the triumvirate of the Medical Directorate took place and it was agreed that in the event of any cases within Medicine that a meeting will take place at 14:00 on the following Wednesday to review the RCA information to that point. This has been effectively carried out during February and March.

A post infection review (PIR) is carried out each month with the Health Protection Principal from Rotherham Public Health who is the Commissioner representative from the CCG to determine if the cases of C diff are potentially avoidable or unavoidable

which reviews not only the Infection Prevention practices but also examines if there is any other lapse of quality of care identified. The PIR has been extended to include the Head of Clinical Quality at the CCG during quarter three.

All samples of C diff are sent for Ribotyping at Leeds reference laboratory in order to determine the exact identify type of the organism. In the event that any samples have the same Ribotype the epidemiology is examined further to determine if there could be any link in time and place between the cases, if such a link is possible enhanced DNA fingerprinting is requested via the Leeds reference laboratory which identifies if the cases are indeed linked and thus caused by cross infection or not. Such a case of cross infection has occurred once during the year to date and as such the PIR determined that the secondary case was avoidable. All other cases reviewed have been agreed by the external members of the PIR meeting to be unavoidable. This is an on-going process so there are currently 10 samples which are not yet determined as further information is outstanding in terms of laboratory analysis and queries to other clinical teams.

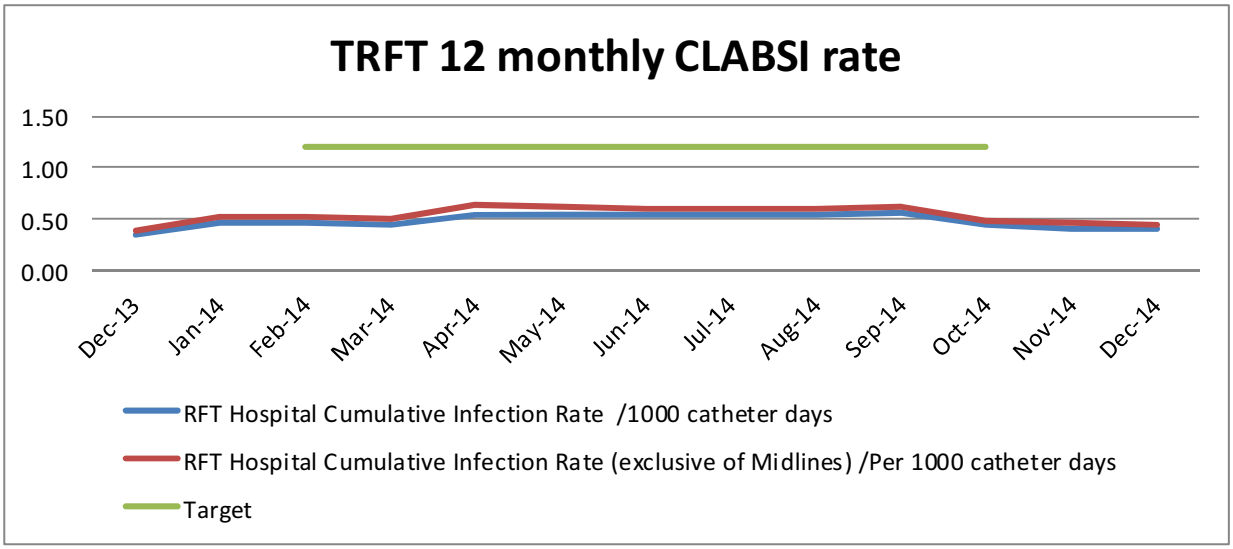
The IPC team undertook a deep dive review of cases 1-30 at the request of the Quality Assurance Committee (QAC), the review which entailed detailed analysis all risk factors associated with C diff infection, was presented by the DIPC.The conclusion was that only one of the 30 of cases was avoidable as a result of cross-infection. A number of recommendations were made of which the QAC have prioritised the top two for 15/16 as:

1) A deep clean rolling programme including the use of hydrogen peroxide vapour (HPV) decontamination to be implemented with the Medical in-patient areas as the primary sites for action.

2) As 40% of patients who have stayed more than 30 days have acquired the infection including those with delayed discharges then reduction of length of stay (LOS) and avoidance of delayed discharges is an important objective that will lead to reduction of C diff cases. This will require a holistic concerted effort to achieve.

The Trust continues to have outstanding extremely low rates of Central Line Associated Blood Stream Infections (CLABSIs) which are monitored by the I/V Access Group via the Vascular Access team.

Table 25



The intravenous (IV) access steering group was established to oversee IV access both in the hospital and community setting and an important initiative is to enhance IV antibiotic therapy in the community. The Access Team in collaboration with the District nurses and other stakeholders have been instrumental in the delivery of this service. A performance dashboard is created with good clinical outcomes and was shared with the commissioners.

Cases of Norovirus and Influenza have been identified but these have been well managed to reduce further cases and to avoid outbreak situations. No wards have been closed due to either of the viruses which are usually challenging during the winter months.

Post-operative surgical site infection (SSI) surveillance following Caesarean section has been led by a Consultant Obstetrician working in conjunction with the IPC team with all ladies being followed up and their wound reported upon by the community midwifery team. They have demonstrated continually low rates of infection and a dramatic improvement from audit study undertaken a few years previously. The data has been confirmed by a further case review by the Head of Midwifery to provide assurance of the system.

Whilst Ebola remains a low threat to the UK the IPC team and the Health & Safety Lead have led a multi-disciplinary preparedness group to ensure that the correct PPE is available in key areas, that a designated area of care has been identified and prepared with appropriate equipment and that the most up to date national and international information has been shared with clinical colleagues. Further practical training in the donning and doffing of PPE is being arranged to increase the number of staff who are familiar with the planned procedures

The Trust is disappointed with the incidence of C-difficile infections and the blood culture contaminant described above but very pleased with infection prevention in other areas such as central line associated blood stream infections, rates of MRSA bacteraemia (zero) and the low SSI rates for Caesarean sections. Norovirus infections have been well managed that there was no need to close wards at all. More patients

are being treated in the community with I/V antimicrobials which means that patients are prevented from hospital admissions or discharged earlier.

MORTALITY

Section will be updated when final data available and validated

With the Trust maintaining a strong focus on reduction and review of mortality rates, further details on the Trust's mortality review process is described in part 2.2: Looking Forward.

Hospital Standard Mortality Ratio (HSMR)

The HSMR can be described as the actual number of deaths occurring in a hospital, compared to the number of those deaths which could be expected to happen.
At the start of the year, the HSMR was **TBA** when data validated compared to the national average of 100. With the engagement of the Board, a programme of work was developed with a goal of providing the organisation with a clear and robust structure for mortality review. The Trust has now achieved considerable improvement in mortality rate over 2014/15, with a current HSMR of **TBA** when data validated

Summary Hospital Level Mortality Indicator (SHMI)

This refers to deaths of patients admitted to hospital which occur within the hospital setting, as well as those which occur up to 30 days following discharge from hospital. The SHMI is the ratio of the observed number of deaths to the expected number of deaths for the hospital. SHMI bands are categorised into one of 3 bands:

- Band 1: higher than expected
- Band 2: As expected
- Band 3:Lower than expected

TRFT is currently in band 2: 'as expected' with a current SHMI rate of 1.059

Table 26

Domain	HSCIC Ref	Indicator name	Latest & previous reporting periods	TRFT value	TRFT previous value	Acute Trust average	Acute Trust previous average	TRFT highest value	Acute Trust previous highest value	TRFT lowest value	Acute Trust previous lowest value
Domain 1 - Preventing people from dying	P01544	Summary Hospital Mortality Indicator – Value	July 13 June 14	1.059	1.11	1.01	0.99	1.08	1.06	0.91	0.89
	P01544	Summary Hospital Mortality Indicator – Banding	July 13 June 14	2 ("As expected")	2 ("As expected")	2 ("As expected")	2 ("As expected")	2 ("As expected")	2 ("As expected")	2 ("As expected")	2 ("As expected")

Table 27 shows a summary of what HSMR and SHMI measure and the differences between these two measures.

Table 27

What does the Hospital Standardised Mortality Rate (HSMR) measure?	What does the Summary Hospital Mortality Index (SHMI) measure?
Records deaths which occur in patients receiving hospital care	Records deaths which occur in patients receiving hospital care, also those which occur outside hospital care and within 30 days of discharge.
Focuses on a group of specific diagnoses within which about 80% of deaths in hospital occur	Includes all diagnoses so covers 100% of deaths
Makes allowance for palliative care	Does not make allowance for palliative care
Sets the expected mortality rate for England at 100 and then hospitals are measured against this	Also calculates a score, also places hospitals into one of three bands for their mortality rating: 1. higher than expected 2. as expected 3. lower than expected

The Trust will continue its focus on mortality rates with further reduction in HSMR an agreed improvement priority for 2014-15 as described in part 2.

NHS STAFF SURVEY

The Trust takes its responsibility for employee engagement very seriously and is resolute in its commitment to developing a workforce which is fully engaged, highly motivated, and committed to delivering excellent standards across all our services.

The national NHS Staff Survey is undertaken each year in the autumn months and again TRFT chose to invite all colleagues to complete a survey, rather than a sample. It has been pleasing to see an increase in completion rates (44%) when the national average has seen a decline.

We have seen our first improvement in the overall engagement score since 2009 and we have seen general improvement in most of the key findings, which again is pleasing, however we recognise there remains the opportunity for further improvements.

Summary of performance – NHS staff survey

Details of the key findings from the latest NHS staff survey:

- Response rate

  The Trust is obliged to survey a sample of a minimum of 850 of its employees (about 20% of our staff), however in 2014 undertook to conduct a full census of all eligible employees. The response rate was an improvement on the previous

year with 44% responding, which, given the larger sample, equated to an additional 1,678 employees giving their feedback on what it feels like to work for the Trust.

- areas of improvement from the prior year and deterioration;

  There were no areas of statistically significant deterioration from the previous year.

  There were two areas of statistically significant improvement, the number of staff appraised in the last twelve months rose to 95% (previously 85%) and having a well-structured appraisal increased to 39% from 35%.

- top 5 ranking scores;

  The results positively compared with other Trusts in relation to the number of staff appraised; those witnessing potentially harmful errors, near misses or incidents in the last month; those experiencing discrimination at work in the last twelve months; those experiencing harassment, bullying or abuse from patients, relatives or members of the public in the last twelve months and those working additional hours.

  This is indicative of the significant amount of work focusing on developing the internal personal development review (appraisal) process, including a redesigned process, additional training and mandating compliance.

- bottom 5 ranking scores;

  The Trust has performed less well than comparative Trusts against staff motivation at work; those agreeing their role makes a difference to patients; those who are satisfied with the quality of work they are able to deliver; those who feel able to contribute to improvements at work; and those who would recommend the Trust as a place to work or receive treatment.

Table 28: Staff survey

	2014/15		2013/14		Trust Improvement / Deterioration
Response rate	Trust	National Average	Trust	National Average	
43%	44%	42%	43%	49%	Increase in 1% points
	2014/15		**2013/14**		**Trust Improvement / Deterioration**
Top 5 Ranking Scores	Trust	National Average	Trust	National Average	

Percentage of staff appraised in the last 12 months	95%	85%	85%	84%	Increase in 10% points
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	28%	34%	26%	33%	Increase in 2% points
Percentage of staff experiencing discrimination at work in the last 12 months	8%	11%	8%	11%	No change
Percentage of staff who have experienced harassment, bullying or abuse from patients, relatives or members of the public in the last 12 months	25%	29%	28%	29%	Decrease (improvement) of 3% points
Percentage of staff working additional hours	67%	71%	71%	70%	Decrease (improvement) of 4% points
	2014/15		**2013/14**		**Trust Improvement / Deterioration**
Bottom 5 Ranking Scores	Trust	National Average	Trust	National Average	
Staff motivation at work	3.68*	3.86*	3.67*	3.86*	Increase in 0.01 points

Percentage of staff agreeing that their role makes a difference to patients	86%	91%	89%	91%	Decrease in 3% points
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	72%	77%	74%	79%	Decrease in 2% points
Percentage of staff able to contribute towards improvements at work	63%	68%	64%	68%	Decrease in 1% points
Staff recommendation of the Trust as a place to work or receive treatment	3.42*	3.67*	3.42*	3.68*	No change

*Please note these figures are not expressed as a percentage. They are an amalgamation of two or more standards and represent a numerical Likert scale with 1 being very poor and 5 being excellent.

Future priorities and targets

In response to the survey feedback a Trust wide action plan has been devised in partnership with the Employee Champions. In addition to this an engagement exercise will take place in departments across the organisation to review the local responses and devise an improvement plan. This will be monitored at board level via the Strategic Workforce Committee.

Culture

1. Applicable staff to have 'in-year' Personal Development Review (PDR)

The Trust has significantly improved PDR compliance since launching its Behavioural based PDR that is carried out between April and June each year. In comparison to 2012/13 (51%) the 2013/14 PDR completion rate was 86%.

- The need to carry out Personal Development Reviews is now a Trust priority, with measures in place to ensure this happens. This has resulted in an increasing compliance rate.

- Improved PDR reporting and visibility at Board level ensures that appraisals and staff engagement through them are regularly discussed at senior management meetings.
- Training is taking place between February and May to support the new PDR process, and includes sections on assessing performance against the Trust values, giving effective feedback and setting SMART goals.

2. Compliance against Mandatory and Statutory Training (MAST)

MAST is under constant evolvement to try and ensure it meets all governance requirements. A full review of all the MAST training requirements, delivery methods, and frequency has taken place leading to some changes to Fire and Manual Handling training. The number of core MAST topics has increased, due to government initiatives, with dementia awareness and PREVENT both added to the core list.

2012/13 overall MAST compliance was reported at 57.75%.

MAST subjects and current compliance rates at time of reporting (March 2015) are shown below with rates for the previous year for comparison

Table 29

MAST Competency	% Compliance 2013/14	%Compliance 2014/15 (at date of reporting)
Conflict Resolution	51.40%	67.34%
Equality & Diversity	65.86%	72.62%
Fire	61.15%	61.25%
Information Governance	78.01%	67.28%
Display Screen Equipment	57.25%	57.99%
Moving & Handling (All levels)	39.39%	47.40%
Adult Safeguarding (All levels)	53.60%	58.83%
Child Safeguarding (All levels)	54.59%	69.80%
PREVENT Anti-Terrorism		40.62%
Dementia Awareness		16.54%
Total	**57.75%**	**55.94%**

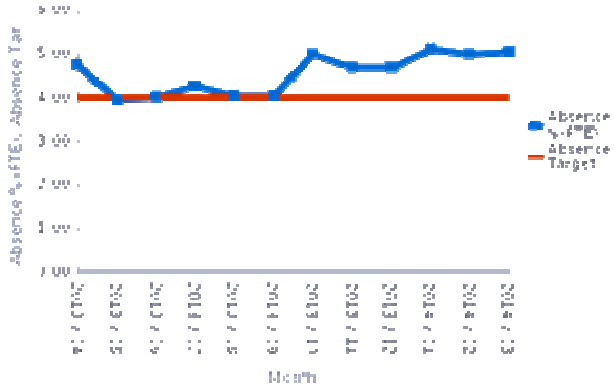
The corporate induction is changing form the 1st of April 2015 and will become days for non-clinical and 3 days for clinical staff. The induction will take place every two weeks so that the new starters are inducted in a timely manner, and will include the 11 Core MAST topics to help increase compliance.

1. Employee sickness rates

The average rate of sickness absence for the Trust in 2013/14 was 4.55%, virtually the same as the previous year at 4.54%. This is above the Trust's internally set target of 4%. During the year the Trust worked with NHS Employers to review sick absence

process, policy, and reporting requirements and this resulted in a number of improvement opportunities being identified. These interventions will be implemented during 2014/15.

Table 30



Sickness absence will be targeted and monitored as part of the new monthly Directorate performance meetings, the aim is to reduce the frequency of individual sick absence episodes as well as ensuring earlier intervention and proactive management for long term absence cases.

NHS IN-PATIENT SURVEY

FOR FULL COMPLETION WHEN RESULTS PUBLISHED BY CQC (expected April 2015)

The Trust is committed to the delivery of excellent patient experience and takes part in the annual in- patient survey. The survey asks 70 questions of XXX patients about the experience of care during August 2014.

The National In Patient Survey was published by the Care Quality Commission on XX/XX/.2015. Table 31 below provides a summary of the over-arching findings from the survey and a comparison with our performance against the 2013/14 in patient survey.

Position in 2014/15 - to be updated on publication

Patients who participate in the CQC survey are asked to answer questions about different aspects of their care and treatment. Based on their responses, CQC give each NHS trust a score out of 10 for each question (the higher the score the better). Each trust also receives a rating of 'Better', 'About the same' or 'Worse'.

- **Better:** the trust is better for that particular question compared to most other trusts that took part in the survey.
- **About the same:** the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- **Worse:** the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

The outcome of the survey which took place during August 2014 is detailed on table 32 below which also provides a comparison with the results from last year.
The Trust is committed to the delivery of excellent patient experience and takes part in the annual in- patient survey. The survey asks 70 questions of XXX patients about the experience of care during August 2014.

2013: 367 : 45% response
2014: xx% response

Table 31: TRFT PERFORMANCE against Patient Experience Domains

Domain	Trust Score Patients admitted 2013 (Out of maximum 10)	Trust Score Patients admitted 2014 (Out of maximum 10)	Performance Rating 2013	Performance Rating 2014
The emergency/A&E department	8.3		About the same	
Waiting lists and planned admissions	9.2		About the same	
Waiting to get to a bed on a ward	7.6		About the same	
The hospital & ward	7.7		worse	
Doctors	8.4		About the same	
Nurses	8.0		About the same	
Care and treatment	7.5		About the same	
Operations and Procedures	8.5		About the same	
Leaving hospital	7.1		About the same	
Overall views and experience	5.2		About the same	

The Trust has been focusing attention on the following five areas over 2014/15 in which TRFT has required improvement over the last two patient surveys, with this monitored by the Patient Experience Group. These are:

1. **Elimination of same sex accommodation across all in patient areas**
   The Trust is disappointed that this goal has not yet been achieved and this remains a quality improvement priority for 2015/16. 16% of patients surveyed said they had shared accommodation with a member of the opposite sex when

first admitted to a bed on a ward which equated to 51 individuals over the survey period. The Trust remains strongly committed to eliminating this.

2. **Reduction in noise at night from hospital staff**
   It is an important element of patients' experience and their recovery from ill-health that they should be able to rest and sleep well at night. We want to reduce the number of patients who report that they were disturbed by noise at night from either other patients, or staff. Our focus remains on this with further detail provided in part 2.2: Looking Forward

3. **Improvement in information about discharge for patients and families including information about medication and ongoing care**
   It is a Trust priority to improve discharge processes which includes ensuring that patients have all the information they need to support them in their continuing recovery at home. Further information about the Trust's approach for the coming year is included in part 2.2: Looking Forward, where detail is presented about the SAFER Care bundle.

4. **Increase choice in hospital food by improving access to patient menus**
   Preliminary figures suggest a 4% increase to 69% in the number of patients who reported that they always were offered a choice of food. We want to see this figure increase further to meet or exceed the national average of 81%. The catering contract has been given was awarded to a new company over 2014 who met the high standards required, and it is hoped that next year's survey results will show improvement as a result with patients offered a good choice of nourishing, highly rated meals.

5. **Improve pain control across all areas**
   It is a very important aspect of good care that patients should receive adequate pain relief during their admission. 218 patients surveyed said they had experienced pain during their admission, of these 66% said hospital staff 'did everything they could to help control their pain. This is similar to last year's result and lower than the national average of 75%. In answer to this question 8% answered 'no'. We will continue to focus on this important aspect of care.

These reflect priorities associated with the survey identified in the Trust's Patient Experience and Engagement Strategy. A detailed implementation plan is being implemented and monitored to completion by the Patient Experience Group. Progress against these areas will be monitored by a monthly survey to be carried out locally
.

National Priorities and Regulatory Requirements 2014-15
Will be updated with full year-end data

The Trust is also assessed through the submission of data against a set of national priorities. Table 32 provides data on performance against these quality metrics.

