The Rotherham NHS
NHS Foundation Trust

Quarterly Quality Report: Integrated Services

Quarter 1

April - June | 2012-13

Contents

1. Executive Summary

Summary of the main issues contained in this report

Quality at a Glance measures

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

CQUINs & Mandated National Quality Board indicators

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

Improvement Programmes

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

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

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

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2. Quality at a Glance: Acute & Community

Key indicators for review

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

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3. Mandated indicators - National Quality Board

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

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

4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

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

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4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

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

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5. Clinical Effectiveness Work Programmes

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

Clinical Audit Activity

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

Clinical Outcome Review Programmes

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

Mortality

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

Other Activity

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

NICE Quality Standards:
Self Assessment of Compliance by Lead

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

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

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

NICE Guidance

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

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

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

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

Comparison at CSU level to identify areas for improvement

No Harm - Falls

		YTD	Apr	May	Jun	Jul
Acute	⊞ Specialist medicine	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Obstetrics & Gynaecology	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-
	⊞ Child health	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Orthopaedics	98.1 %	100.0 %	94.0 %	100.0 %	97.8 %
	⊞ Alternative level of care	98.0 %	95.8 %	100.0 %	96.0 %	100.0 %
	⊞ Integrated Medicine	96.9 %	98.4 %	94.0 %	97.1 %	98.3 %
	⊞ General surgery	96.6 %	91.1 %	97.8 %	98.1 %	100.0 %
	⊞ Urology	94.5 %	93.8 %	100.0 %	91.7 %	92.9 %
Community	⊞ Community South	100.0 %	-	100.0 %	100.0 %	100.0 %
	⊞ Community North	100.0 %	-	100.0 %	100.0 %	100.0 %
	⊞ Community Central	98.7 %	-	98.0 %	99.2 %	99.1 %
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No Harm - Pressure Ulcers

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

No Harm - Venous Thromboembolism

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

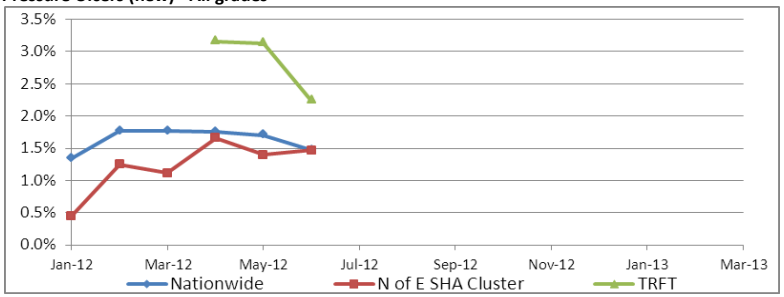
No Harm - Urinary Tract Infection

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

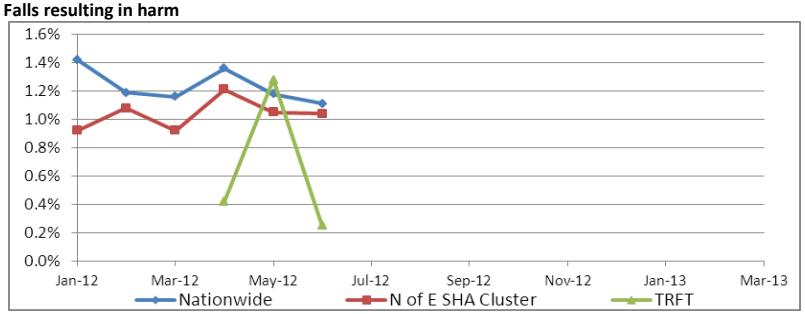
7. National & Regional Benchmarking - Safety Thermometer indicators