Table 32

Measure	*DOH	*MON	2013/2014		2014/15	
			Year-end Position	National Target	Year end Position	National Target
					End of January position	
Number of cases - Clostridium Difficile Infection (Cdiff)	X	X	29 cases	22 cases	25 cases	24 cases
Number of cases - MRSA	X	X	1 case	0 cases	0 cases	0 cases
Delayed transfers of care	X	X	2.10%	3.5%	3.12%	3.5%
Infant health & inequalities: breastfeeding initiation	X	X	59.91%	66%	59.50%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool -	X	X	97.8% (Feb position)	95%	98%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate, ADMITTED PATIENTS, NON ADMITTED PATIENTS and INCOMPLETE PATHWAYS.						
Admitted	X	X	96.90%	90%	94.60%	90%
Non - Admitted	X	X	98.70%	95%	99.1%	95%
Incomplete	X	X	93.7%	92.0%	97.3%	92.0%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	X	X	0.3%	less than 1%	0.2%	less than 1%
Patients waiting less than 4 hours A&E	X	X	95.10%	95%	93.50%	95%
Cancelled operations for non medical reasons	X		0.63	0.8%	0.7%	0.8%
Women who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 weeks of pregnancy.	X		89.17%	90%	91.0%	90%
Patients who spend at least 90% of their time on a stroke unit	X		81.40%	80%	77%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	X		88.60%	60%	82%	60%

Elective Adult patients readmitted to hospital within 30 days of discharge from hospital	X		3.80%	3%	4.9%	6%
Non Elective Adult patients readmitted to hospital within 28 days of discharge from hospital	X		12.70%	12.50%	13.4%	12.50%
Elective patients 0-16 years readmitted to hospital within 28 days of discharge from hospital	X		3.60%	3%		3%
Non Elective 0-16 years patients readmitted to hospital within 28 days of discharge from hospital	X		8.10%	12.50%		12.50%
Ensuring patients have a positive experience of care (Pt survey overall score)	X		76.2	100		100
Community care data completeness - activity information completeness		X	100%	100%	100%	100%
Community care data completeness - patient identifier information completeness		X	100%	100%	100%	100%
Community care data completeness - End of life patients deaths at home information completeness		X	100%	100%	100%	100%
Patients waiting no more than 31 days for second or subsequent cancer treatment						
Anti Cancer Drug Treatments - Chemotherapy	X	X	100%	98.0%	99.0%	98.0%
Surgery	X	X	100%	94.0%	99.1%	94.0%
Radiotherapy (from 1 January 2011)	X	X	N/A	94.0%	N/A	94.0%
62-Day Wait For First Treatment (All cancers)						
Patients treated within two months of consultant upgrade	X	X	98.20%	Not yet available		Not yet available
From Consultant Screening Service Referral	X	X	87.10%	90.0%	96.4%	90.0%
Urgent GP Referral	X	X	88.20%	85.0%	92.7%	85.0%
31-Day Wait For First Treatment (Diagnosis To Treatment)						
	X	X	99.50%	96.0%	99.2%	96.0%

All cancers						
Two week wait from referral to date first seen						
All cancers (%)		X	95.50%	93.0%	93.8%	93.0%
For symptomatic breast patients (cancer not initially suspected)		X	92.20%	93.0%	94.7%	93.0%
Health visitor numbers against plan	X		43.4	54 wte	57	54 wte

DOH= Department of Health

MON= Monitor

Table 33: Quality Indicators identified by The Rotherham NHS Foundation Trust for Quality Account, for continuing monitoring & reporting over 2015/16

Domain	ID	Indicator name	Rationale for monitoring	Continued focus 2015/16?
Patient Safety	PS_1	Have zero 'Never Events'	Zero target not achieved over 2014/15	yes
	PS_2	Rate of patient safety incidents/1000 admissions	Linked to 'no blame' reporting culture	yes
	PS_3	Percentage of patient safety incidents resulting in severe harm or death	Linked to 'no blame' reporting culture and Harm Free Care (NHS Safety Thermometer)	yes
	PS_4a	Number of patients with C. Diff	On-going infection control surveillance	yes
	PS_4b	Number of patients with MRSA	On-going infection control surveillance	yes
Patient Experience	PE_1	Increasing our responsiveness to our patients' needs using a composite indicator of care, from April 2011 baseline	Links to 'caring' objectives/on-going Trust requirement	yes
	PE_2	Increase in the number of patients assessed using the MUST nutritional tool	Important safety metric	Routine Monitoring to continue
	PE_3	Increase in the number of patients with completed (and calculated) fluid balance charts	Monitoring to continue as part of Ward2Board indicators, linked to IOFM improvement programme	Routine monitoring to continue
	PE_4	Increase in number of complaints	Focus will continue on monitoring complaints KPIs including volume but with a greater focus on quality measures, patient satisfaction and learning from complaints continue to aim for increase but to focus on the Trust's responsiveness to complaints	This specific priority in relation to complaints will not be monitored. Priorities for Quality Accounts asdetailed part 2.2

Domain	ID	Indicator name	Rationale for monitoring	Continued focus 2015/16?
Clinical Effectiveness	CE_1	Reducing emergency re-admissions to hospital within 28 days of discharge	Patients aged 0-15: national target achieved. Monitoring to continue Patients aged 16 or over: 0.2 % above national target (non-elective admission) 2013-14:	Routine monitoring to continue.
	CE_2	Reducing weekend mortality rates as at April baseline 2012	monitoring to continue as an integral part of the Mortality Review process	yes
	CE_3	Dementia Find, Assess/Investigate, Refer (F.A.I.R)	Summary indicator to reflect progress against Improvement Programme	yes
	CE_4	Looked After Children's assessments	Important element of safeguarding children	Routinely monitored through Family health directorate, performance meetings and safeguarding processes
Culture	C_1	All applicable staff to have in year PDR	Links to 'caring' objectives	yes
	C_2	Increase in incident reporting via Datix	Linked to 'no blame' reporting culture	yes
	C_3	All staff to maintain compliance against MAST training	Links to supporting staff objectives	yes
	C_4	Employee sickness rates	Proxy marker reflecting morale/wellbeing of staff	yes
Data Quality	DQ_1	Data Quality index (CHKS Live -HRG4 based)	On-going Trust requirement – links to DQ Improvement Programme	yes
	DQ_2	Blank or invalid or unacceptable primary diagnosis rates (CHKS Live -HRG4 based)	On-going Trust requirement – links to DQ Improvement Programme	yes

Domain	ID	Indicator name	Rationale for monitoring	Continued focus 2015/16?
	DQ_3	Depth of coding average diagnosis per coded episode (CHKS Live)	On-going Trust requirement – links to DQ Improvement Programme	yes
	DQ_4	Data quality summarised indicator	Summary indicator to reflect progress against Improvement Programme	yes

Annexe 1:

Statement of Directors' responsibilities in respect of the Quality Account
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trusts on the form and content of annual Quality Accounts (which incorporates the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support data quality for the preparation of the report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the report meets the requirements set out in the NHS foundation Trust Annual Reporting Manual, 2014/15 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers April 2015 to May 2015
    - Papers relating to quality reported to the Board and Quality Assurance Committee April 2014 to May 2015.
    - Feedback from commissioners dated 09/05/14
    - Feedback from Governors dated 06/05/14
    - Feedback from Healthwatch Rotherham dated 13 May 2014
    - Feedback from Rotherham Select Health Commission dated XXXX
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 14 May 2014
    - The national in-patient survey published 08 April 2015
    - The national staff survey published 25 February 2015
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2015
    - CQC intelligent monitoring reports published October 2013 and March 2014.
- The Quality Report represents a balanced picture of the NHS Foundation Trust over the period covered;
- The performance information in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance in the Quality Report are robust and reliable, conform to specified data quality standards and prescribed definitions, are subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations, published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report. (available at www.monitor.gov.uk/annualreportingmanual)

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality accounts

By order of the Board:

.....	.....
Mr Martin Havenhand	**Mrs Louise Barnett**
Chairman	**Chief Executive**
23 May 2014	**23 May 2014**

Annexe 2

Annexe: Statement on behalf of Council of Governors.
Date

Insert statement

Annexe 3: Statement from Rotherham Clinical Commissioning Group

Insert statement

Annexe 4: Statement from Healthwatch Rotherham
DATE:

Insert statement

Annexe 5: Statement from Rotherham Select Health Commission Governors:
DATE:

Insert statement

CQUIN tables to be inserted when available – subject to publication of national CQUIN requirements

Appendix 1: CQUIN Indicators 2014-15 (Q4 data not yet available)

Appendix 2: CQUIN agreed goals for 2015/16

Appendix 3: GLOSSARY

Acronyms

A&E	Accident & Emergency Department
CEO	Chief Executive Officer
CEPOD	Confidential Enquiry into Perioperative Deaths
CMACE	Centre for Maternal and Child Enquiries
CHKS	Comparative Health Knowledge System,
CCG	Clinical Commissioning Group
C Difficile	Clostridium Difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSES	Child Sexual Exploitation Strategy
DAD	Data Assurance Document
Datix	National risk management and reporting system
DQI	Data Quality Index
DoH	Department of Health
EPAU	Early Pregnancy Advisory Unit
EPR	Electronic Patient Record system
ESBL	extended spectrum beta-lactimase
ESR	Electronic Staff Record
GP	General Practitioner
HES	Hospital Episode Statistics
HFC	Harm Free Care
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
IOFM	Intra Operative Fluid Management
KPI	Key Performance Indicator
LSCB	Local Safeguarding Children Board
MAST	Mandatory and Statutory Training
MDT	Multi-Disciplinary Team
MRSA	methicillin-resistant staphylococcus aureus
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide by people with mental illness
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OLM	Oracle Learning Management
PALS	Patient Advice and Liaison Service
PIR	Post Infection Review
PROMS	Patient Reported Outcome Measures
PDR	Personal Development Review
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident
TRFT (RFT)	The Rotherham NHS Foundation Trust
WHO	World Health Organisation
WNAS	Ward Nursing Accreditation System

Glossary of Terms

Clinical Coding
The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.

Comparative Health Knowledge System,
A web based performance benchmarking system, utilised by many hospitals

Commissioning for Quality and Innovation
A series of nationally and locally agreed improvement targets, linked to a proportion of Payment by Results funding as an incentive to achieve

Council of Governors
An elected group of local people who are responsible for helping to set the direction and shape the future of the Trust based on members' views

Deloitte LLP
Professional services firm which provides audit, tax, consulting, enterprise risk and financial advisory services to their clients

Dr Foster
A provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public

Healthwatch
The independent consumer champion that gathers and represents the public's views on health and social care services in England.

Monitor
Sector regulator for foundation trusts in England.

Never Event
Defined by the DoH as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place

Data Quality Index
A composite indicator reflecting data quality, provided by CHKS

Risk Assessment Framework
This document sets out Monitor's approach to making sure NHS foundation trusts are well run and can continue to provide good quality services for patients in the future. Introduced October 2013.

Safety Thermometer
The expanded National patient safety improvement initiative, promoting 'Harm Free Care', linked to National CQUIN funding – previously known as NHS QUEST

The Secondary Uses Service (SUS)
the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**16 April 2015**
3.	**Title:**	**Special Schools Nursing Service**
4.	**Directorate:**	**The Rotherham NHS Foundation Trust**

5. Summary

The report provides Members with an overview of the Special Schools Nursing Service in Rotherham which provides holistic nursing care for children and young people with additional health needs, enabling them to access education.

6. Recommendation

That Members:

Note the contents of the report and the services provided for children and young people with specific health needs.

7. Proposals and Details

The Health Select Commission identified information on the Special Schools Nursing Service as part of its work programme for 2014-15. This follows up a presentation about the revised specification for the mainstream School Nursing Service. Appendix 1 provides an overview of the current service in Rotherham and illustrates the differences and commonalities with the mainstream service. The report covers the following areas:

- Team composition and location
- Role of the Special School Nurse
- Training
- Safeguarding
- Education and health care plans

8. Finance

No direct financial implications from this report.

9. Risks and Uncertainties

The caseload of the team and the health needs of the children and young people accessing the service will vary over time as different cohorts enter and leave education.

10. Policy and Performance Agenda Implications

Individual education and health care plans aim to maximize the child's educational experience and to provide adequate preparation for responses to urgent situations.

11. Background Papers and Consultation

None

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Appendix 1

Report for Health Select Commission

Special School Nursing Service

The special school nursing service is jointly commissioned by Public Health which is now part of RMBC. The health education element is commissioned separately and funded by schools. Special school nurses provide holistic and focused nursing care for children and young people, with additional health needs, in order that they may access education in school or early years setting.

Team Composition

Band 6 = 1.6WTE
Band 5 = 1.9

The team consists of a mixture of children's trained and learning disability trained nurses. This variety is essential in order to meet the needs of the children and young people with additional health needs.

The team currently service 6 schools:

- Abbey
- Hilltop
- Kelford
- Milton
- Newman
- Willows

In addition to these schools the team work with all other RMBC schools where children attend who have additional health needs requiring care plans. At present there are 50 of these which are active.

Role

The school nurse has a unique role in the provision of school health services for children with special health needs, including children with chronic illnesses and disabilities of various degrees of severity. These children are included in the regular school classroom setting. The school nurse will assess the student's health status, identify health problems that may create a barrier to educational progress, and develop a health care plan for management of the problems in the school setting. The school nurse ensures that the child's individual health care plan is developed and implemented with the participation of school and the main carers, to ensure the child's needs are met. The school nurse's participation in the health care plan development heightens the potential for achieving the goals of the plan, which are to maximize the

child's educational experience and to provide adequate preparation for responses to urgent situations.

Dialogue with subspecialists, and other staff, can add important information. The school nurse will provide safe and effective services or facilitate the performance of special health care procedures, such as tracheostomy care, suctioning, Epipen training and nasogastric tube feeding etc.

The team works with social care and contributes to effective planning for those children requiring a safeguarding or child in need plan. Health assessments and attendance at meetings are also completed for those children who are 'Looked After'. The team works collaboratively with other agencies and health professionals and will offer sign posting for parents to ensure the child's needs are met.

Service Provision differs from mainstream school nursing service and includes

- Completion of and updating care plans
- Contributing to medical assessments
- Home Visits to meet parents and child prior to attending school
- Contribute to complex health assessments
- Work collaboratively with parents and other health professionals
- Liaison with SEN panel to identify children with additional health needs earlier in order to provide early support.
- Contribute to safeguarding, child in need and looked after children plans.
- Attend open days and highlight the service.
- Advice and support schools in ensuring the child's needs are met safely whilst accessing the education setting

The team also provides services that mainstream school nursing provide including immunisations, drop in clinics, health assessments and assessment of growth.

Training delivered

- Monthly Epipen training for new staff, as well as yearly updates
- Gastrostomy training
- Suction training
- Tracheostomy care
- Adrenal insufficiency training
- Medication training

Once the training has been delivered the staffs are required to assess and sign off the named individual ensuring they are competent to deliver the task they have been trained for. Training is delivered to staff for the benefit of the child in the educational setting they attend. This could be in an early years setting, primary or secondary school.

Safeguarding Role

The team members must ensure they maintain their skills in managing safeguarding cases and are required to ensure their training is up to date. Individual supervision is given by a specialist nurse from the safeguarding team to support practitioners. Collaborative working with schools and colleagues in children services is the main route for identification of those children who are deemed to be vulnerable and need social care intervention and support. If a member of the special school nursing team identifies a vulnerable child who is deemed to be at risk, they will follow The Rotherham NHS Foundation Trust safeguarding procedures.

If a child is identified as being sexually exploited again The Rotherham NHS Foundation Trust safeguarding procedures would be followed as well as making contact with the children's advocate and appropriate agencies.

Future

With the advent of Education and Health Care Plans this team of nurses will be well placed to contribute and become involved with the formation of Rotherham's EHC plans. They will be able to contribute and support parents in ensuring the plan meets the needs of the child and family.

Endnote

The AAP recommends and supports the continued strong partnership among school nurses, other school health personnel, and pediatricians. These partners should work together closely to promote the health of children and youth by facilitating the development of a comprehensive school health program, ensuring a medical home for each child,[8] and integrating health, education, and social services for children at the community level.

Committee on School Health, 2001–2002

Rotherham Health Select Committee

16 April 2015

‘Quality Matters’

Karen Cvijetic

What is a Quality Report?

- Nationally mandated
- 2014/15 is our seventh Quality Report

RDaSH
leading the way with care

2014/15 Quality Performance

- **Care Quality Commission (CQC)**
  - **Registered with no conditions**
- **CQC Inspections**
  - **1 inspection of Trust services – Rotherham Learning Disability: Cranworth Close**
- **Compliant with all essential standards of quality and safety reviewed**
- **CQC Mental Health Act Monitoring visits**
  - **12 monitoring visits of Trust mental health inpatient services – 6 in Rotherham**
- **Compliant with some minor improvement actions**

2014/15 Quality Performance

Commissioner led quality visits

- 2 visits to mental health and community services in Doncaster – Woodlands (Older Peoples Mental Health), Swallownest Court (Adult Mental Health)
- Positive feedback :
  - Positive patient interaction
  - Staff demonstrated competence and confidence in care planning, commitment and compassion in care delivery
  - Environment was clean, with staff doing activities with patients
  - Patient feedback forms available on the ward and the patients knew how to complain
- Areas for improvement:
  - Develop training plan to help increase staff awareness on how to recognise and help patients with a learning difficulty
  - Easy read should be used whenever possible for patient information
  - Look at how the ward areas help prevent the spread of infections
  - Support staff to help them understand the use of Deprivation of Liberty Safeguards

Quality Improvement Strategy 2014-16

Patient Safety

- Sign up to Safety

Sign up to Safety is:

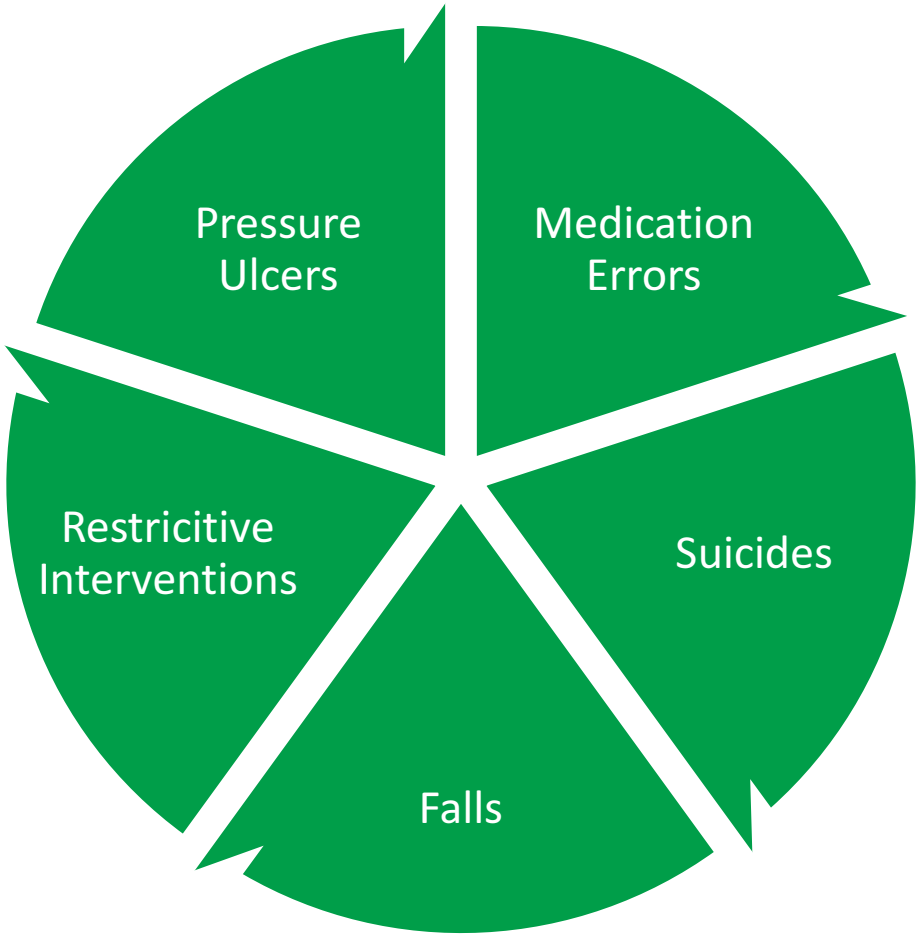
- a National Campaign led by NHS England
- that aims to deliver harm free care for every patient, every time, everywhere
- it champions openness and honesty and supports everyone to improve the safety of patients
- Sign up to Safety's 3 year objective is to reduce avoidable harm by 50% and save 6,000 lives.

RDaSH leading the way with care

Quality Improvement Strategy 2014-16

Patient Safety

- Five key areas:



Quality Improvement Strategy 2014-16

Clinical Effectiveness

- Care Pathways and Packages
- Commissioning for Quality Indicators (CQUIN)
- NICE

Quality Improvement Strategy 2014-16

Patient Experience

- Commissioning for Quality Indicators (CQUIN)
- Listen to Learn
- National Mental Health Service User Survey
- NHS Friends and Family Test

RDaSH leading the way with care

Quality Improvement Strategy 2014-16

Our Staff

- Safer Staffing
- Leadership
- Professional Strategy
- Leading the Way with Quality
- NHS Staff Survey

RDaSH leading the way with care

Francis Declaration

- Trust Francis Declaration jointly signed off by Board of Directors and Council of Governors in December 2013
- Four Francis priorities for 2014:
  - Culture
  - Engagement
  - Non professionally qualified staff
  - Whistleblowing

Local Commissioning Priorities 2014/15

- Consideration of investment in priority areas
- A review of mental health and learning disability services
- A review of the Learning Disabilities Assessment and Treatment Unit and community services
- Development of a comprehensive CAMHS strategy
- Development of care pathways and packages (Mental Health Payment and Pricing Systems)

Next Steps

- Receive HSC comments for inclusion in the Quality Report – May 2015
- Report to Board of Directors – 30 April 2015
- Report to Council of Governors – 15 May 2015
- Report to Monitor – 29 May 2015
- Review by Audit Commission – April/May 2015

Thank you

Any questions

PDaSH
leading the way with care

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**16 April 2015**
3.	**Title:**	**Scrutiny review: Child and Adolescent Mental Health Services**
4.	**Directorate:**	**Resources and Transformation** **All wards**

5. Summary

This report sets out the main findings and recommendations of the scrutiny review of access to GPs. The draft review report is attached as Appendix 1 for consideration by Members.

6. Recommendations

That the Health Select Commission:

6.1 Endorse the findings and recommendations of the report and make any amendments as necessary.

6.2 Agree for the report to be forwarded to the Overview and Scrutiny Management Board for their consideration.

7. Proposals and details

At its meeting in April 2014, the Health Select Commission (HSC) decided to focus its work around the theme of mental health and wellbeing during the 2014-15 municipal year. Further to this it was agreed in July 2014 that a review of Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Child and Adolescent Mental Health Services (CAMHS) be included in the work programme, following local concerns and a report from Healthwatch.

The key focus of Members' attention was to identify any issues or barriers which impact on children and young people in Rotherham accessing timely and appropriate RDaSH CAMHS services at Tiers 2 and 3, and in particular in having an assessment within three weeks.

There were seven aims of the review, which were to:

1. understand the prevalence and impact of mental health problems and illness amongst children and young people in Rotherham
2. understand the costs, value for money and quality of current services
3. clarify how partners work together to support children and young people across all the tiers, especially the role of the RDaSH Duty Team
4. establish how RDaSH engages with service users and their families/carers in order to deliver appropriate and effective services
5. ascertain how identifying and responding to child sexual exploitation is integrated within RDaSH Child and Adolescent Mental Health Services provision
6. determine how effective support for the mental health and emotional wellbeing of Looked After and Adopted Children is provided
7. identify any areas for improvement in current service provision and support

A full scrutiny review was carried out by a sub-group of the Health Select Commission and the Improving Lives Select Commission, chaired by Cllr Stuart Sansome. Evidence gathering began in September 2014, concluding in February 2015. This comprised presentations, round table discussion and written evidence from health partners, RMBC officers, Rotherham Youth Cabinet and desktop research.

Although the principal focus of the review was RDaSH CAMHS these services are not provided in isolation but are part of a complex system of service commissioning and provision. The new emotional health and wellbeing strategy and recent changes to RDaSH CAMHS, such as the reconfigured Duty Team and self-referral are positive. More flexible services across a range of community settings, and greater links to youth services and schools is a priority to progress further. The volume of referrals to RDaSH is high and although waiting times have been reduced for routine assessments the target is still being exceeded with the service likely to continue to face high demand.

Improved communication between agencies and with families; clear access criteria, referral and care pathways; and renewed attention on health promotion, self-help and early support will help to reduce the number of young people with deteriorating mental health and emotional wellbeing. Data quality remains an issue and greater attention should be paid to improving and measuring outcomes. Prevention and early intervention should remain a focus to try and reduce the number of young people needing support at higher levels or continuing into adulthood, given the emergence of many lifelong conditions during adolescence.

Recommendations:

The review formulated 12 recommendations as follows:

1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.

2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on the service users and patients:
    a. to help maintain a detailed local profile of C&YP's mental health over time
    b. to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.

3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.

4. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.

5. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.

    "Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)

    Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.

6. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.

7. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.

8. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.

9. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.

10. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.

11. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.

8. Finance

Any recommendations from the Select Commissions will require further exploration by RMBC and health partners on the cost, risks and benefits of their implementation.

9. Risks and Uncertainties

Accessible and high quality mental health care is essential for children and young people in all parts of the borough to achieve improved health outcomes and reduced health inequalities for our community. Higher levels of deprivation in Rotherham mean the prevalence of mental health disorders is estimated to be 14% above the UK average. The Joint Strategic Needs Assessment and local consultation identified high levels of emotional, behavioural and attention deficit disorders at 4-19 years and high levels of depression from 20+.

It is difficult to maintain an accurate overall picture of children and young people's mental health and the prevalence of mental health conditions across the borough, including comparisons over time. This is due to the complexity of multiple providers, different IT systems, variations in data recording, and young people moving between or in and out of services as their level of need changes, or potentially not accessing support.

Prevalence rates of mental health conditions in the population are estimated on the basis of national studies, taking account of the impact of socio-economic and demographic factors. However the current national prevalence rates were published by the Office of National Statistics in 2004 and are likely to be out of date.

10. Policy and Performance Agenda Implications

RMBC Corporate Plan Priorities:
- Helping to create safe and healthy communities
- Ensuring care and protection are available for those people who need it most.
Health and Wellbeing Strategy
Public Health Outcomes Framework

11. Background Papers and Consultation

See Section 8 of the review report and appendices.

12. Author

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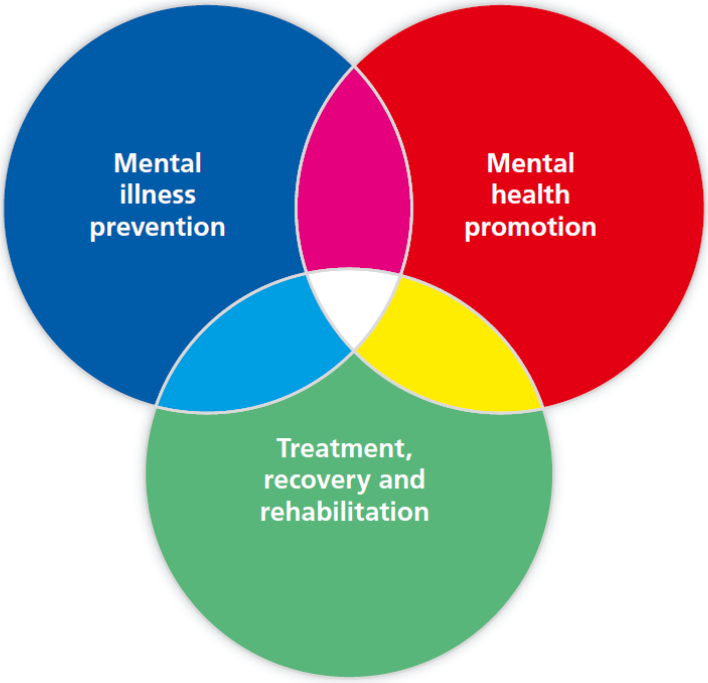
Rotherham Metropolitan Borough Council
Where Everyone Matters

DRAFT

Scrutiny review:
Child and Adolescent Mental Health Services



Joint Review of the Health Select Commission and the Improving Lives Select Commission

September 2014 – March 2015

Scrutiny Review Group:

Cllr Shabana Ahmed
Cllr Judy Dalton
Cllr Jane Hamilton
Cllr Barry Kaye
Cllr Stuart Sansome (Chair)
Cllr Maureen Vines

Report v2 27 March 2015

Contents

Executive summary

The review group comprised the following members: Cllr Shabana Ahmed, Cllr Judy Dalton, Cllr Jane Hamilton, Cllr Barry Kaye, Cllr Stuart Sansome (Chair) and Cllr Maureen Vines.

There were seven aims of the review, which were to:

1. understand the prevalence and impact of mental health problems and illness amongst children and young people in Rotherham
2. understand the costs, value for money and quality of current services
3. clarify how partners work together to support children and young people across all the tiers, especially the role of the Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Duty Team
4. establish how RDaSH engages with service users and their families/carers in order to deliver appropriate and effective services
5. ascertain how identifying and responding to child sexual exploitation is integrated within RDaSH Child and Adolescent Mental Health Services provision
6. determine how effective support for the mental health and emotional wellbeing of Looked After and Adopted Children is provided
7. identify any areas for improvement in current service provision and support

The review was structured around these aims with evidence gathered through written information and discussions with Rotherham Clinical Commissioning Group, Rotherham, Doncaster and South Humber NHS Trust, Rotherham Youth Cabinet and the Looked After and Adopted Children Support and Therapeutic Team; written evidence from RMBC officers and other agencies, supported by desk research.

Summary of findings and recommendations

Although the principal focus of the review was RDaSH CAMHS these services are not provided in isolation but are part of a complex system of service commissioning and provision. The new Emotional Wellbeing and Mental Health Strategy for Children and Young People is a welcome development and should address key issues Members explored in this review, helping to resolve many of the problems young people are experiencing in accessing mental health services. Improved communication between agencies and with families; clarity over access criteria, referrals and care pathways; and renewed attention on health promotion, self-help and early support/treatment will help to avoid the numbers of young people with deteriorating mental health and emotional wellbeing, or in crisis. Data quality remains an issue and there should be greater attention paid to improving and measuring outcomes.

Recent changes to RDaSH CAMHS are positive, such as the reconfigured Duty Team and self-referral. More flexible services available across a range of community settings, and greater links to youth services and schools are a priority to progress further. The volume of referrals is high and although waiting times have been reduced for routine assessments the target is still being exceeded with the service likely to continue to face high demand.

Prevention and early intervention should still be a focus to try and reduce the number of young people needing support at higher levels or continuing into adulthood, given the emergence of many lifelong conditions during adolescence.

Exploring a single point of access to CAMHS, with young people triaged to the most appropriate service, seems a positive step towards developing services with the needs of the YP at its heart and surmounting some of the difficulties noted in the course of this review.

Recommendations

1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.

2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on the service users and patients:
    a. to help maintain a detailed local profile of C&YP's mental health over time
    b. to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.

3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.

4. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.

5. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.

6. *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)*

    Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.

7. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.

8. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.

9. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.

10. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.

11. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.

12. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.

1. Why Members wanted to undertake this review

At its meeting in April 2014, the Health Select Commission (HSC) decided to focus its work around the theme of mental health and wellbeing during the 2014-15 municipal year. Further to this it was agreed in July 2014 that a review of Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Child and Adolescent Mental Health Services (CAMHS) be included in the work programme, following local concerns and a report from Healthwatch.

The overall purpose of the review was to identify any issues or barriers which impact on children and young people in Rotherham accessing timely and appropriate RDaSH CAMHS services at Tiers 2 and 3, and in particular in having an assessment within three weeks.

There were seven aims of the review, which were to:

1. understand the prevalence and impact of mental health problems and illness amongst children and young people in Rotherham
2. understand the costs, value for money and quality of current services
3. clarify how partners work together to support children and young people across all the tiers, especially the role of the RDaSH Duty Team
4. establish how RDaSH engages with service users and their families/carers in order to deliver appropriate and effective services
5. ascertain how identifying and responding to child sexual exploitation is integrated within RDaSH Child and Adolescent Mental Health Services provision
6. determine how effective support for the mental health and emotional wellbeing of Looked After and Adopted Children is provided
7. identify any areas for improvement in current service provision and support

2. Method

A full scrutiny review was carried out by a sub-group of the Health Select Commission and Improving Lives Select Commission, consisting of Cllrs Ahmed, Dalton, J Hamilton, Kaye, Sansome (Chair) and M Vines. Cllrs Hoddinott and Steele were also involved in the early stages of scoping the review and determining lines of inquiry.

An initial report to the Health Select Commission provided an introduction and set the national and local context. Several evidence sessions then followed during which current services, referral processes, resources, performance measures, service user engagement and partnership working were explored in depth. Evidence for the review was gathered through the following means:

- Presentations and discussion with Rotherham Clinical Commissioning Group (RCCG) and Rotherham, Doncaster and South Humber NHS Trust (RDaSH)
- Written information submitted by Rotherham Healthwatch and RMBC officers in Public Health, Commissioning and the Looked After and Adopted Children's Support and Therapeutic Team
- Anonymised case studies to understand how services work together in complex cases
- Round table discussion with members of Youth Cabinet
- Follow up information from RCCG and RDaSH
- Desk top research
- Public engagement at Fair's Fayre event at Magna

Members would like to thank everyone who gave evidence for the review and in particular colleagues from RDaSH and RCCG who provided comprehensive information about mental health services for children and young people in Rotherham. The review group also appreciate the willingness of Rotherham Youth Cabinet to share the findings of their work on mental health.

3. Background

Parity of esteem is the principle that mental health should be given equal priority with physical health. This means equal access to support, treatment and services for both mental and physical ill health and resources for mental health that are commensurate with need. At present no national waiting time targets for mental health are in place, unlike physical health, although these are being introduced, commencing with Improving Access to Psychological Therapies.

Rotherham's new Emotional Wellbeing and Mental Health Strategy for Children and Young People (EWS) includes the following definition of CAMHS, highlighting the importance of an integrated approach across a range of partner agencies.

> "Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone."
>
> (Source – http://www.everychildmatters.gov.uk/health/CAMHS)

In Rotherham mental health services for children and young people are delivered by a range of providers (see model in Appendix A), so it is important to emphasise that this review primarily focused on the CAMHS services provided by RDaSH. Members also considered the interface between RDaSH and other partner agencies and RDaSH involvement in multi-agency working.

At present services are structured around the pyramid model on the next page. This also indicates the percentage of children and young people (C&YP) estimated to have emotional wellbeing and mental health needs at each level, based on national prevalence rates. Recently this model has been challenged for being based around the services provided, rather than services being developed based upon the needs of C&YP and their families. RDaSH Duty Team plays a central role as a pathway and link between universal services and targeted (Tier 2) and specialist (Tier 3) services and is covered in more detail in section 5.3.

Non-specialised services Tier 1 - services provided by professionals in universal services who are in a position to identify mental health problems early on, provide general advice to young people and families, and to take up opportunities for mental health promotion and prevention.

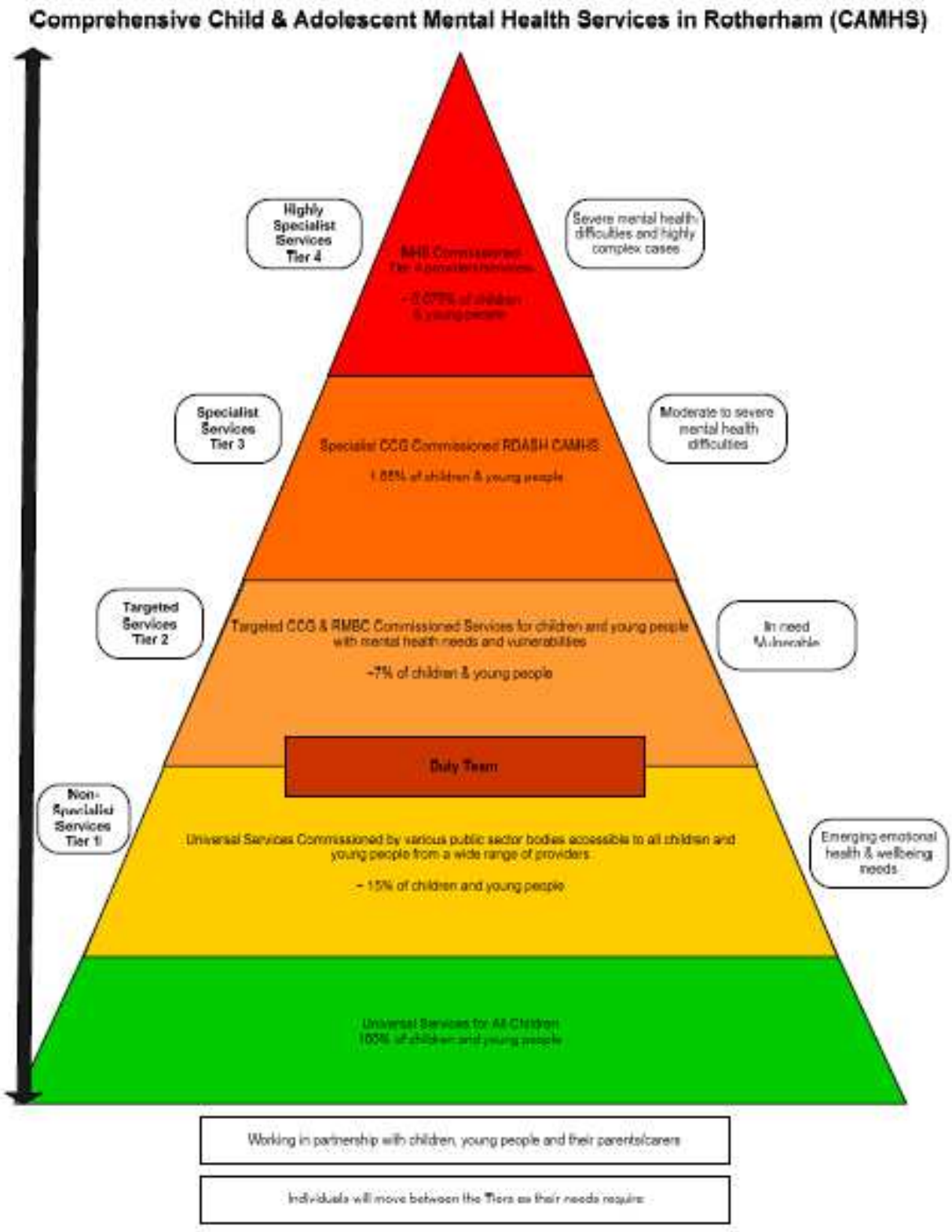
Targeted services Tier 2 - services provided by professionals with training in mental health, usually 1:1. From RDaSH CAMHS this includes social workers, therapists, nurses, doctors and psychologists. Services include assessment, brief mental health interventions, advice for C&YP with mental health problems, and support to GP's and workers from universal services.

Specialist services Tier 3 - services for more severe, complex or persistent conditions, usually by a multi-disciplinary team. Professionals involved may be child psychiatrists, clinical child psychologists, child psychotherapists, nurses, occupational therapists, speech and language therapists, family therapists, and art, music and drama therapists. Tier 3 includes specialist therapeutic interventions, services for those with established problems, diagnostic assessment pathways for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD), and mental health interventions for children with a dual diagnosis (learning disability and mental health).

Highly specialised services Tier 4 - such as day services, specialist out-patient teams and inpatient units provided by a range of professionals as in Tier 3, but these are not provided by RDaSH in Rotherham.

Rotherham's 0-19 Population

0-4	5-9	10-14	15-19	Total
16,300	15,400	14,900	15,700	62,300



Kurtz Z, 1996.

4. Context

4.1 National Policy Framework

No health without mental health, a cross-government mental health outcomes strategy for people of all ages was launched by the Government in February 2011, setting out its vision for improving mental health and wellbeing in England in the longer term based on six core objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The strategy was followed by the *Mental Health Strategy Implementation Framework* and *Suicide Prevention strategy* in 2012. In February 2014 *Closing the gap: priorities for essential change in mental health* was published by the Department of Health. This "seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems". It identifies 25 areas where people can expect to see and experience the quickest changes, with four specific issues for children and young people being:

- There will be improved access to psychological therapies for children and young people across the whole of England.
- We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services.
- Schools will be supported to identify mental health problems sooner.
- We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18.

The Children and Families Act 2014 introduced reforms for disabled children and young people and those with Special Education Needs through the introduction of new Education, Health and Care Plans from birth to 25 years. This latest legislation adds to other longer standing policy and guidance on services for children and young people as outlined in the *Analysis of Need*.

4.2 Children and Young People's Mental Health and Wellbeing Taskforce

NHS England published its *CAMHS Tier 4 Report* in July 2014, looking at concerns regarding inpatient services and drawing attention to the complex commissioning arrangements for CAMHS. As a result the Government established a taskforce comprising experts on children and young people's mental health, including children and young people themselves, and key organisations from health, social care, youth justice and education.

The Commons Health Select Committee also undertook an inquiry into CAMHS and their report *Children's and adolescents' mental health and CAMHS* identified problems across the whole of CAMHS. The Committee made a number of recommendations, many directed to the taskforce to address.

The taskforce published its report *Future in Mind* in March 2015 outlining changes and improvements necessary to bring about better access to support and to improve the commissioning and provision of CAMHS. The report identified five key themes viewed as "fundamental to creating a system that properly supports the emotional wellbeing and mental

health of children and young people". These are Promoting resilience, prevention and early intervention; Improving access to effective support – a system without tiers; Care for the most vulnerable; Accountability and transparency; and Developing the workforce.

4.3 Local strategy

Health and Wellbeing Strategy
Rotherham Joint Health and Wellbeing Strategy, together with the Joint Strategic Needs Assessment (JSNA), guide commissioning plans and priorities in order to improve health across the borough and reduce health inequalities. Following a life course framework the "starting well" and "developing well" stages cover ages 0-19. High levels of emotional, behavioural and attention deficit disorders at 4-19 years and high levels of depression from 20+ are key issues that emerged from the JSNA and consultation. The strategy is being refreshed in 2015, providing an opportunity for renewed focus on mental health and wellbeing and in his annual report last year the Rotherham Director of Public Health recommended: "Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems."

Emotional Wellbeing & Mental Health Strategy for Children and Young People 2014-19
A comprehensive strategy and action plan was developed by RMBC and RCCG in partnership with provider services, drawing upon research, national guidance and a detailed needs analysis. Consultation with stakeholders, including parents/carers and young people informed the final version. The strategy contains 12 recommendations (see Appendix B) and has taken account of the Attain review commissioned by RCCG and the RDaSH CAMHS review by Healthwatch.

The Child and Adolescent Mental Health Services Strategy and Partnership Group meets quarterly and oversees the implementation of the strategy and action plan. Representatives from all areas of commissioning and service provision across CAMHS are involved, plus Healthwatch and the Parents Forum. The immediate focus has been on care pathway development, including for ASD and ADHD where specific concerns have been raised, and developing a new website with dedicated sections for young people, parents and professionals.

Other initiatives and plans
Workstreams address mental health and wellbeing across all ages, such as the *CARE about Suicide* guide which follows the principles of Concern, Ask, Respond, Explain developed by Public Health. Specific to young people are the excellent work by Rotherham Youth Cabinet on self-harm in 2014 and a new pathway for support for C&YP bereaved by suicide.

5 Findings

5.1 Impact and prevalence of mental health problems

Impact
Higher levels of deprivation in Rotherham mean the prevalence of mental health disorders is estimated to be 14% above the UK average. This has a significant impact on our community and for individual people and their families and friends, as well as creating more demand for services and support. There is also a substantial financial implication as the annual short term costs of emotional, conduct and hyperkinetic disorders among children aged 5-15 years in the UK was estimated to be £1.58billion in 2012.