Comparison at National & SHA level to identify areas for improvement

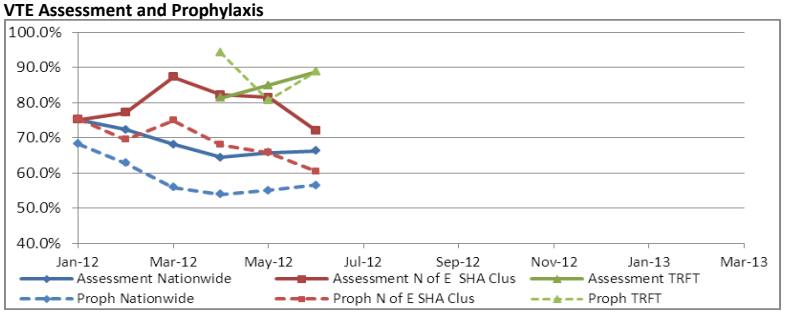
Pressure Ulcers (new) - All grades



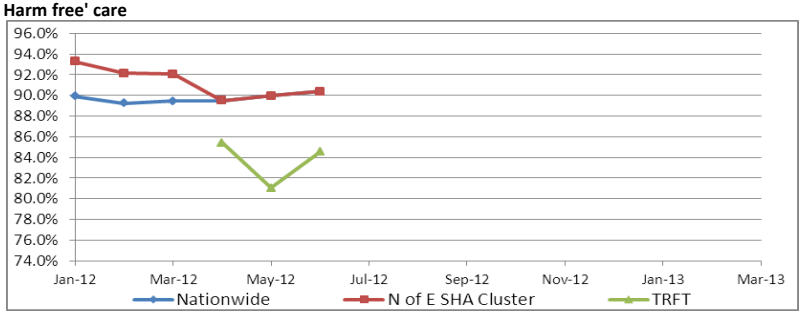
Falls resulting in harm



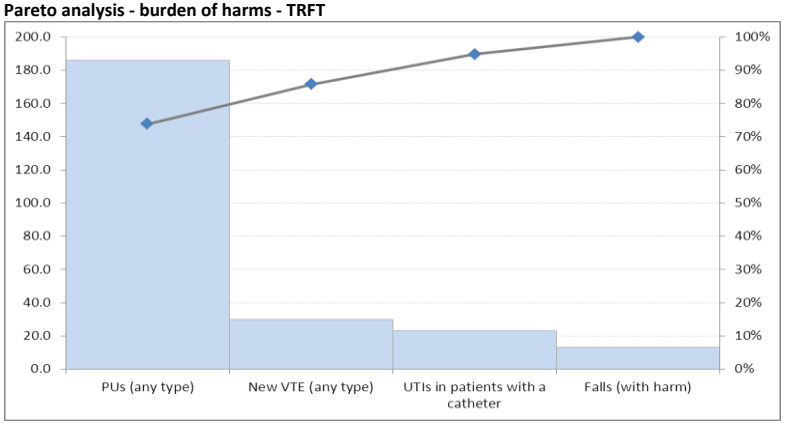
VTE Assessment and Prophylaxis



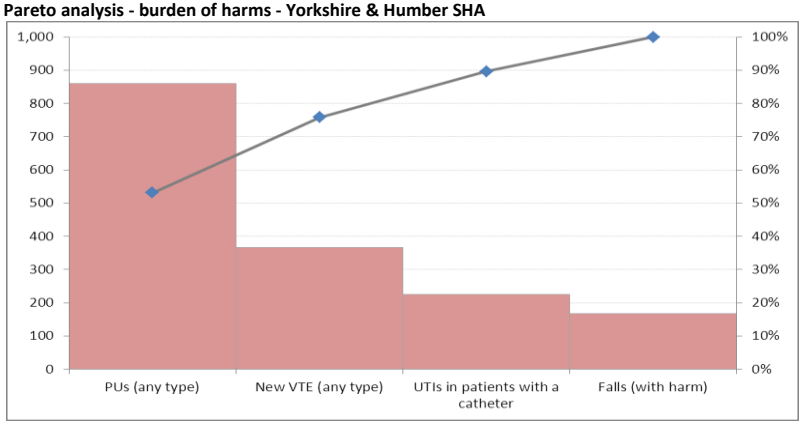
Harm free' care



Pareto analysis - burden of harms - TRFT



Pareto analysis - burden of harms - Yorkshire & Humber SHA



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