Key facts

- 1 in 4 adults in the UK experience a mental health disorder in the course of a year
- 1 in 5 children have a mental health problem in any given year
- 1 in 10 children aged 5-16 years has a clinically diagnosable mental health problem

- 50% of adult mental health problems occur before the age of 14
- Mental ill health is the largest single cause of disability in Rotherham
- People with serious mental health problems have their lives shortened by 14-18 years on average
- Mental health affects people's academic achievement, employment opportunities and economic activity
- Poor physical health also impacts on mental health with children experiencing a serious or chronic illness twice as likely to develop emotional disorders
- 11–16 year olds with an emotional disorder are more likely to smoke, drink or use drugs
- Around 60% of Looked After Children and 72% of those in residential care have some degree of emotional and mental health problem
- 1 in 10 people wait over a year for access to talking therapies

Prevalence

Although a broad needs analysis informed the development of the EWS it is difficult to maintain an accurate overall picture of C&YP's mental health and the prevalence of mental health disorders/conditions across the borough, including comparisons over time. This is due to the complexity of multiple providers, different IT systems, variations in data recording, and young people moving between or in and out of services as their level of need changes, or potentially not accessing support.

Prevalence rates of mental health disorders in the population are estimated on the basis of national studies, taking account of the impact of socio-economic and demographic factors. However the current national prevalence rates were published by the Office of National Statistics (ONS) in 2004 and are likely to be out of date. This is best illustrated by the scrutiny review of autism spectrum disorder (ASD) which found that the higher than predicted rate of ASD in Rotherham was due to good work locally in raising awareness and successfully identifying ASD as a condition. The ONS rates pertain to ages 5-16 rather than 0-19, so further extrapolation across the full age range was carried out in Rotherham for the needs analysis.

During the course of the Health Select Committee inquiry in Parliament the Government committed to fund a refresh of the national prevalence rates. Members welcome having more up to date research to inform local need and future commissioning plans to ensure effective support and services for children and young people.

The National Institute for Health and Care Excellence (NICE) also publishes clinical guidance on mental health topics and conditions. Other useful sources of local information include:

- annual Rotherham Secondary Schools Lifestyle survey
- numbers of C&YP under 18 who are entitled to Disability Living Allowance for a mental health condition
- numbers of children with a Special Educational Need

In Rotherham, there are an estimated 6,800 children and young people aged 0-19 with a diagnosable mental health disorder, 2,600 with an emotional disorder (anxiety or depression), 4,100 with a conduct disorder, 1,100 with a hyperkinetic disorder (ADHD), 640 with ASD and 280 with a rare disorder. Marked gender differences in prevalence show a much higher incidence of conduct and hyperkinetic disorders and ASD in boys than girls across all age groups and a higher incidence of emotional disorders in girls aged 11-16. Services and support should meet the needs of both male and female C&YP and be sensitive to any specific needs in relation to their other equality protected characteristics or additional vulnerabilities such as homelessness or being a looked after child.

5.2 Costs, value for money and quality of current services

Costs and value for money

It is a challenge to obtain a detailed breakdown of overall spending on CAMHS provision across all the tiers and on respective spending on the three areas of prevention, promotion and treatment as in the World Health Organisation framework. Much activity at lower levels forms part of workstreams that are not dedicated entirely to mental health and emotional wellbeing. Similarly it has been hard to unpick RDaSH areas of spend within its overall contract and RCCG are progressing this with them. Understanding spending will become more significant if there is a move away from the current position of a block contract to a payment by results system for mental health, which is on the horizon. In terms of value for money and the efficiency and effectiveness of spending it is also critical to understand the cost base and to have a robust set of outcome measures.

National

NHS net expenditure was £109.721bn in 2013/14, with planned expenditure for 2014/15 increasing to £113.035bn (NHS confederation). Dawn Rees[1] commenting on the Chief Medical Officer's Report in September 2014 stated that "CAMHS receives only 0.7% of the total NHS budget and only 7% of the total mental health budget is spent on CAMHS. Mental health care receives only 13% of the NHS spending but mental health accounts for 25% of total morbidity in England. The CMO's report shows that there has been a real terms fall in investment in CAMHS since 2011".

Local

The following table shows current spending by RMBC and RCCG within each tier of CAMHS provision.

Tier	Service	Commissioner	Annual cost
1	Families for Change Intensive Family Support	RMBC	112,946
2	IYSS Youth Start	RMBC	128,000
2	Rotherham & Barnsley Mind	RMBC	60,000
2	LAAC Support & Therapy Team	RMBC	229,000
2/3	RDaSH CAMHS	RCCG	2,101,080
		RMBC	139,166

Via a partnership agreement with RMBC the CCG is the lead commissioner for Tier 2 and 3 RDaSH CAMHS services. RMBC contributes £139k p.a. through the CAMHS grant and also funds Know The Score (KTS), the YP's substance misuse service (£218k p.a.). £20,000 of the Public Health budget is specific to mental health for activity such as mental health awareness raising and stress management training. However other workstreams such as promoting healthy lifestyles, occupational health and the work of health trainers also contribute to mental health and emotional wellbeing. For the current partnership agreement period April 2014 - March 2015, RMBC has stipulated that its funding is to be utilised for three CAMHS Locality Workers and workforce development (universal services and RMBC), which aligns with agreed priorities in the EWS.

In terms of mental health spend RCCG is within the top 20 CCGs, spending £30.9m in 2013-14 (including learning disability services) with planned spend for 2014-15 of £31.3m, or just under 10% of the budget. Of this the contract with RDaSH is £28m for services across all age groups, including the £2.3m approx. for CAMHS. The remainder funds out of area and continuing healthcare placements, plus some other smaller providers including VCS.

As with all health providers RDASH has had to make 4% efficiencies in 2014-15 (equating to £1.1m achieved through savings in non-pay expenditure and non-clinical posts) and again in 2015-16. 4% efficiency means a reduction in real income of 1.9% as there is a 2.1% allowance for inflation. There is scope for RCCG to reinvest savings realised in wider services.

Quality of current services
RDaSH was fully compliant in a CQC inspection of Trust services in October 2013 and fully compliant with the Essential Standards of Quality and Safety inspected by the CQC since July 2012, including care planning and record keeping.

'Fit 4 the Future' is RDaSH's organisational development programme, which includes modules dedicated to quality, innovation, culture and leadership. This quality priority is aligned to the Strategic Goal of 'Continuously improving service quality (safety, effectiveness and patient experience) for our patients and carers'. A relatively new quality review team comprising staff from across the trust, equivalent to a "mini Care Quality Commission", has been formed to consider all services. The Strategic Leadership Team in Rotherham meets every two weeks and monitors improvements. Other internal processes include team meetings, business division monitoring, looking at plan delivery, and consideration of complaints and any serious incidents.

Following a contract query RCCG has worked closely in partnership with RDaSH to address certain issues in relation to the CAMHS contract. Through the implementation of a detailed action plan improvements have been made, with positive feedback from GPs. RDaSH provides regular performance data to RCCG as part of the contract monitoring arrangements but there is scope for further development in this area. Monthly contract performance meetings and bi-monthly CAMHS Service Development and Improvement Plan meetings consider performance and quality of services. As stated above the CAMHS Strategy & Partnership group also meets quarterly.

RDaSH engages with families and C&YP to obtain feedback on services and their experiences, which is covered in more detail in section 5.4.

5.3 RDaSH services for children and young people in Rotherham

RDaSH is commissioned to deliver Tier 2 and 3 generic CAMHS services for specific issues including self-harming behaviours, suspected psychosis, mood disorder/depression, eating disorders, severe behavioural problems, anxiety disorders, gender dysphoria, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, suspected ASD and suspected ADHD. The trust also delivers Learning Disability CAMHS and Know the Score. There is no internal step up and down process within RDaSH for C&YP moving between Tier 2 and Tier 3 as the service is an integrated one with interventions delivered dependent on assessed needs. Appendix C provides an overview of staffing and the service model.

"A gentleman visited the shop to tell us the support he receives from CAMHS was excellent. His daughter is currently using CAMHS. " *(Source: Healthwatch Feb 2015)*

"Difficult to access support when someone has a dual diagnosis ..... "

In answer to question 'what worked well?' at Fair's Fayre:
"Talking about problems and working out health related issues." *(Source: Fair's Fayre)*

RDaSH is also participating in the national Improving Access to Psychological Therapies initiatives (also known as talking therapies) for both adults and children and young people. C&YP's Improving Access to Psychological Therapies services are not available in GP surgeries and there is a focus on more use of ICT in delivering the services.

Snapshot of caseload

In December RDaSH provided the review group with a useful snapshot of their current caseload at that time and key information from this snapshot is included throughout this section in addition to the graphs below.

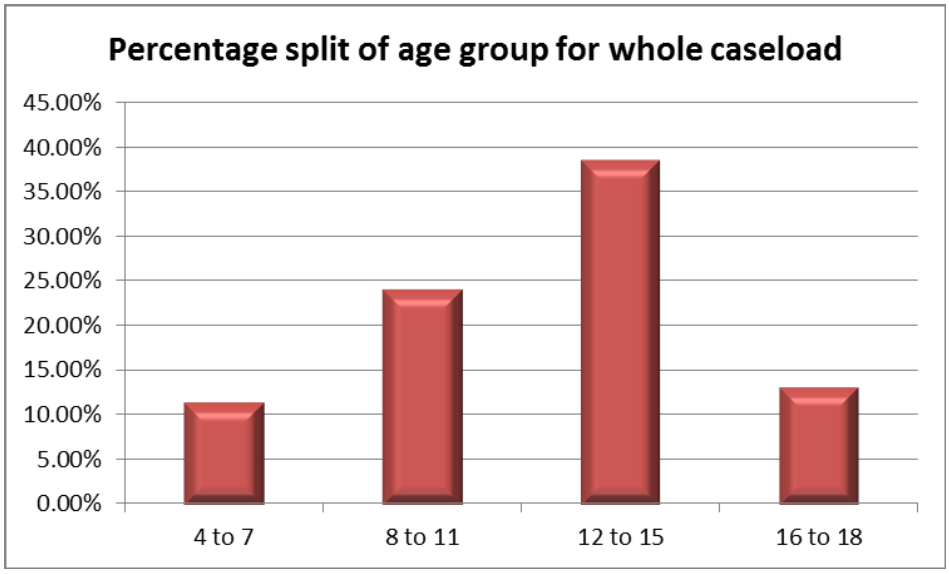
- The caseload includes C&YP from various ethnic communities, although the vast majority (where ethnicity is recorded) are White British. Ethnicity recording is an area for improvement in helping to develop a broader picture of C&YP's mental health across the borough.

- 493 (38%) cases of the open caseload were female and 799 (61.6%) male with five cases where the gender was not recorded, 1297 cases in total.

- LD CAMHS have an on-going case load of approximately 100 service users and KTS 101 cases.

- The 12-15 age group accounts for just under 40% of the caseload.

- The service currently has 12 Looked After Children on its caseload, 23 young people being worked with who are children in need and ten on a child protection plan. None of the Looked After Children had made a self-referral into the service



Referrals by postcode area	Postcode area	Number of referrals	% of caseload by postcode
	S25	119	9.2%
	S26	113	8.7%
	S60	135	10.4%
	S61	190	14.6%
	S62	74	5.7%
	S63	94	7.2%
	S64	83	6.4%
	S65	205	15.8%
	S66	238	18.4%
	Other	46	3.6%
		1297	

Further information provided in February 2015 gives an overview of the numbers of young people within various care pathways but also illustrates where data is not currently collected and reported on at present.

<table>
<tr><th rowspan="2"></th><th colspan="2">On diagnostic pathway</th><th rowspan="2">Comments</th></tr>
<tr><th>Waiting for diagnostic assessment</th><th>At some stage of diagnostic assessment</th></tr>
<tr><td>ADHD</td><td>14</td><td>78</td><td>Plus 274 on the post diagnostic ADHD pathway who are monitored for medication.</td></tr>
<tr><td>LD</td><td colspan="2">90</td><td rowspan="2">In addition to the individual ADHD, LD and ASD figures there are 517 YP currently in treatment with the service who will be receiving interventions from those pathways and may be involved with multiple pathways at any given time e.g. a YP on the ADHD pathway may also be receiving interventions from the self-harm or emotional disorders pathway.</td></tr>
<tr><td>ASD</td><td>57</td><td>45</td></tr>
<tr><td>Self-harm</td><td colspan="2" rowspan="3">RDaSH do not currently collect data</td><td>Anecdotally staff in the core and duty teams observe that an increasing number of YP are presenting with self-harm.</td></tr>
<tr><td>Depression</td><td></td></tr>
<tr><td>Conduct Disorder</td><td>Anecdotally CYP-IAPT trainees say that for YP meeting the NICE criteria for conduct disorder it was often challenging to maintain sessional work with the families to provide interventions due to the wider nature of the social/welfare issues.</td></tr>
</table>

RDaSH CAMHS Duty Team

Following a service reconfiguration in November 2014 the team comprises four experienced clinicians on a permanent basis rather than being staffed in a less structured manner, including with agency staff. Three of the clinicians are on duty each day supported by a medical member of staff as necessary. The team is available between 9am and 5pm Monday to Friday for families and professionals to contact them for advice and guidance on referrals and support. The aim of the reconfigured service is to improve the consistency of decision making for referrals and build expertise, as well as being an access pathway.

The team members will also link with and signpost to other agencies if referrals do not meet RDaSH criteria. They lead the weekly clinic at the IYSS Youth Hub (see below) and liaise with paediatricians and A&E at the hospital. Another role of the Duty Team is to build links with GPs through attending the GP locality meetings. The next phase of locality based work to roll out will be in schools and other youth and community settings in line with the CAMHS grant funding and EWS.

Staff are supported through clinical supervision to manage their caseload workload with fortnightly clinical meetings for multi-disciplinary discussions around complex cases and risk management.

Further developments through the EWS are to look at developing a single point of access for services with an RDaSH Duty team member working with RMBC Early Help team. In this way

people presenting to community services or GPs with a low level of need that is inappropriate for RDaSH CAMHS can be referred promptly to the right support, with less likelihood of C&YP slipping between tiers or providers. RDaSH suggested that to ensure gaps are minimised a series of locally agreed standards for services would enable each referring or transitioning agency to be assured that the care of the YP had been accepted.

Self-referral
RDaSH CAMHS initiated a self-referral system for young people aged 14+ to refer themselves to their service in September 2013. In the period Jan-Nov 2014 there were 17 self-referrals, numbering between 0 and 3 each month.

The IYSS Youth Hub at Eric Manns Building in Rotherham hosts a joint Youth Start and RDaSH weekly drop-in clinic for assessment and self-referral into the most appropriate CAMHS to meet the needs of the young person. Between April and November 2014 37 young people aged 12-17 years, mainly female, had attended. Joint decision making takes place with the young person regarding their support. Young people have also phoned the Duty Team directly to self-refer rather than go through the joint clinic.

GPs are informed following assessment as with any other referral, but not necessarily the family. This will be dependent on the wishes of the YP and their competency to consent although RDaSH try to persuade all YP to involve their family. In any cases where the risk assessment suggests there are risks the family need to be aware of (and the YP does not wish RDaSH to inform them), discussion would take place with the safeguarding nurse.

Pilot - Additional Psychiatrist
Concerns were raised by practitioners and GPs regarding access to consultant psychiatrists, leading to long waiting times for diagnostic appointments and treatment. Another issue was in relation to access to suitable staff by ADHD clinic users who have a medication review every 3-6 months. In response it was decided to pilot having an additional 1.0 WTE Consultant Psychiatrist (through non-recurrent funding at present) so that service users, families and GP's would benefit from better and timely access to specialist expert knowledge and skill. A locum Consultant Psychiatrist was recruited in June 2014 to support the duty team, paediatric liaison and ADHD clinics. This will be reviewed during the discussions regarding service planning and funding for 2015-16. Members would like to see this additional funding become recurrent.

Out of hours
As part of the service specification RDaSH must provide a 24/7 emergency assessment service by a CAMHS clinician for children and young people experiencing acute mental health difficulties. Another pilot project has established an out of hours on-call service staffed by CAMHS clinicians on a rota at weekends, with the clinician on duty at Rotherham Hospital. Referrals may be by other professionals or people may arrive at A&E initially. In addition the Crisis Team provide 'out of hours' support to CAMHS patients aged 16 to 18.

Sickness absence
RDaSH staff turnover is very low in Rotherham but there has been high sickness absence in the last 12-18 months (5.4% in 2013). Longer term absences will be covered by agency staff but sometimes on the day appointments have to be cancelled if no-one else is available. There is a robust monitoring system with triggers for both short- and long-term absence. Counselling and staff workshops such as stress busting are available for support if staff have difficulties. The trust is working to tackle sickness absence but it is another factor that has impinged on access to services.

Referrals
A key concern has been referrals made to RDaSH CAMHS that do not meet their criteria and in the past this has led to referrals being bounced back rather than referred on to another service.

On the other hand RDaSH have tried to signpost to other agencies only to find that some provision is no longer available or the thresholds have changed.

One of the issues that emerged during the review was the lack of core information provided on many of the referrals to RDaSH from partner agencies. This is causing delays in triaging the referral as the Duty Team waste time chasing up the requisite information on which to make a decision. RDaSH calculate that a lack of sufficient information results in an additional average of 90 minutes time spent, per referral, contacting various parties. Between 1 Nov – 18 Dec 2014 RDaSH received 11 GP referrals that provided little or no clinical information that would allow the duty team to triage the referral. This will be fed back to the commissioners through existing reporting processes.

Common Assessment Frameworks (CAFs) are a comprehensive source of information but are not appropriate for all referrals and would be too time consuming for GPs to complete. The service does not currently record whether or not a CAF is received with the referral and anecdotally this is thought to be less than 5% of all referrals received.

Although RDaSH assured Members that all agencies may contact the Duty Team and make referrals the review heard of schools not making direct referrals themselves but referring families to their own GP first. This contributes to further delays in the YP receiving support and potentially means an unnecessary GP appointment when it is widely documented that GPs are struggling with the volume of demand for appointments. Conversely information shows referrals from health professionals seemingly being rejected by RDaSH because schools had not been involved. Members learned that for ADHD and ASD diagnosis RDaSH need to take account of reports from Educational Psychologists. This may sometimes cause delays as the service is now commissioned in a different way and is no longer universal although the vast majority of schools do buy in the non-statutory element.

"Eight year old who has been referred to CAMHS once by a consultant from RGH and twice by her GP. CAMHS have refused to assess her son stating that it has to be the school who refer. School have also refused to refer to CAMHS."

"Son has been referred three times to CAMHS and three times CAMHS have refused to assess him." *(Healthwatch)*

'Top Tips' documents developed through the CAMHS Strategy and Partnership Group provide guidance for GPs and partners (Appendix D) respectively to assist them in referring young people to the appropriate mental health service. In essence these outline the access criteria for services depending on the issues or symptoms presented. Complementing these is a directory of services outlining emotional health and wellbeing provision and the level of need (universal, vulnerable, complex or acute) at which the services operate.

Members emphasised the importance of awareness raising and training with partners and schools to resolve the issues for making and accepting referrals and to ensure the right information is provided at the outset. Using the top tips guidance and maintaining the directory of services up to date is also vital to ensure referrals are made to the right service as provision and access thresholds change over time.

It is understandable that parents will not always agree with decisions made regarding support and assessment for their children, especially when they are struggling. Tensions and upsets have arisen in particular when RDaSH have said that a case is a parenting issue. This is where clear communication and sensitivity is called for with parents/carers and C&YP, explaining the reasons why a referral to a particular service is not judged to be appropriate and ensuring that the YP or their family are signposted or referred on correctly.

Waiting times for assessment and treatment

RDASH CAMHS have key performance indicators (KPIs) for waiting times for assessment and treatment to meet as part of their contract specification. All referrals are triaged within 24 hours by the Duty Team, who also assess the urgent cases within 24 hours of receipt of referral, with face to face follow up within 7 days. The KPI for assessing routine referrals is 15 days, which is a higher target than many areas in the country. Waiting times for both assessment and treatment have been reduced after a concerted effort to address them and additional short term funding but the service is struggling to meet demand. As at December 2014 the number of C&YP awaiting assessment was 245 with new referrals coming in each month. Appendix E provides detailed statistics on waiting times for assessment and for treatment on a monthly basis and weekly data with regard to the three week target. In June/July 2014 C&YP were waiting over 14 weeks for a generic appointment, but this is now down to five weeks.

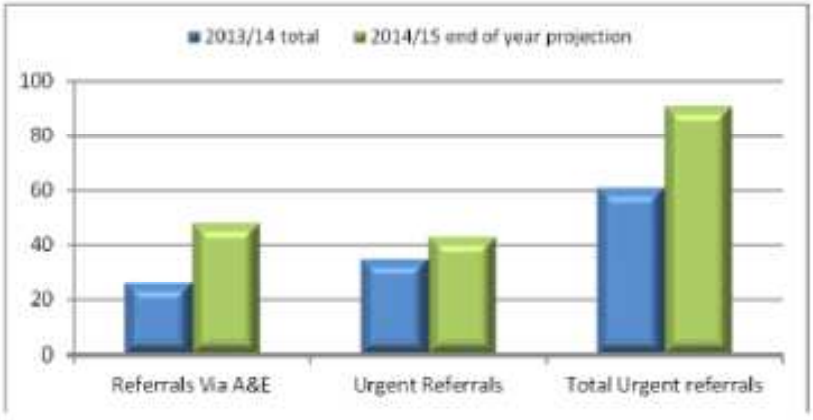
At the evidence session in November the following data was presented.

Target	Performance
100% of patients receiving initial Mental Health Assessment within 24 hours in A & E	100%
100% of referrals triaged for urgency within 24 hours	73.6% due to a recording issue (but usually above 97%)
100% of Urgent referrals assessed within 24 hours	80% (family reasons such as not wanting assessment)
95% of triaged referrals assessed within 3 weeks	11.2% - current wait 8 weeks (since reduced to 5)
95% of patients treated within 18 weeks	93% (at September).

Overall RDASH CAMHS is receiving a high level of referrals, which impacts on the numbers waiting for a service, particularly C&YP waiting for routine assessments as the urgent referrals will be prioritised first. Service capacity is for 131 referrals per month with an average of 91 referrals accepted into the service, the remainder referred on or signposted to other services. Averaging 158 referrals per month on top of those still waiting adds to the difficulties. In addition urgent referrals have averaged 12 per month, plus the small number of self-referral assessments. Extra agency staffing has augmented the number of assessment and follow up treatment slots available each month to try and reduce the backlog. Appendix F has more details of capacity and demand.

Numbers of referrals reduce in August and December and rise again after the school holidays. Contacts with the duty team and referrals also increase during the build up to school exams and coping with exam stress is an area the Youth Cabinet are discussing with RDaSH.

The graph below shows the projected total of urgent referrals for 2014-15 compared to 2013-14 (based on data to the end of October 2014) – a projected increase of 50%. Urgent referrals via A&E had already passed the total for last year by October.



Health partners believe reductions in provision in universal Tier 1 services have had a knock on effect on services at Tier 2 and above, evidenced by greater numbers of referrals, especially urgent referrals. A shortage of inpatient beds at Tier 4 also creates pressures at Tier 3 and RDaSH has had to redirect resources to provide a safe, appropriate service for some YP.

Other factors contributing to increased referrals are benefit reform and long-term sickness absence from work through stress and mental health disorders during the economic downturn in recent years. Financial pressures and parental mental health and wellbeing issues tend to increase the risk and vulnerability for their children's emotional health and wellbeing.

RDaSH undertook a detailed capacity and demand review, working with individual clinicians, reviewing their caseloads and developing a job plan that fits with the requirements for their current post. This has been shared with commissioners and discussions are taking place regarding possible additional funding to meet the increased demand.

Members did discuss the overall resourcing of CAMHS services across the board and in particular at the lower levels to support prevention and early help and support, which is central to RMBC's policy framework for C&YP and the Joint Health and Wellbeing Strategy. C&YP benefit as they receive support and/or treatment earlier before their needs increase, including also hopefully preventing escalation into adulthood, and saves money in the longer term. Members recognise the squeeze on resources and the negative impact this has had on some services but hope their recommendations will help to deliver change through more effective use of existing resources coupled with the positive changes made by RDaSH and through the implementation of the new EWS.

"Waiting long time between getting to speak to someone and getting help – 2 month backlog"

"Daughter getting worse whilst waiting for treatment." (Fair's Fayre Oct 2014)

Length of time in RDaSH CAMHS

One point discussed with health partners was the length of time some C&YP are engaged in services and whether there was scope to move patients/service users on more quickly, reducing waiting times for other YP to gain access to services. This is a difficult issue as there are always judgements to be made about prioritisation of need and how ready people are to move on safely to other services or to be discharged. Such decisions have to be made by the clinicians with patient/service user and family/carer involvement, ensuring that adequate support is in place for the next phase of their recovery. RDaSH say that if young people form an attachment it can be hard for them to cut links. Members did not request data on this issue so it is not clear if length of time in services is routinely captured to inform a borough wide profile.

Appointment times and missed appointments (DNAs)

Concerns had been raised that CAMHS deleted children's names from the waiting list if they missed the first appointment but RDaSH made it clear that this does not happen. However, if a family DNA then their waiting time re-calculates to the date of the missed appointment so their position on the waiting list changes in line with the revised date. The waiting list is refreshed and monitored daily, and also forms an integral part of weekly performance monitoring meetings and monthly divisional performance meetings.

A Trust Policy deals with the process for both DNAs and families who are disengaging from the service. A revised Standard Operating Procedure and flow chart details the process to follow after a DNA for an initial assessment. A clinician assesses the risks and action needed if either the family cannot be contacted or they have been contacted and do not want a further

appointment. Members also noted in one of the case studies determined efforts made by RDaSH to remain in contact with one YP who had missed an appointment.

RDaSH CAMHS are primarily delivered from 9-5 at Kimberworth Place, which can be a barrier to access as this is during standard working hours for parents/carers and within the school or college day for young people. This is also reflected in satisfaction scores for convenience of appointment times which was the lowest score on the questionnaire (see Appendix G Figure 1). RDaSH would prefer to have the current 15 day target for routine assessments raised to 20 days feeling that this would enable them to offer families more choice of appointment time and venue. This issue is currently under discussion with RCCG.

Members sought feedback via the Parents Forum around the timing of appointments, with the following response:

"The general consensus is that in the main families appreciate a quick appointment and value the short time scale, alleviating fear and feeling relieved that the process has begun. However, they were also anxious that should they not be able to make the appointment offered because of other commitments they would be 'put to the bottom of the list' (direct quote from experience of a parent when offered an appointment). In light of this, once contact is made with the family for an appointment, a mutual time/date arranged would be valued. Quite often the appointments are set in stone and offered with no alternative rather than mutually agreed."

Members spent some time discussing the 15 day target and current performance on waiting times for treatment and assessment. Their view was very clearly that C&YP need to be assessed and receiving treatment and support at the earliest opportunity and that every effort should be made to reduce delays in the system to reduce the risk of the young person's mental health deteriorating. Plans to roll out services to a wider range of locations across the borough and with more flexibility over times were welcomed by the review group and this should be prioritised as part of service reconfiguration and development. However Members recommend that the 15 day target remains in place during 2015-16 as some of the recent positive changes being made by RDaSH and through the EWS action plan should be bedding in.

Communications and information

Clarity on what the various providers deliver and their respective access criteria is paramount for all agencies, C&YP and their families. This is best illustrated again by ASD, as although RDaSH CAMHS carry out diagnosis of ASD their remit is not post diagnosis support unless the young person also has a mental health problem that meets their criteria. As the Autism Communication Team is a school based resource RDaSH cannot refer YP to the team post diagnosis. To this end the pathway development planned for a number of conditions within the EWS will be positive and as stated earlier the CAMHS Strategy & Partnership group has prioritised its work on this.

A new website with sections for C&YP (with involvement from Youth Cabinet members), parents/carers and professionals respectively is under development and due to go live from April. Members expect the website to be accessible and include a mechanism for feedback from users and that it will be capable of recording the number of hits each section receives so partners know the extent to which it is being used.

Transition

Transition refers to YP leaving CAMHS services when they reach 18 years and transferring into Adult Mental Health Services (AMHS) if required. Nationally and locally transition has been recognised as an area for improvement and the quotes show two very different experiences.

"Long time still in CAMHS when should be in AMHS"

"CAMHS ended and AMHS not commenced, information wasn't shared." (Youth Cabinet research)

Currently six young people have a referral to AMHS ADHD Clinic, plus 27 potential transitions that may be required to this service, depending on whether they require medication reviews or therapy post 18 years of age. Five young people within the Learning Disability Pathway Team are at various stages of transitioning to adult services. Within the core team three young people have had a joint transition plan meeting and are in the process of transitioning to adult services, two of whom currently have a referral to AMHS. Another three young people may also require transition to adult services and discussions are currently taking place.

Peer Support Workers
In this award winning initiative the trust has recruited people who have a lived experience of mental health problems to support young people through the transition process if they require on-going mental health support beyond their 18th birthday. Transition work commences at 17½ years when the worker will meet with the YP, talk about the transition, provide support in meetings with AMHS and advocate on behalf of the YP. In conjunction with Speak Up one of the Peer Support Workers supports YP who also have learning disability who will need to transfer to Adult learning disability services. Service user evaluation of the benefits of the Peer Support Worker role has been positive.

Outcome Measures
Routine outcome measures and session by session feedback are being introduced to improve the quality and experience of services, with CYP-IAPT trainees initially being the main providers of data. Peer Support Workers are also using sessional feedback. Figure 2 in Appendix G shows good average feedback scores for four questions. Some outcome measures particularly promote the principles of recovery, mainly goals based outcomes with young people identifying their own goals and measuring progress against them each session.

This is a positive step and an area for further development. Outcome measures also need to be linked to the definition of treatment which is currently classed as the second appointment by RDaSH. The service is working with RCCG on this matter to ensure new definitions are agreed that are meaningful for both the individual and in general for mental health services.

5.4 Engagement with young people and their families and carers

'Listen to Learn', is the Trust's Patient, Carer and Public Engagement and Experience Strategy. It is defined as the active participation of citizens, patients and carers and their representatives in the development of health services and as partners in their own health care.

RDaSH employ a range of methods to engage with service users and their families and to elicit feedback on their experiences of using services. Examples include:

- 'Experience of Service' questionnaires - as part of capturing service evaluation parents/carers are invited to complete anonymous surveys, available at Kimberworth Place and community settings. Results are collated every quarter (see Appendix G Figure 1).
- Patient feedback is received via the Patient Advice and Liaison Service (PALS) and local Your Opinion Counts surveys
- Rotherham Parents Forum Ltd. – parents/carers from across the borough who work in partnership with RMBC and RCCG to influence policy and improve the quality, range and accessibility of services for C&YP who are disabled or who have additional needs.
- RDaSH created a new Parent Support Officer post as a result of the Healthwatch report to set up support groups for parents/carers.
- The Peer Support Workers designed a poster campaign to recruit children, young people and families to engage in service planning and consultation; and led various consultation events in local colleges and schools which have informed service development.

- Young people have been involved in interview panels for clinicians.

The Healthwatch report did identify engagement and communication with families as an issue, including parents/carers not feeling listened to or not being involved in their child's care and discharge planning. RDaSH responded positively to their findings and are working with them on further improvements, so this report will not replicate further details from the Healthwatch report.

5.5 Rotherham Youth Cabinet

Like the Health Select Commission Rotherham Youth Cabinet (RYC) have a focus on mental health this year, following on from their recent work on self-harm. They have carried out their own research to gather the experiences of YP who have used RDaSH CAMHS and are currently working with RDaSH clinicians to discuss ways to improve services and information.

"Better to have counselling in youth centres as this is a more comfortable setting for YP and they are more likely to open up." (Youth Cabinet research)

Key issues they have identified include long waiting times, uncertainty about available services, support with exam stress, feeling uncomfortable at Kimberworth Place and transition to AMHS, especially if YP have only started using CAMHS at 16 or 17.

Members recognise the valuable input that RYC will have in helping to inform service development and will request an update report later in the year to see how RDaSH have responded to their research and suggestions.

From meeting with RYC during the review Members learned that Personal, Social, Health and Economic education (PSHEE) in schools seems to be reducing, despite good resources being available through the Health Schools co-ordinator. This is a concern as schools do have wider social responsibilities and should be working with young people on a range of issues such as domestic abuse and healthy relationships, mental health and wellbeing, bullying and CSE - providing support, via the curriculum and through PSHEE. The recent House of Commons Education Committee report *Life Lessons: PHSE and SRE in schools* recommended that PSHE and Sex and Relationships Education (SRE) should be given statutory status.

In addition to identifying and responding to C&YP with behavioural difficulties or potential ASD or ADHD schools are well placed to identify any emerging emotional wellbeing issues.

5.6 RDaSH Case studies

As requested prior to one of the review sessions RDaSH brought anonymised case studies with them to discuss in depth, which included different complex issues for three young people, two female and one male. Referral routes to RDaSH had been through the GP and by self-referral. A range of factors were covered which had contributed to the young people becoming unwell and/or needing support. These case studies included difficult personal and family relationships or home environments, being a looked after child, the YP's sexuality, attachment issues, bullying at school and issues arising from the YP developing their gender identity. YP presented to services with issues that included low mood, self-harm, trauma, suicidal thoughts, and possible ADHD.

All three cases involved services and support from multiple agencies and two of the three showed very clear involvement of the YP in decisions about their care. The third was at an earlier stage so the focus was on engagement and support to manage risk. One case necessitated a very intensive intervention in the first few days to deal with the immediate crisis

and ensure the young person's safety before starting to deal with the underlying issues. Two cases resulted in a referral by RDaSH CAMHS to the child sexual exploitation team.

Members recognised the good interventions in these case studies to ensure the young people were safe and the multi-agency partnership working approaches to provide support, manage risk and ensure continued engagement by the YP with the service.

5.7 Partnership working

Multi-agency work
RDaSH confirmed that once more than one partner is involved in a case multi-agency meetings usually take place even if the case is not at the level of safeguarding. Different agencies call the meetings including RDaSH, and social care will call them if there are legal issues. As there are potentially so many meetings RDaSH staff seek advice over which to prioritise and this is decided on a case by case basis. Sometimes meetings are called with very tight deadlines and if someone is on leave or off sick a written report is submitted. Commitment from all agencies is improving but there needs to be clear outcomes, actions and respective responsibilities.

Partnership working on child sexual exploitation and support for looked after children are covered in sections 5.8 and 5.9.

Multi Agency Safeguarding Hub
Data provided by the Multi Agency Safeguarding Hub (MASH) shows the origin of contacts to the team. Between 1 January – 24 March 2015 17,845 contacts were logged from 79 sources such as self-referral, members of the public, family members, schools and a range of partner agencies including RDaSH. 46% of contacts were from the police. Contacts with the team relate to many issues and include messages about current cases and requests for information, not only referrals. From 1st April 2015, when the MASH is fully established, further work is planned with regard to logging contacts as currently there is some grouping under broad headings such as "Other health services" so this will provide a more precise overview.

Mental and physical health
Members were keen to explore how RDaSH works together with other partner agencies to improve both the mental and physical health of C&YP, given the impact that one has on the other. The expectation of RDaSH is that every care plan will address the issues identified in the initial assessment and risk assessment and be holistic, addressing physical, mental, social, personal relationships, spiritual, cultural, emotional, educational and daytime activity needs. The care plan should draw on any available wider multi-agency assessment information such as a Common Assessment Framework, Early Help Assessment or Core Assessment and be shared effectively with those who are part of it.

All YP are assigned a care coordinator or lead clinician who would take responsibility for their overall mental health care whilst involved with RDaSH CAMHS. The care coordinator liaises with other agencies such as school or CYPS if needed and also informs the GP about the assessment information, plan of care, any changes whilst in treatment and a discharge letter outlining the intervention and treatment received. Whilst the care coordinator will be expected to deliver a holistic plan of care the GP would be expected to retain oversight of wider health issues. Where there are co-existing or potential concerns related to physical health or development, systems are in place to ensure GP's and paediatricians can assess and treat physical health needs as part of the overall care delivery. There is also weekly dietician input into the service.

Clinical staff represent the service on the multi-agency pathway development meetings which take a multi-agency approach to care. The service is also represented at the clinician to

clinician meetings where all partners discuss and explore solutions for the delivery of joined up multi-agency care.

5.8 How child sexual exploitation is integrated within RDaSH CAMHS provision

Overview and Scrutiny Management Board (OSMB) undertook in-depth scrutiny of Rotherham's plans to tackle child sexual exploitation (CSE) in December 2014 following publication of the Jay Report. Therefore in this review Members did not intend to duplicate that work but wished to be clear on the current position. OSMB established that RDaSH will ask direct questions of service users, which may uncover issues of historical abuse for some people.

RDaSH work with C&YP who are vulnerable and have been abused when there are known or suspected emotional or mental health needs that meet their service criteria. However they are not commissioned specifically to provide post abuse support. Currently there are 30+ C&YP in the service with mental health problems who have experienced CSE and they tend to be in either generic CAMHS or Know the Score. Additional disclosures have been made recently.

RCCG have provided RDaSH with additional short term funding for 0.4wte clinical psychotherapist to March 2015 as part of the local response to CSE. The extra clinician is providing therapeutic work and consultation (specific to CSE victims) across child and adult mental health and providing support for other practitioners.

RDaSH are represented on the Local Safeguarding Children Board and involved in the multi-agency safeguarding arrangements. Two of the three case studies discussed during the review involved referrals from RDaSH to the CSE team. Information was fed back that RDaSH needed to keep the YP safe but not all information is shared by the CSE team if it could impact on investigations or evidence.

Staff are trained to recognise the signs of CSE but as Members learned during the review C&YP will present with one issue but often have other underlying issues which it may take time to uncover and it is not easy for C&YP to disclose abuse to a stranger.

Ongoing work is taking place on CSE by Scrutiny, which will include support to victims and survivors, and the evidence gathered as part of this review will feed in and inform the further scrutiny of services.

5.9 Support for Looked After and Adopted Children

Following a service reconfiguration seven years ago RMBC established the Looked After and Adopted Children's Support and Therapeutic Team (LAACSTT), providing a dedicated service based around the needs of LAAC in the areas of emotional and developmental health and attachment. The service provides training, resources, advice and support to foster carers and adoptive parents, residential staff, social workers and other professionals. Support and direct interventions offered include art therapy, parenting advice, attachment based care, life story work, trauma based work, theraplay, counselling and solution focussed work. The LAACSTT operates mainly at Tier 2 with a clear focus on prevention through training, but also deliver some Tier 3 work in clinics. All the LAC have experienced abuse or neglect otherwise they would not be in care, therefore they all need therapy but not all will want it.

The team work with carers so they better understand why a child might be acting up or rejecting them. This entails teaching and training with carers to skill them up in being able to offer therapeutic care to C&YP and to be able to talk about issues as a family. Group work enables work with larger numbers but some carers prefer 1:1s. Others prefer to ring for advice without wishing to attend a course, or being able to because of work commitments for example. Health

visitors can help when children are under 5 and it is important that all parents and carers are able to access telephone advice. The LAACSTT also wishes to develop the therapeutic skills of staff in residential care homes to work with C&YP in a similar way to foster carers.

The team has to complete an annual Strengths and Difficulties Questionnaire for each individual LAC as a government performance indicator. Over 11s complete their own version of the form and once analysed the LAACSTT ring the YP back to discuss it. The key is to capture information with regard to outcomes and if the C&YP are doing better in care.

RDaSH provide services for LAAC with more complex needs at Tier 3 but there is liaison between the two services, and with Education Psychology where needed, to ensure appropriate interventions. LAAC at risk of self-harm or with suspected autism would be referred to RDaSH CAMHS as they are specialists in these areas. .

"Young people have felt that the waiting times are too long."

"Waiting 18 weeks to be seen isn't good enough, she was in a bad place, however when she was seen she felt positive about the support she received" (*Youth Cabinet research)*

One local gap is that RDaSH do not have a forensic team for work with YP who have committed offences but are not under the Youth Offending Team, for example YP who could be sexually harmful to other children. Special assessments are in Sheffield and often the LAACSTT arranges to take the YP rather than incur higher costs of the clinician coming to Rotherham.

The LAACSTT ensures Rotherham C&YP in care placements out of the borough, or who have been adopted and moved to another area, receive the right service. If other CAMHS services are needed the team has worked well with RCCG who will commission the necessary services. One example was a YP out of area whose local CAMHS had a seven month waiting list so arrangements were made for RDaSH to see the YP.

The Departments of Health and Education published new joint statutory guidance in March 2015, *Promoting the health and wellbeing of Looked After Children*, for local authorities, NHSE and clinical commissioning groups. It reflects changes to the NHS following the Health and Social Care Act 2012, the reform of the special educational needs legislative framework and the need for parity of esteem between mental health and physical health. Partners will have to take account of this guidance in their work. A recent CQC inspection of RCCG with regard to LAC and Safeguarding is also likely to make recommendations about future services and support.

Child Sexual Exploitation
The LAACSTT takes clinical psychology trainees from university, who are close to qualifying, on placement. One of whom recently worked with the CSE team, helping to devise their in-school strategy and working with them on evaluating their work on CSE to help them think more therapeutically and about needs.

Training for foster carers to spot any signs of CSE and training for in house staff as to why YP are vulnerable was highlighted as being vital. The LAACSTT have worked with victims and survivors of CSE, providing some with therapy for the trauma they have experienced and others with support for anger management to deal with their anger towards their abusers.

6 Conclusions

Although the principal focus of the review was RDaSH CAMHS these services are not provided in isolation but are part of a complex system of service commissioning and provision. As a result the review group has made a number of wider recommendations besides ones which are pertinent only to RDaSH.

The new Emotional Wellbeing and Mental Health Strategy for Children and Young People is a positive development and good example of partnership working. Implementing the supporting action plan should address key issues Members explored in this review and help to resolve many of the barriers and difficulties C&YP and families are experiencing in accessing mental health services. Data quality remains an issue and it is important that once the initial activities in the strategy are carried out there should be greater attention on improving and measuring outcomes for C&YP.

Similarly changes to RDaSH CAMHS provision are also positive, such as the reconfigured Duty Team, joint clinic with IYSS and self-referral. As some changes are still quite recent they will take time to embed and should be reviewed and their impact evaluated in due course. More flexible services available across a range of community settings, and greater links to youth services and schools are a priority to progress further.

Reduced provision within universal Tier 1 services has had a knock on effect on demand for services at higher levels of the pyramid and C&YP's problems are likely to become more acute through not being able to access earlier support. Shortages of inpatient beds at Tier 4 also increase pressures at Tier 3 to provide a safe, appropriate service.

Although RDaSH has succeeded in reducing waiting times for routine assessments the target is still being exceeded and the service is likely to continue to face high volumes of referrals. Nevertheless with the potential for the improvements mentioned to relieve some of the pressure on RDaSH CAMHS, and taking account of parent and YP's views, Members recommend that the target waiting time for routine assessments should remain at three weeks.

In line with the strategic framework for C&YP in the Children's Plan and Early Help Strategy prevention and early intervention work should still be the focus to try and reduce the number of young people needing support at higher levels or continuing into adulthood, given the emergence of many lifelong conditions during adolescence. The refresh of the Joint Health and Wellbeing Strategy with its core priority of prevention and early intervention provides an opportunity to revisit provision in Tier 1 and to focus more on the role of schools in early identification of problems, pastoral care and Personal, Social, Health and Economic education.

Improved communication and information sharing between agencies and with families, clarity over access criteria and pathways, and renewed attention on health promotion, self-help and early support/treatment will help to reduce the number of young people with deteriorating mental health and emotional wellbeing, or in crisis.

Clearly it is better for C&YP's health and wellbeing if they receive support and treatment early before their problems increase or their condition worsens, but it also saves money on costlier interventions at a higher level or later in life. This issue is the focus of action 4.5 in the EWS and is a key one in the context of ensuring early support within ongoing financial pressures.

A single point of access to CAMHS, with the young people then referred to the most appropriate service based on their level of need through effective triage, seems a positive step towards building services with the needs of the YP at its heart and surmounting some of the operational difficulties noted in the evidence to this review.

Members discussed vulnerability and additional needs of YP at length during the review. They emphasised that the care pathway development needs to take account of equality protected characteristics and potential additional vulnerability such as being a looked after child.

7 Recommendations

1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.

2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on the service users and patients:
    a. to help maintain a detailed local profile of C&YP's mental health over time
    b. to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.

3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.

4. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.

5. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.

6. *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)*

    Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.

7. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.

8. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.

9. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.

10. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.

11. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.

12. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.

8. Thanks

Our thanks go to the following for their contributions to our review:

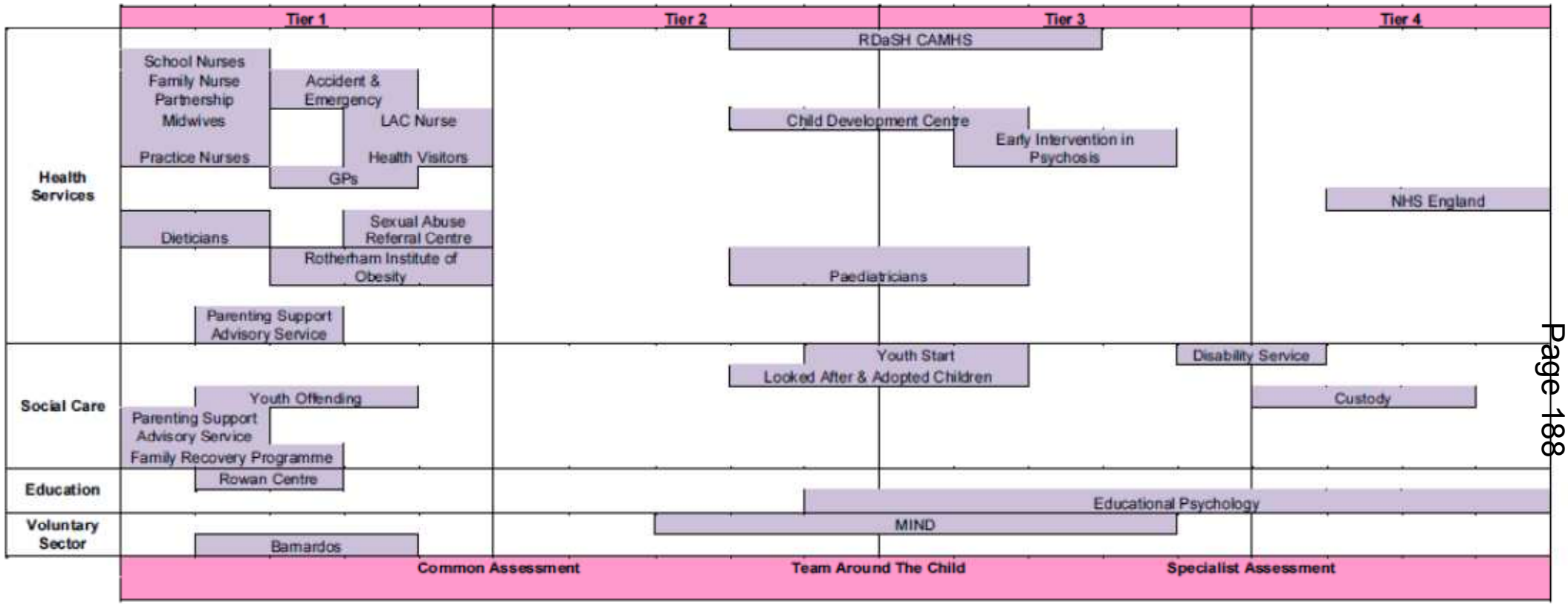
Partners and RMBC

Nathan Batchelor - Rotherham Healthwatch
Dr Russell Brynes - Rotherham Clinical Commissioning Group
Dr Robin Carlisle - Rotherham Clinical Commissioning Group
Dr Alison Davies - Rotherham, Doncaster and South Humber NHS Trust
Karen Etheridge - Rotherham, Doncaster and South Humber NHS Trust
Ruth Fletcher-Brown - RMBC
Melanie Hall - ex Rotherham Healthwatch
Nigel Parkes - Rotherham Clinical Commissioning Group
Neil Power - Rotherham, Doncaster and South Humber NHS Trust
Sharon Schofield - Rotherham, Doncaster and South Humber NHS Trust
Rotherham Youth Cabinet members: Ashley, Avumile, Emilia, Katie, Koukab, Leah, Mark, Oliver, Owen, Paige, Rebecca, Tom, Toni and Zakki (supported by Sarah Bellamy from IYSS)
Paul Theaker - RMBC
Dr Sara Whittaker - RMBC

9. Background papers

- Mental Health Scrutiny Reviews, Report to Health Select Commission, 11 September 2014
- Notes and presentations from review evidence sessions
- Emotional Wellbeing and Mental Health Strategy, Report to Health and Wellbeing Board, 12 November 2014
- Notes from Youth Cabinet meeting 20 November 2014
- Notes and information from Youth Cabinet meeting with CAMHS 17 February 2015
- Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014-2019
- Analysis of Need: Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014
- Children and Adolescent Mental Health Services, Produced by Parents and Healthwatch Rotherham, May 2014
- Executive Summary of NHS Rotherham CCG Mental Health, Child and Adolescent Mental Health, and Learning Disabilities Review, May 2014
- NHS Rotherham CCG – Review of CAMHS Services Project Initiation Document
- Service Specification for RDaSH CAMHS
- RDaSH Quality Account 2013-14
- NHS Rotherham CCG Commissioning Plan 2014-19
- Closing the Gap: Priorities for essential change in mental health, Department of Health, February 2014
- Children's and adolescents' mental health and CAMHS Third Report of Session 2014–15 House of Commons Health Committee, November 2014
- Parity of Esteem, Centre for Mental Health October 2013
- Child and Adolescent Mental Health Services Tier 4 Report, NHS England, July 2014
- Promoting the health and wellbeing of Looked After Children Statutory guidance for local authorities, NHS England and clinical commissioning groups, March 2015, Departments of Health and Education
- Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing, Department of Health and NHS England March 2015
- CSN policy briefing *Life lessons: PSHE and SRE in schools* – Commons Education Committee, 25 March 2015
- Diagram on front cover - Source: Annual Report of Chief Medical Officer 2013 - model based on WHO framework

Appendix A **Model of CAMHS providers in Rotherham**



Appendix B

The recommendations from the Emotional Wellbeing and Mental Health Strategy for Children and Young People

Recommendation 1
- Ensure that services are developed which benefit from input by young people and parents/carers.

Recommendation 2
- Develop multi-agency care pathways which move service users appropriately through services towards recovery.

Recommendation 3
- Develop family focussed services which are easily accessible and delivered in appropriate locations.

Recommendation 4
- Ensure that the services being delivered are effective, appropriate and represent the best value for money for the people of Rotherham.

Recommendation 5
- Ensure that the services being provided are delivered at the appropriate time as required and not restricted to normal operating hours.

Recommendation 6
- Ensure that services across all tiers of provision are delivered by appropriately trained staff and that training and support is provided to Universal/Tier 1 services to ensure that patients do not unnecessarily move to higher tiers of provision.

Recommendation 7
- Ensure well planned and supported transition from child and adolescent mental health services to adult services.

Recommendation 8
- Explore the option of a multi-agency single point of access to mental health services for children and young people to ensure that appropriate referral pathways are followed.

Recommendation 9
- Ensure that services are better able to demonstrate improved outcomes for children and young people accessing mental health services.

Recommendation 10
- Promote the prevention of mental ill-health.

Recommendation 11
- Reduce the stigma of mental illness.

Recommendation 12
- Ensure that patients do not face inappropriate delays in accessing services, across all tiers, for assessment and treatment which adversely affect their recovery.

Appendix C **RDaSH staffing and service model**

50.6 wte staff cover whole service provision as follows:-

- 21.8 wte staff including nurses, a social worker, art and occupational therapists provide tier 2 and 3 CAMHS services
- 5.0 wte employed on Learning Disability CAMHS pathway
- 4.5 wte on the substance misuse pathway
- 9.7 wte admin across the service
- 5.25 wte medical:
  - 1.85 wte Consultant Psychiatrists
  - 0.4 wte Specialist Consultant Psychiatrist LD CAMHS
  - 1.0 wte Associate Specialist doctor
  - 2.0 wte trainee Medical staff

- Duty team
- CAMHS generic clinicians:
  - routine referrals and follow up treatments weekly for 6 sessions (non-specialist)
  - manage and support mental health pathway (anxiety, phobias, depression, psychosis)
  - link with tier 4 and adult services
- Cognitive Behaviour therapist provides specialist cognitive behaviour interventions mainly to mental health pathway
- Family therapists work across pathways
- ASD Pathway - assessment and diagnosis
- ADHD pathway - diagnosis and follow up clinics

If the YP reaches 6 sessions then there is a review to see what else is needed.

RDaSH have one CB therapist so the YP would go on their list for a 1hour session; the therapist then reviews the situation.

Appendix D "Top Tips" guidance

Guidance for Universal Workers and targeted workers on Referral of Children & Young People with Emotional Wellbeing Issues		
Referrals to **Universal Services** and **Routine CAMHS** and **Urgent CAMHS** referrals.		
Issue	**Symptoms/presenting problems**	**Refer to:-**
Behavioural Difficulties	• Poor behaviour at Home only	**Evidence Based Parenting Programme.** For under 5s please contact Health Visiting Team in the first instance
	• Poor behaviour at School only	School (Learning mentor, SENCO, Behaviour Support Team) Integrated Youth Support Service (IYSS)
	• Severe behaviour in both home & School Note – The CDC will accept referrals for behaviour difficulties where they are associated with additional development concerns, e.g. social communication differences, speech and language delay, gross or fine motor problems.	Discuss with Health Visitor first. Child Development Centre (CDC) for under 5 years, CAMHS (Routine) for over 5 years.
Eating Disorders	• Eating Issues (Low Level) – Will only eat certain foods	**Health Visitor if under 5 or GP if over 5**
	• Anorexia: evidence of self induced weight loss and/or fear of fatness • Rapid and sustained weight loss • Bulimia: Persistent binge & purge behaviour.	**CAMHS (Routine) & also GP (for physical assessment)**
	• Obesity	**Rotherham Institute for Obesity (RIO)**
Anxiety Disorders	• Worrying about specific situations	**School Nurse, School (learning mentor, Behaviour Support Team etc.), Youth Start, MIND, MAST**
	• Severe, persistent anxiety. • Panic attacks. • Attachment disorders • Severe and disabling phobia where it is impacting on a young person day to day life and ability to functions (Social and specific phobias).	**CAMHS (Routine)**
Mood Disorder or Depression (Refer if symptoms present for at least 2 weeks)	• Low mood, not impacting on daily life and no risk evident (no suicidal thoughts or self harm)	**School (learning mentor pastoral support, Behaviour Support Team), Youth Start, MIND, School Nurse, MAST**
	• Persistent low mood. • Physical symptoms – poor sleep (or early wakening) or loss of appetite and weight • Cognitive symptoms inc. pervasive negative thoughts • Loss of interest/Social isolation/withdrawal seen at home and school. • Suicidal thoughts without planned intent (discuss urgency of referral with team)	**CAMHS (Routine)**
	• Suicidal thoughts with planned intent **REFER URGENTLY.** • Suicidal thoughts without planned intent (discuss urgency of referral with team) • Previous attempts to end life	**CAMHS (Urgent)**
Post Traumatic Stress Disorder – Symptoms Following an event very traumatic to the individual	• Avoidance of reminders of the traumatic event. • Persistent anxiety. • Repeated enactment of reminders of the traumatic event. • Intrusive thoughts and memories – e.g. nightmares. • Sleep disturbance. • Hypervigilance. • Symptoms continuing longer than three months following event.	**CAMHS (Routine)**
Self-Harm	Always discuss case with duty team to help guide urgency • Presenting with maladaptive coping strategies but less severe/frequent/recent.	**CAMHS (Routine), Youth Start, MIND and MAST**
	• Presenting with maladaptive coping strategies (e.g. self-cutting and **where recent occurrence**).	**CAMHS (Urgent)**
Obsessive Compulsive Disorder (OCD)	• Repetitive, intrusive thoughts, images or behaviour affecting daily life & activity. • Obsessions/compulsions causing functional impairment.	**CAMHS (Routine)**

Relationship Difficulties	• General relationship difficulties	**Youth Start, School (Learning Mentors, pastoral support, Behaviour Support Team), School Nurse, Family Recovery Programme, Grow (15-19 years), MIND, MAST**
	• Persistent patterns of abnormal functioning in interpersonal relationships. • Where family dynamics are fractured and conflicts unresolved.	**CAMHS, Intense Family Support**
Suspected Autism Spectrum Disorder (ASD)	• Persistent and severe problems with communication & social & emotional understanding in 2 or more settings – e.g. Home, School. Consider whether referral would be better made by school and/or Educational Psychologist.	**Child Development Centre (CDC) for under 5 years, CAMHS (Routine) for over 5 years.**
Suspected Attention Deficit Hyperactivity Disorder (ADHD)	For Children aged 6 years & above only. Initially refer to parent training. Refer if symptoms persist after parenting work. • Poor concentration • Over-activity • Distractibility • Impulsivity All the above onset before 12 years old and persistent and evident in at least 2 settings, e.g. home, school.	**CAMHS (Routine)**
Psychosis or suspected psychosis	Criteria for Routine / Urgent referrals – Always discuss with duty team to assist decision making re urgency. If child over 16 refer to early intervention in psychosis team • Active symptoms inc.; Paranoia, delusional beliefs & abnormal perceptions, (hearing voices & other hallucinations). Fixed, unusual ideas. • Negative symptoms inc.; deterioration in self-care & social & family functioning.	**CAMHS (Routine)** **CAMHS (Urgent)**
Conduct Disorder	• Very severe and persistent behavioural problems, at home, school and in the community, and unresponsive to parent training. • If school related – preferable for school/ Educational Psychologist to make referral with relevant background information.	**CAMHS (Routine)**
Gender Identity Disorder	• Initial exploration of issues	**LGBT Youth Worker, LGBT Youth Group & Youth Start,**
	• Strong, persistent cross-gender identification. • Persistent discomfort in gender role. • Above causing impairment in social, family and school functioning.	**CAMHS (Routine)**
Chronic Fatigue/Somatisation Disorder (When physical symptoms are caused by mental or emotional factors it is called somatisation)	Criteria for Routine referrals – refer to GP in first instance. • Excessive fatigue. • Unexplained medical symptoms.	**CAMHS (Routine)**

A Directory of Services – **'Emotional Wellbeing Services for Children & Young People Living in Rotherham'** has been produced which gives further information on the **Universal Services** referred to above.

Process to be followed for CAMHS referral:-

1. In order to effectively triage a referral, please provide the contact telephone number for the child/young person and parent/carer
2. **Referrals** will be **acknowledged within 5 working days**, with the aim to have an **initial appointment within 15 working days** of receipt of referral. **Urgent referrals are seen within 24 hours.** If available, a copy of the Common Assessment Framework (CAF) should also be provided and parent/carer/child/young person permission demonstrated.
3. Following **Initial Assessment** – Needs are identified & where appropriate a management plan communicated to the referrer.

Where appropriate, referrals may be **signposted to other services** but only where child/young person and parent/carer contact details and consent is provided with the referral.

CAMHS Referrals should be sent with the child/young persons and/or family's consent and using the agreed **referral form** to:- **The Duty Team, Child & Adolescent Mental Health Service, Kimberworth Place, Kimberworth Road, Rotherham, S61 1HE.** Tel. 01709 304808. Fax. 01709 302547. Please **do not** send an electronic version of referral form attached to an e-mail. The form needs to be sent via postal services or faxed.

DO NOT REFER	**Do not refer** if not included in the above list. **If in doubt please discuss with the CAMHS Duty Team**
Date Approved: December 2014	**Review Date: April 2015**

Appendix E Waiting times for RDaSH CAMHS 2013-14

CAMHS - Waiting times against the RTT (referral to treatment)
Incomplete pathway within 8 Weeks
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks -28.0wks	28.1+wks	Total Above 8 Wks	Total	% of Patients Waiting for Treatment <8 Wks	Total Waiting for Treatment <8Wks
December	32	17	6	3	16	7	7	11	**99**	3	5	1	1	0	1	0	1	1	0	1	1	1	0	11	81	**108**	207	**48%**	99
January	43	28	19	15	10	5	2	2	**124**	4	4	10	1	3	1	1	0	1	0	1	0	0	1	6	81	**114**	238	**52%**	124
February	40	21	19	19	21	10	15	6	**151**	9	3	1	6	6	4	10	5	6	1	2	2	8	1	10	81	**155**	306	**49%**	151
March	35	24	32	30	19	16	11	6	**173**	1	4	2	2	2	0	1	0	0	1	1	4	1	1	3	16	**39**	212	**82%**	173

CAMHS - Waiting times against the RTT (referral to treatment)
Completed pathway within 8 Weeks
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks -28.0wks	28.1+wks	Total Above 8 Wks	Total	% of Patients seen within 8 Wks	Total seen <12Wks
December	5	5	9	7	3	6	4	3	**42**	2	3	1	0	1	0	0	0	0	0	0	0	0	0	1	3	**11**	53	**79%**	42
January	8	7	7	10	7	4	5	1	**49**	1	2	2	0	0	2	0	0	2	0	0	0	0	0	1	10	**20**	69	**71%**	49
February	7	1	10	14	2	4	3	3	**44**	0	2	0	3	1	0	0	1	0	0	0	0	0	0	1	1	**9**	53	**83%**	44
March	4	2	2	4	10	3	4	1	**30**	0	0	2	0	1	2	0	1	0	0	0	0	0	0	0	5	**11**	41	**73%**	30

Note Incomplete pathways are where the patient is still waiting for treatment and complete pathways are where they have started treatment. Under current reporting, treatment is defined as the second appointment.

Waiting times for RDaSH CAMHS 2014-15

CAMHS - Waiting times against the RTT (referral to treatment)
Incomplete pathway within 8 Weeks (92%)
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	Total Equal to or Above 18Wks	19.1wks - 20.0wks	20.0wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total	Total Above 8wks	% of Patients Waiting for Treatment <8 Wks	% of Patients Waiting for Treatment <18Wks
April	35	32	27	21	17	16	21	19	188	33	22	10	11	5	3	2	4	3	5	3	289	2	2	2	2	87	384	196	49%	75%
May	31	29	18	29	27	23	20	15	192	16	21	16	24	10	3	9	3	3	1	4	302	3	4	1	9	75	394	202	49%	77%
June	44	31	20	9	15	20	19	14	172	26	21	16	13	12	12	12	3	11	2	2	302	3	1	0	7	71	384	212	45%	79%
July	26	20	17	13	33	19	10	8	146	15	16	13	15	13	13	7	2	9	6	4	259	3	7	1	12	72	354	208	41%	73%
August	43	32	23	23	18	19	13	15	186	11	25	12	4	1	5	6	7	9	7	3	276	6	1	5	16	45	349	163	53%	79%
September	48	34	43	40	26	17	13	16	237	13	5	8	6	9	8	8	7	3	4	6	314	3	6	8	25	41	397	160	60%	79%
October	55	37	20	18	23	19	11	14	197	6	8	1	10	9	5	6	5	6	7	5	265	6	1	1	24	45	342	145	58%	77%

CAMHS - Waiting times against the RTT (referral to treatment)
Completed pathway within 8 Weeks (Target 95%)
New Patient Wait

Weeks	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	Total Equal to or Below 8 Wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	Total Equal to or Below 18 Wks	19.1wks - 20.0wks	20.0wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total	Total Above 8Wks	% of Patients seen within 8 Wks	% of Patients seen within 18Wks
April	7	2	3	1	8	7	5	4	37	4	0	2	2	1	0	1	0	1	0	1	49	2	0	0	0	2	53	16	70%	92%
May	5	1	1	0	2	1	2	5	17	7	3	2	2	4	0	1	0	1	0	0	37	1	0	0	0	3	41	24	41%	90%
June	7	2	0	1	0	2	0	1	13	0	6	9	6	3	1	1	2	1	1	0	43	0	1	0	0	4	48	35	27%	90%
July	5	2	0	1	1	0	1	0	10	1	0	2	3	5	2	2	1	2	0	1	29	0	0	0	2	0	31	21	32%	94%
August	5	1	2	2	2	1	0	1	14	0	3	3	3	4	11	5	3	2	4	0	52	3	0	0	1	3	59	45	24%	88%
September	6	4	1	2	0	1	1	4	19	1	11	5	11	3	1	2	1	2	0	1	57	0	0	1	1	2	61	42	31%	93%
October	3	5	0	2	6	9	13	2	40	5	3	2	2	4	1	2	0	1	1	0	61	0	1	0	2	2	66	26	61%	92%

The following relates to weekly data provided to the team regarding the waiting list for an initial assessment

CAMHS - Rotherham: Incomplete Pathway Assessment Waits - within 3 weeks - Excluding ADHD/ASD

Weeks/Data at this point in month	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	Total Equal to or Below 3 Wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total Above 3 Wks	Total	% of Patients waits within 3 weeks	% of Patient waits >3Wks
09/09/2014	27	34	22	**83**	19	10	17	12	26	17	10	6	7	7	1	0	1	0	0	0	0	0	0	0	0	**133**	**216**	**38%**	**62%**
15/09/2014	28	27	15	**70**	23	17	17	11	11	22	15	3	1	6	3	0	1	0	0	0	0	0	0	0	0	**130**	**200**	**35%**	**65%**
22/09/2014	46	21	25	**92**	15	21	16	15	11	11	20	7	2	1	3	2	0	1	0	0	0	0	0	0	0	**125**	**217**	**42%**	**58%**
29/09/2014	56	41	18	**115**	22	15	21	14	12	4	2	6	1	0	0	0	1	0	1	0	0	0	0	0	0	**99**	**214**	**54%**	**46%**
08/10/2014	70	41	52	**163**	19	21	20	9	10	3	5	2	3	4	0	0	0	0	1	0	0	0	0	0	0	**97**	**260**	**63%**	**37%**
13/10/2014	46	53	42	**141**	30	21	16	8	7	6	3	4	3	2	2	0	0	0	0	0	0	0	0	0	0	**102**	**243**	**58%**	**42%**
21/10/2014	48	43	53	**144**	39	28	11	5	5	2	4	0	3	0	3	1	0	0	0	0	0	0	0	0	0	**101**	**245**	**59%**	**41%**
27/10/2014	43	40	35	**118**	38	20	14	8	5	2	1	2	0	2	1	1	1	0	0	0	0	0	0	0	0	**95**	**213**	**55%**	**45%**
03/11/2014	38	42	36	**116**	29	24	14	4	3	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**77**	**193**	**60%**	**40%**
10/11/2014	32	32	31	**95**	23	15	15	8	3	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**68**	**163**	**58%**	**42%**
17/11/2014	53	21	21	**95**	17	19	6	9	4	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	**59**	**154**	**62%**	**38%**
24/11/2014	54	35	20	**109**	17	18	8	3	5	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	**55**	**164**	**66%**	**34%**
01/12/2014	46	43	22	**111**	13	6	4	6	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**34**	**145**	**77%**	**23%**
08/12/2014	42	42	33	**117**	14	3	3	3	5	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**31**	**148**	**79%**	**21%**

The following relates to weekly data provided to the team regarding young people that have had an initial assessment by how long they waited to be seen

CAMHS - Rotherham: Completed Pathway Assessment "Completed" - within 3 weeks - Excluding ADHD/ASD

Weeks/Data at this point in month	0-7days	1.1wks - 2.0wks	2.1wks - 3.0wks	Total Equal to or Below 3 Wks	3.1wks - 4.0wks	4.1wks - 5.0wks	5.1wks - 6.0wks	6.1wks - 7.0wks	7.1wks - 8.0wks	8.1wks - 9.0wks	9.1wks - 10.0wks	10.1wks - 11.0wks	11.1wks - 12.0wks	12.1wks - 13.0wks	13.1wks - 14.0wks	14.1wks - 15.0wks	15.1wks - 16.0wks	16.1wks - 17.0wks	17.1wks - 18.0wks	18.1wks - 19.0wks	19.1wks - 20.0wks	20.1wks - 21.0wks	21.1wks - 22.0wks	22.1wks - 28.0wks	28.1+wks	Total Above 3 Wks	Total	% of Patients waits within 3 weeks	% of Patient waits >3Wks
09/09/2014	4	0	0	**4**	0	0	0	0	0	0	0	1	9	3	0	0	0	0	0	0	0	0	1	1	0	**15**	**19**	**21%**	**79%**
15/09/2014	6	0	1	**7**	0	1	1	0	0	0	1	5	12	3	0	0	0	0	0	0	0	0	1	1	0	**25**	**32**	**22%**	**78%**
22/09/2014	10	0	1	**11**	1	2	1	1	0	3	6	9	13	4	1	0	0	0	0	0	0	0	1	1	0	**43**	**54**	**20%**	**80%**
29/09/2014	14	1	2	**17**	1	2	1	1	7	9	19	17	17	5	0	0	0	0	0	0	0	0	1	1	0	**81**	**98**	**17%**	**83%**
08/10/2014	1	0	1	**2**	1	0	3	4	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**12**	**14**	**14%**	**86%**
13/10/2014	3	3	1	**7**	1	0	6	8	3	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**22**	**29**	**24%**	**76%**
21/10/2014	4	7	3	**14**	1	5	17	12	3	1	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	**42**	**56**	**25%**	**75%**
27/10/2014	8	7	5	**20**	1	13	21	13	3	1	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	**56**	**76**	**26%**	**74%**
03/11/2014	10	11	7	**28**	2	15	26	16	4	1	2	1	0	2	1	0	0	0	0	0	0	0	0	0	0	**70**	**98**	**29%**	**71%**
10/11/2014	0	2	0	**2**	2	6	4	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**13**	**15**	**13%**	**87%**
17/11/2014	3	3	2	**8**	4	20	8	2	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	**37**	**45**	**18%**	**82%**
24/11/2014	6	3	3	**12**	4	26	9	3	2	2	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	**49**	**61**	**20%**	**80%**
01/12/2014	14	4	6	**24**	6	41	10	4	5	3	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	**74**	**98**	**24%**	**76%**
08/12/2014	2	0	4	**6**	6	3	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**12**	**18**	**33%**	**67%**

Appendix F

Figure 1 Assessment Waiting Times Capacity and Demand

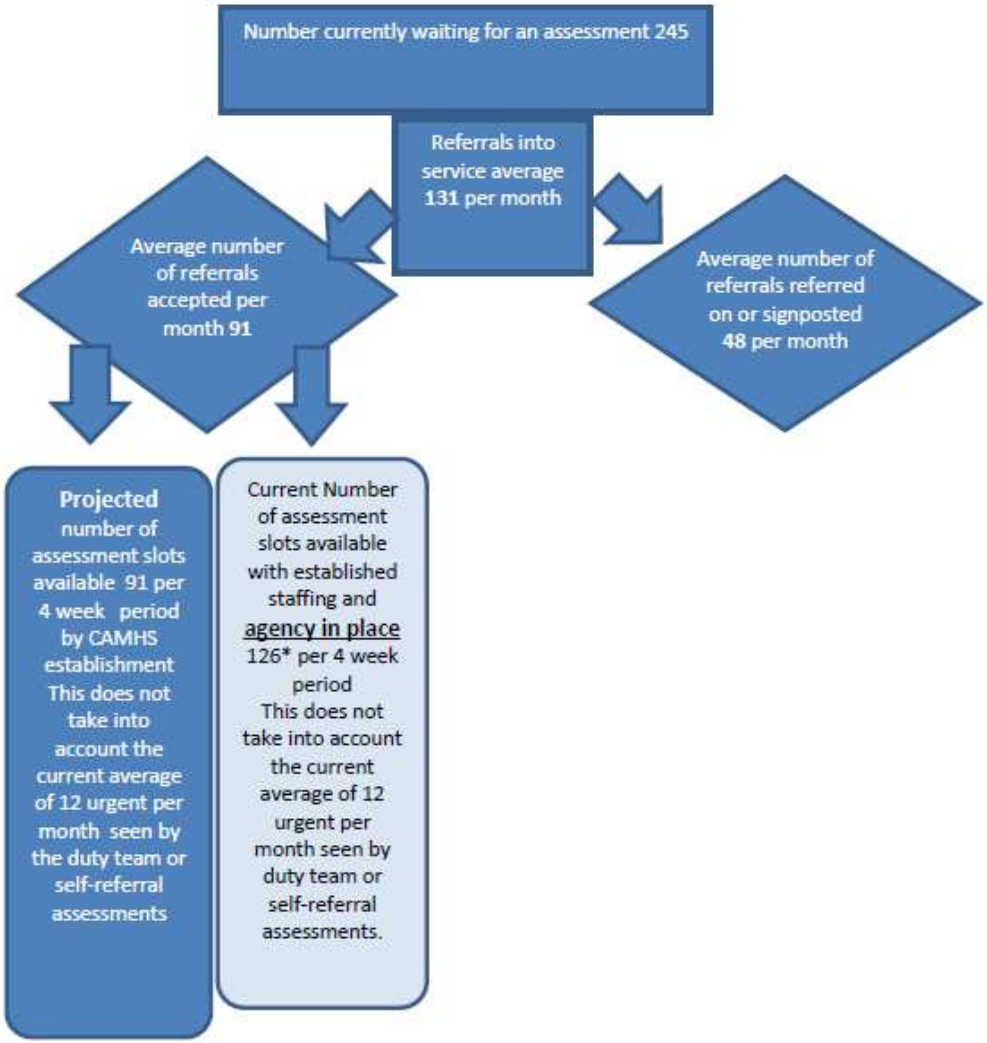
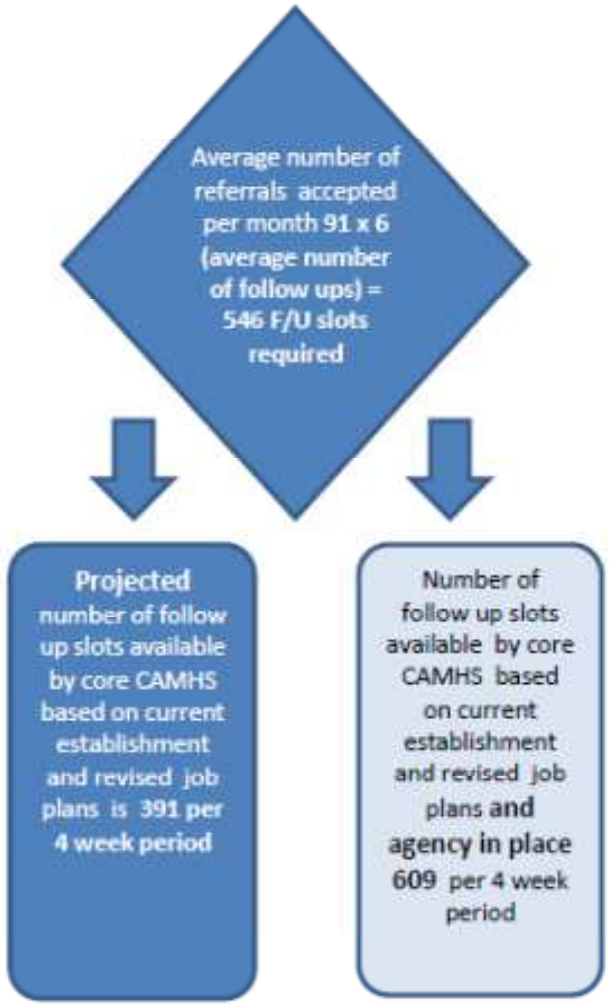
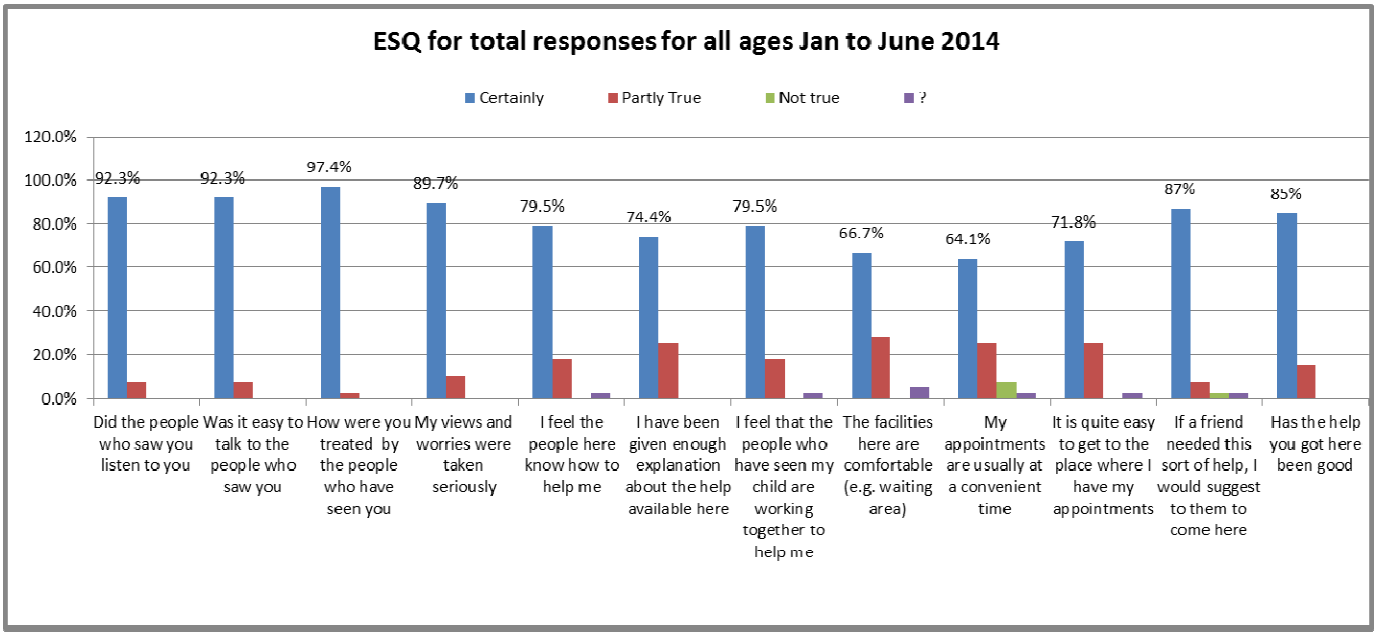


Figure 2 Treatment Waiting Times Capacity and Demand



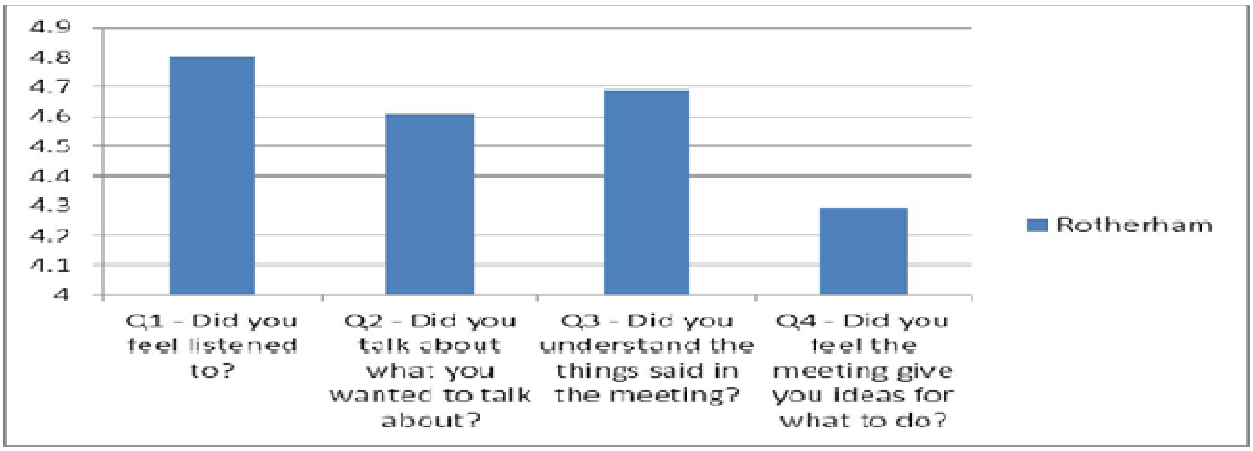
Appendix G **Satisfaction survey scores**

Figure 1 All ages Jan- June 2014 Experience of Services Questionnaire



Note - Lowest scores related to opinion of convenience of appointment time.

Figure 2 Session Feedback Questionnaires (October 13 - April 14)



Average scores for each question, possible maximum score is 5.

Key 1 – not at all
2 only a little
3 somewhat
4 quite a bit
5 totally

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
AMHS	Adult Mental Health Services
CAMHS	Child and Adolescent Mental Health Services
C&YP	Children and Young People
CYPS	RMBC Children and Young People's Services
DNAs	"Did Not Attend" – people not cancelling appointments in advance that they cannot attend or which are not needed
EIP	Early Intervention in Psychosis (EIP) is a mental health service that works with young people aged over 14, who are experiencing a first episode of psychosis
EWS	Emotional Wellbeing and Mental Health Strategy for Children and Young People
GPs	General Practitioners
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
KTS	Know the Score – drug and alcohol misuse service for young people
LAAC	Looked After and Adopted Children
LAACSTT	Looked After and Adopted Children Children's Support and Therapeutic Team
LD	Learning Disability
MASH	Multi Agency Safeguarding Hub
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OSMB	Overview and Scrutiny Management Board
ONS	Office of National Statistics
OOH	Out of Hours services
Prevalence	the number of people with a particular mental health diagnosis at a given time
P/EI	Prevention and Early Intervention
PSHEE	Personal, Social, Health and Economic Education
QIPP	Quality Innovation Productivity and Prevention - a programme to improve NHS care whilst simultaneously achieving efficiency savings
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham Doncaster and South Humber Mental Health NHS Trust
RYC	Rotherham Youth Cabinet
TRFT	The Rotherham Foundation Trust
VCS	Voluntary and community sector
WTE	Whole time equivalent
YP	Young person/people

Endnote:

1 Guest blog by Dawn Rees, Principal Policy Advisor for Health on the Office of the Children's Commissioner website 10 September 2014

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**16 April 2015**
3.	**Title:**	**Updated response to Scrutiny Review: Access to GPs**
4.	**Directorate:**	**Resources and Transformation** **All wards**

5. Summary

This report provides an updated response to the Access to GPs scrutiny review after the original response was referred back to Scrutiny by Cabinet for further consideration.

6. Recommendations

That the Health Select Commission:

6.1 Receive the updated response to the Scrutiny Review following the further work undertaken.

6.2 Request that the Health and Wellbeing Board ensures responsible agencies report progress to the Board and to Scrutiny.

6.3 Request that the Health and Wellbeing Board discuss the relevant elements of recommendation 7 with regard to borough wide publicity and awareness raising.

6.4 Note that further liaison with NHS England will be undertaken to finalise certain timescales.

6.5 Agree to forward the report to Overview and Scrutiny Management Board.

7. Proposals and details

7.1 Scrutiny review

The Health Select Commission (HSC) carried out a full scrutiny review of Access to GPs, focusing on identifying any anomalies, issues or barriers which impact on patients in Rotherham accessing their GP and in particular in respect of obtaining a convenient appointment within 48 hours. The review resulted in 12 recommendations which addressed improving access; sharing good practice; improving information for patients; and capacity to deliver primary care.

Further to Minute No. 86 of the meeting of the Cabinet held on 5th November 2014, the response to the scrutiny review was referred back to the HSC for further consideration, due to concerns over the lack of detail regarding implementation of certain recommendations (11 of the 12 were accepted and one deferred). At the request of Overview and Scrutiny Management Board a special meeting of the HSC considered the response on 15 January 2015. NHS England South Yorkshire and Bassetlaw Area Team (NHSE SY&B) and Rotherham Clinical Commissioning Group (RCCG) were requested to attend and asked to provide further written information in advance of the meeting. The Care Quality Commission (CQC) was also invited in light of their forthcoming inspections of Rotherham GP practices in 2015.

7.2 Background

Since the review was carried out there have been changes in the NHS that impact upon the original review recommendations. These changes are outlined in section 7.4 below. As a result of the additional information received by the HSC an updated version of the response template is attached at appendix 1 for consideration (updates are in blue). Timescales for actions need to be finalised and some will depend on work at national level by NHSE.

Improving access to GPs is a complex issue due to the roles and responsibilities of various health bodies and the fact that each GP practice is an individual business. Uncertainty with regard to national level changes in the NHS persists, such as revisions to the funding formula for GP contracts to take greater account of deprivation. Outcomes from the review of Personal Medical Services (PMS) contracts are unknown as yet.

Balancing the different priorities and expectations of patient groups is a key question and is summed up in this extract from a report by Monitor in 2014:

> "… different patient groups want different things from general practice. In particular, for many older patients, those with long-term conditions, disabilities or communication and language barriers, continuity of care is an important requirement. These patients prefer to develop an ongoing relationship with an individual GP who can help them to manage their treatment and co-ordinate their care. Many time-constrained or less frequent users of general practice place a greater emphasis on swift and easy access than on continuity of care."

It is also reflected in the satisfaction rates of different patient groups from the National GP Patient Survey. For England as a whole older patients and patients with one or more long-standing health conditions are groups who are more likely to report a positive experience of accessing GP services. The lowest satisfaction rate is people aged 18-24 years from a minority ethnic background because they are expecting a different service.

7.3 Waiting times

Long waits for appointments have regularly featured in the national media. One local GP was recently quoted as saying there was a wait of up to four weeks for an appointment at his practice and citing a recruitment crisis for GPs and rising patient demand. RCCG has funded additional weekday put-of-hours appointments until the end of March in areas of high need to help practices cope with demand.

7.3 Context

Contractual obligations of GPs
NHSE SY&B emphasised that GPs have a contractual duty to meet the urgent or immediate clinical needs of their patients, providing access, including opening hours and sufficient appointments that are appropriate to the population served. New contractual duties come into force in April regarding patient engagement through patient participation groups and the Friends and Family test was introduced for GPs last December.

Commissioning and management of GP contracts
At the time of the review commissioning and managing GP contracts was the responsibility of NHS England. This will change from 1st April 2015 with co-commissioning as RCCG will assume delegated responsibility for GP contracts from NHSE SY&B, joining up the CCG and primary care and benefitting from localised decision making about services.

Place based plan
Each area will be responsible for developing a “place based plan” which will include the development of local services, commissioned separately from the core GP contract. These plans will be central to ensuring services meet local needs.

NHSE’s vision for the future, shared by CCGs, is to achieve 24/7 access to a range of community based diagnostic treatment, care and advice for patients with community and hospital based services also available in the community. In time this may involve practices increasingly working together, in networks or federations, pooling resources and cooperating to offer their patients wider and better access to a greater range of GP and other care services. This will be considered as part of the proposed co-commissioning arrangements with the CCG and will feature in the place based plans referred to earlier.

Personal Medical Services (PMS) contracts review
This national review is significant for Rotherham as 75% of GP practices have this contract type and it relates to funding. NHSE say that as some practices lose some gain. The difference could be quite small in some places but very big in others and adjustments would be made for practices which have an atypical population. NHSE SY&B have given a commitment to reinvest any funding released from an individual practice into primary care within the Rotherham area. Reviews have started in Rotherham and NHSE SY&B anticipate all reviews will be completed by mid-April 2015.

Where it is a question of the range of services practices offer, and these are services the CCG wish to continue to buy, these will be explicitly commissioned and funded. Practices may not see a change in funding but will be commissioned by the CCG.

CQC inspections of GP practices
The new CQC inspection regime focusses on patient experience and quality of that experience. Access will form a key aspect. All General Practices will be inspected and rated from October 2014 onwards and inspections in Rotherham commence in April 2015.

National Patient Survey
NHSE relies heavily on the annual survey to capture patients' views and satisfaction levels with GPs. Analysis of the most recent survey indicates that the time of the appointment has more impact on satisfaction that the type of appointment i.e. satisfaction is higher for patients getting an appointment at the time they wanted, even if it was a different style or with a different person than originally requested.

In addition to enabling comparative analysis the survey provides a means of assessing the overall primary care capacity within the area. For example looking at clusters of practices serving the same locality and using the results as the basis for making judgements about commissioning new practices or the scope for existing practices to improve or expand to meet local 'gaps' in delivery of high quality, accessible care.

Recruitment and retention of GPs and health professionals
Nationally although there is a target to increase the numbers of doctors training to be GPs to 3,250 per annum, numbers have only averaged 2,700 in the last four years. NHSE are focusing on the wider workforce within a GP practice as a means of reducing demands on GPs and this also links with plans to have more services delivered in community settings.

New ways to improve access to GP services
For 2015, NHSE agreed with the General Practitioners Committee that the GPC will actively promote and support practices in a number of national initiatives to use ICT to improve patient access to GP services. This includes:

- improving the offer of electronic transmission of prescriptions – 60% of practices will be expected to be transmitting prescriptions electronically using Electronic Prescription Service EPS Release 2 by 31 March 2016.
- practices offering patients secure electronic communication with the practice.
- All GP practices will promote and offer the facility for patients to receive consultations electronically, either by email, video consultation or other electronic means.

NHS Improving Quality (NHS IQ)
NHS IQ foster innovation through sharing best practice across the country and supporting training for practices, including how they can be more effective in responding to patient needs and be more efficient in running their business. Practices pay a fee for support.

8. Finance
NHS bodies will need to incorporate any financial consequences from the recommendations in their annual planning arrangements.

9. Risks and Uncertainties
It is essential that people in all parts of the borough have accessible and high quality primary care to help achieve improved health outcomes and reduced health inequalities for our community. People's health in Rotherham is generally worse than the average for England and with a growing and ageing population and high incidence of long term conditions and co-morbidities, demand for GP services is high and likely to increase further over time.

As the NHS undergoes considerable change this is presenting difficulties and challenges for practices and patients. As much is determined at national level scope for change at local level through effective commissioning of services matched to local need and sharing innovative practice is paramount.

Patients' experiences of accessing GPs do vary from practice to practice; their expectations and preferences are changing, and it is a question of striking the balance between clinical need, patient expectations and convenient access. Supply side factors of funding and investment; workforce planning, recruitment and retention; and suitable premises to deliver the full range of GP based services will all need to be addressed to meet growing demand.

10. Policy and Performance Agenda Implications

RMBC Corporate Plan Priorities:

- Helping to create safe and healthy communities.
- Ensuring care and protection are available for those people who need it most.

Rotherham Joint Health and Wellbeing Strategy
Public Health Outcomes Framework

11. Background Papers and Consultation

See Section 8 and appendices of the review report.
Rotherham Advertiser 6 March 2015

12. Author

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Appendix 1 Updated Cabinet Response to Scrutiny Review Access to GPs

Recommendation	**Cabinet Decision** *(Accepted/ Rejected/ Deferred)*	**Cabinet Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Agency Responsible**	**Action by** ***(Date)***
1. Patients' experiences of accessing GPs vary from practice to practice; therefore NHS England needs to ensure that patients' views on access are reflected in the forthcoming Personal Medical Services contract re-negotiations and five year commissioning plan.	Accepted	**NHSE** - NHSE take seriously the results of the National Patient Survey and include these in monitoring all primary care contractors. In addition to enabling comparative analysis the survey provides a means of assessing the overall primary care capacity within the area. - NHSE are working with RCCG to develop a coherent place based strategy for improving health care and outcomes for the population of Rotherham. As part of that there is a commitment to reinvest any funding released from one practice (following the PMS contract reviews) into primary medical care within RCCG area, ensuring that we secure real improvements in care and outcomes for patients. **CCG** The ability to have varying co-commissioning of services has been incorporated into the 5 year strategy, with access and improving access highlighted. **CQC** - Inspections involve preparation beforehand - they send out comment cards to the practices and ask them to place them for patients to complete. CQC look at patient surveys, CCG data on the profile of patients and other data. We specifically look at patient themes of vulnerability, mental health illness, work age population, children, over 75, those with long term conditions. - The key to the inspection is to speak to all the staff in the	NHS England (NHSE) Rotherham Clinical Commissioning Group (RCCG) Care Quality Commission (CQC)	October 2014 CQC visits begin nationally, Rotherham from April 2015 April 2015 Place Based Plan in place for Rotherham

		practice and 8-10 patients on the day about their experience and use of the practice. - We want to see policies, procedures and processes on how practices capture patient feedback, how they investigate incidents, their outcomes, how they measure actions and implementation so it is a robust process - corroboration and evidence.		
2. The continuation of the Patient Participation Directed Enhanced Service in 2014-15 should be used to ensure patients are well informed and empowered through the Patient Participation Groups to challenge poor access and suggest improvements. All practices should be encouraged either to participate in the PPDES or to establish other effective mechanisms for ensuring patient engagement.	Accepted	**NHSE** CQC will continue to look for evidence that access to clinicians is sufficient to meet reasonable need, and that patient survey results alongside any complaints are addressed. In December 2014 the new compulsory Friends & Family Test was introduced to all practices. All patients that attend the practice on a given day, whether to see a clinician, or pick up a prescription, will be asked two questions (the first is mandatory): a. Would you recommend this Practice to another person? b. One other question the Practice want to ask the patient (this could be agreed with the Patient Participation Group) Following national negotiation on revised contractual arrangements, the existing PPDES will cease on 31 March 2015 as existing arrangements should be largely embedded in general practice. From 1 April 2015 it will be a contractual requirement for all practices to have a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population.	Rotherham CCG NHS England CQC	On-going
3. Although recognising the importance of clinical need, the expectations and preferences of patients are changing, and practices should explore more hybrid and flexible approaches to	Accepted that helpful to have a flexible approach to appointments and access but not sit	*Context (Dr John Radford)* *All General Practices should have adequate arrangements to see urgent or same day cases. Appropriate arrangements will vary from practice to practice. These should form part of the new CQC inspections. The Commissioner (CQC) should be requested to produce a report summarising the adequacy of access on the basis of these reports to Health and Wellbeing Board in Oct 2015.*	NHS England Rotherham CCG	October 2015

appointments. All GP practices should be encouraged to have a part of each day for sit and wait slots.	and wait slots.	**NHSE** All practices have processes and systems in place that enable them to respond to requests that are clinically appropriate. Most GP practices operate as independent contractors and are responsible for organising the delivery of primary medical care services as they choose, subject to meeting specific contractual requirements. As such it is for each individual Practice to determine how they meet patient demand for appointments and NHSE is unable to require them to respond in specific ways. - An increasing numbers of practices are offering more flexible opening times and new innovative ways of contact with patients e.g. electronic prescriptions, text reminders, emails, better use of telephone triage and there is further scope for e-consultations etc. We will be working with CCGs to encourage those practices that have not yet done so, to embrace new technologies and new approaches to improving patient access. - NHSE has worked with the Royal College of General Practitioners and other organisations such as NHS IQ to support practices to operate more efficiently and effectively to respond to their patients' needs. - RCCG and NHSE will continue to work with practices to achieve our shared aim for a more varied and flexible approach, to improve patient satisfaction with their access to GP services. - The vast majority of patient s would prefer to be able to make a specific appointment and such arrangements also provide a more manageable way for practices to manage their workload.- NHSE cannot find evidence that having periods where patients "sit and wait" will improve patient satisfaction with either the quality of, or access to, the consultation they seek. Indeed, they believe such systems may only increase the demand and pressure on the provision of GP appointments by those who can wait rather than improve overall care for the whole population served.		

		NHSE propose the following potential actions: - Looking to extend the availability of General Practice • Expanding PM Challenge Fund pilots: models for 7-day access to general practice • 'Doctor First' – this is now being used by some practices. This enables same day telephone triage, with around two thirds of patients being dealt with by phone. - Ambition of 'Patient Online' – providing the ability to book appointments, prescriptions and view medical records online		
4. NHS England should maintain access to interpretation services for GPs, with an emphasis on professional services, supported by training for GPs and practice staff to increase confidence in using telephone services where appropriate.	Accepted	NHSE have agreed a national service specification (early 2015) and asked the main players to procure a framework contract for the NHS people to use a group of providers who can meet that service specification to secure consistent and reliable access for patients across England. We will continue to work closely with Rotherham CCG, Rotherham MBC Public Health, and the Health and Wellbeing Board, and where appropriate, other stakeholders, to consider how by working together we can ensure people are able to access care services appropriate to their needs and are able to easily navigate such services.	NHS England	Immediate
5. NHS England should review their current interpretation provision to see if economies could be achieved through signing up to Rotherham MBC's framework agreement, which is open to partner agencies.	Accepted	NHSE welcomes the opportunity to look at ways to jointly commission interpreting services with RMBC, so as to provide a more coherent and effective service for the population of Rotherham within the level of expenditure each party currently spends. It should be noted that interpreting services are currently commissioned from a variety of different providers separately by NHS England and the 5 CCGs within the South Yorkshire & Bassetlaw area. RCCG and NHSE are committed to get better interpretation services because we are wasting money between us in buying the different services.	NHS England	Date needed
6. GP practices should regularly showcase best practice and share successes on providing good access to patients through existing means such as the practice	Accepted	**NHSE** New national programmes to support General Practice to improve patient access to primary care provision have been established, including the Prime Minister's Challenge Fund. We will fully support Rotherham practices to take the opportunity to innovate themselves or to learn from existing PM Challenge Fund pilots. (Note: no practices from SY&B took part in the first tranche and	NHS England Rotherham CCG	NHSE Immediate RCCG Actioned

manager forum and Protected Learning Time events. (Please see pages19-22 of review report)		no Rotherham practices have submitted applications for the second funding round in 2015.) NHS IQ also operates a programme to improve the efficiency and effectiveness of GP practices, which we are encouraging practices to participate in. We are also considering whether an e-based learning platform could be developed to further support practices to share and learn from each other. NHSE regionally will continue to hold events that will support GP practices and CCGs to learn from new innovative approaches that will support delivery of better and more accessible care to patients. A number are planned across the north of England for February and March 2015 to try and showcase what practices are doing and learn from each other but we only ever can get to 100 GPs at a time so are more reliant on what the CCG are doing. **CCG** RCCG is building relationships with NHSE so that quality in GP practice can be developed. The bi-monthly practice managers' forum already has designated time for NHS England. Best practice is a standing item on that agenda. There is a regular programme of events and although we schedule things in, we leave space for topical issues. Sharing of best practice will also become a topic for consideration when planning future Protected Learning Time (PLT) events which happen bi-monthly and cover a wide range of topics aimed at improving care and outcomes for patients. Sharing of best practice is also considered when GP Peer review visits are undertaken. We also encourage practices to have their own in-house events and we monitor what topics are looked at.		

7. Patient information and education is important, both generic information about local services and specific information about how their surgery works.	Accepted bar 7b which was deferred	*Since the initial response was received the Health and Wellbeing Board has launched a new health website which may provide an opportunity for promotional health campaigns*. **See sub-recommendations a-e below**.	NHS England Rotherham CCG	
a. GP practices should ensure their practice leaflets and websites are kept up to date about opening times, closure dates for training and how the out of hours service works.	Accepted	**NHSE** It is a contractual requirement for each Practice to maintain a practice leaflet and website, containing up-to-date information for patients with specific information, although the format is not specified. NHSE monitor practice compliance on a regular basis. We have been increasingly encouraging practices to use the internet to facilitate more access and make more information available on the practice website - being able to book appointments, order repeat prescriptions - and do more on electronic communication. Not all patients want to do that and information is available through NHS Choices and various helplines. We can still do more to improve communications - ourselves to practices and practices to patients - and we will continue to work on that. NHS IQ support and best practice aims to improve efficiency and effectiveness. **CQC** We do look at the information provided to patients and if we do not see it we give practices feedback.	NHS England	Immediate
b. NHS England should explore developing an App with practice information that people with smartphones and tablets can download.	Deferred	NHS E will explore this option further, recognising the importance of harnessing new technology, in use by many age groups. The GPC and NHSE will jointly promote the use of new technology, especially where it would bring benefits to both GP practices and patients.	NHS England	To add

c. Health and Wellbeing Board should consider developing a borough wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments.	Accepted	RCCG and NHSE would welcome the opportunity to engage with the Health & Wellbeing Board on this matter. NHSE do not collect data on missed appointments in a consistent manner and where there has been such an exercise it showed that the rate had not increased or changed. It is a bugbear for GPs that patients do not attend but also for many the 10-15 minutes without a patient means they can catch up time.	TBC	To add
d. GP practices should work with their reception staff, patients and Patient Participation Groups to encourage patients to provide more information to staff when contacting the practice, enabling them to see the right person in the practice team.	Accepted	NHSE agree that patients should be encouraged to provide sufficient information to aid their signposting to the most appropriate service/professional. Patients must also have a right to expect that personal information about their health and care is treated confidentiality to give confidence to them to share. One of the reasons patients are less satisfied is because of longer waiting times. NHSE think the solution is to improve the access and convenience, increase capacity and get more people who walk in general practices to make better use of practice nurses, doctors from hospitals, physiotherapists and other health professionals. The Prime Minister's Challenge Fund was starting to demonstrate that with the whole new skill mix placed in and around the GP this can relieve some of the pressure on GP practices and ensure patients are still seeing a clinician. That is what we need to build on and try to do more.	NHS England RCCG	
e. Health and Wellbeing Board should consider revisiting the "Choose Well" campaign to raise awareness of how to access local services and which is the most appropriate service in a range of situations.	Accepted	NHSE propose the following potential actions: • Right Care: clearer to patients and the population how best to access the right care to meet their needs • Using 111 can direct people to get the right care – which can include self-care • Encouraging use of pharmacy as an alternative to GP: - Feeling Under the Weather is a national campaign focusing on the management of winter illnesses. - Treat Yourself Better is a national campaign focusing on management of illness without expectation of antibiotics. - Pharmacy First is a national 'brand' used by many CCGs which encourages patients with some minor ailments to		

		use the pharmacy. Patients who are exempt from prescription charges receive free medicines. Choose Well campaign is featured on TRFT website; RCCG website has Right Care, First Time on its website. Local publicity for Pharmacy First has been distributed.		
8. In light of the future challenges for Rotherham outlined in the report the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care.	Accepted	In the light of co-commissioning of primary care between NHS England and RCCG the Board has agreed to receive a report on GP access for patients and will expect the CCG Commissioning plan to reflect a proactive approach to ensuring Rotherham is an attractive place to undertake General Practice.	Health and Wellbeing Board	April 2015
9. NHS England should consider incentives to attract GPs to start their career in Rotherham following training in the area, to help address the demographic issues of our current GPs.	Accepted non financial	NHSE and RCCG are working with Health Education England (HEE) to explore how to minimise recruitment and retention difficulties so as to attract as many more GPs and nurses as possible. We are looking at examples where non-traditional GP professionals (Physiotherapists, Pharmacists, etc.) have joined practices and the impact this has had on reducing GP workload. We will continue to work with HEE to promote practices becoming involved in the Advanced Training Practices scheme which aims to generate increasing numbers of qualified practice nurses. But it is not just about the practice workforce, we will support CCGs to explore further the scope for attaching community and current hospital based clinical staff to work closer with general practice so as to be able to offer a wider range of care and services close to the patient and enabling general practice to increasingly act as a care co-ordinator to patients with a number of chronic conditions. NHSE propose the following potential actions to increase the overall supply of clinicians in primary care, including: • increase the number of training places for GPs;	NHS England	On-going

		• increasing number of doctors qualifying that wish to enter general practice; • changes to the induction and returner scheme to enable GPs to return more swiftly to the GP performers list; • new models of care which meet demand differently, including through widening skill mix; (e.g. minor ailments services, direct physio access, and e-consultations) **CCG** Rotherham has some very challenging communities which are difficult to attract GPs to and Sheffield attracts more. One big advantage in Rotherham is that we have a training scheme with 14 registrar GPs training. Rotherham is the only place that is fully staffed and our training scheme is perceived to be the best in Yorkshire and Humber. We have tried to get the 14 GPs to stay, embrace Rotherham and feel a sense of ownership. We have looked at everything from payments and financial incentives but cannot attract extra funding for that. It is still tough and primary care staffing levels are not where we would want them to be.		
10. Rotherham CCG should collect and analyse monitoring information to ensure services are resourced to meet peaks in demand during protected learning time at the new Emergency Care Centre from 2015.	Accepted	NHS 111, who now provide the call handling information and Care UK (who provide the Out of Hours) have been asked to provide regular activity information. This will feed into the planning process for the Emergency Centre. RCCG regularly speak to the Walk-in Centre to see if demand has been catered for. The System Resilience Group set up by the NHS in all areas of the Country to ensure proper access to emergency care will also consider this matter.	Rotherham CCG	By April 2015

11. NHS England needs to be more proactive in managing increases in GP demand due to new housing developments, rather than waiting for existing services to reach capacity.	Accepted	NHSE have established formative links with some Local Authority planning departments across South Yorkshire & Bassetlaw and welcome the recommendation that health partners are invited by the Planning Department to be part of a multi-disciplinary approach to proposed new developments in Rotherham. - Funding for practices is done on a weighted capitation basis, with core contract income adjusted on a quarterly basis to reflect any changes in practice list size. Therefore, as practices increase their list size so funding increases, enabling employment of more staff to deliver services to the registered list. -Where a significant new housing development is planned, NHS England and the relevant CCG will work ahead of that development to consider available primary care capacity in that locality to take on additional patients and where that is assessed to be less than desirable, to undertake a new procurement for contractors to meet that population's needs.	NHS England	Immediate
12. Rotherham MBC, when considering its response to the scrutiny review of supporting the local economy, should ensure health partners are invited by the Planning Department to be part of the multi-disciplinary approach to proposed new developments.	Accepted	Planning are aware of the request for GP's to be better informed on planning applications – particularly in relation to residential development and care homes as this may impact on their service. - Planning have requested a central contact in the NHS who can feed into the process from a strategic perspective around provision of service and who can also provide information on capacity of local surgeries and collate GP's comments as necessary on individual applications. A meeting is planned with CCG Deputy Chief Officer to discuss this in early 2015. - In relation to future housing sites in the local plan we have liaised with public health colleagues to allow them to comment on proposed sites but also to provide them with general information about areas of future development which may come forward during the next 15 years to assist them with their longer term financial planning.	Rotherham MBC	Immediate