The Rotherham NHS
NHS Foundation Trust

Quarterly Quality Report: Integrated Services

Quarter 2

July - September | 2012-13

Contents

1. Executive Summary

Summary of the main issues contained in this report

Quality at a Glance measures

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

CQUINs & Mandated National Quality Board indicators

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

Improvement Programmes

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

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

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

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

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

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

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4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

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

4. Improvement Programmes 2012-13

Areas selected for focussed improvement activity

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

5. Clinical Effectiveness Work Programmes

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

Clinical Audit Activity

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

Clinical Outcome Review Programmes

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

Mortality

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

Other Activity

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

NICE Guidance

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

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

NICE Quality Standards: Self Assessment of Compliance by Lead

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

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

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

NICE Quality Standards with Red Ratings:

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

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

Comparison at CSU level to identify areas for improvement

No Harm - Falls

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

No Harm - Pressure Ulcers

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

No Harm - Venous Thromboembolism

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

No Harm - Urinary Tract Infection

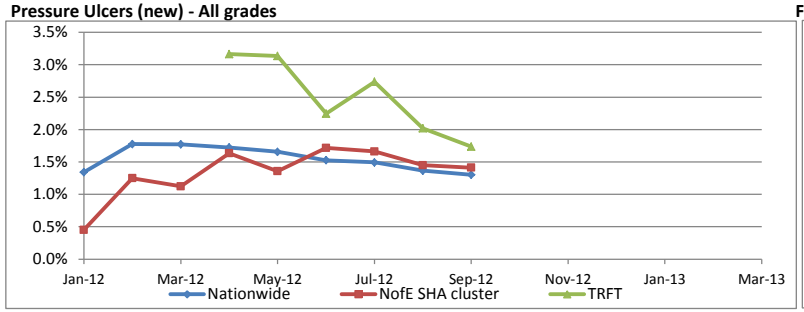
		YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
Acute	⊞ Ophthalmology	100.0 %	100.0 %	-	-	-	-	-	-
	⊞ Theatres & Anaesthetics	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
	⊞ Child health	98.8 %	100.0 %	100.0 %	100.0 %	90.5 %	100.0 %	100.0 %	100.0 %
	⊞ Obstetrics & Gynaecology	98.7 %	100.0 %	100.0 %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

The Rotherham NHS
NHS Foundation Trust

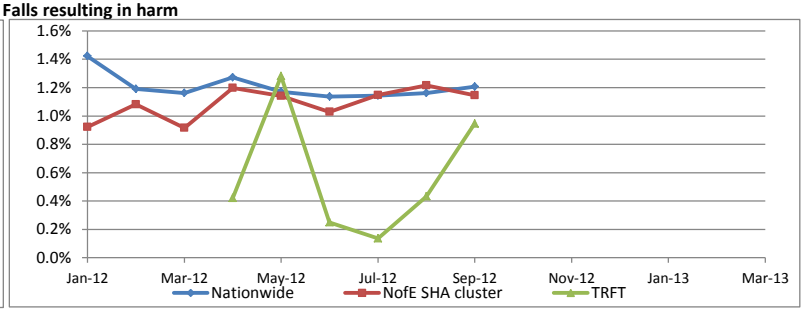
7. National & Regional Benchmarking - Safety Thermometer indicators

Comparison at National & SHA level to identify areas for improvement

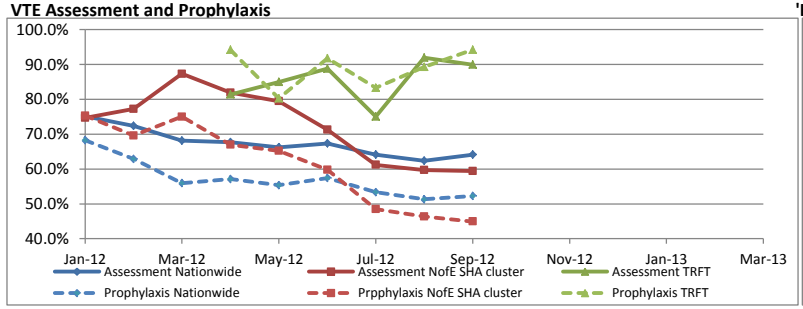
Pressure Ulcers (new) - All grades



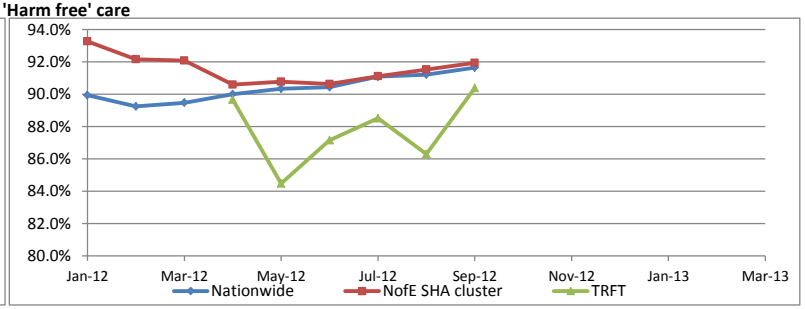
Falls resulting in harm



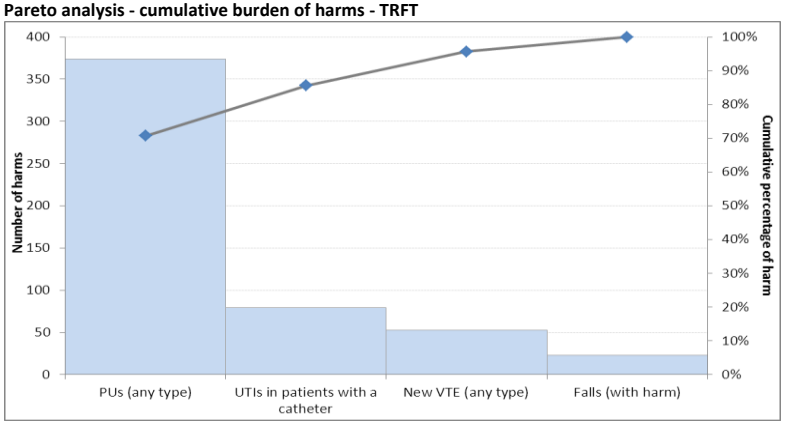
VTE Assessment and Prophylaxis



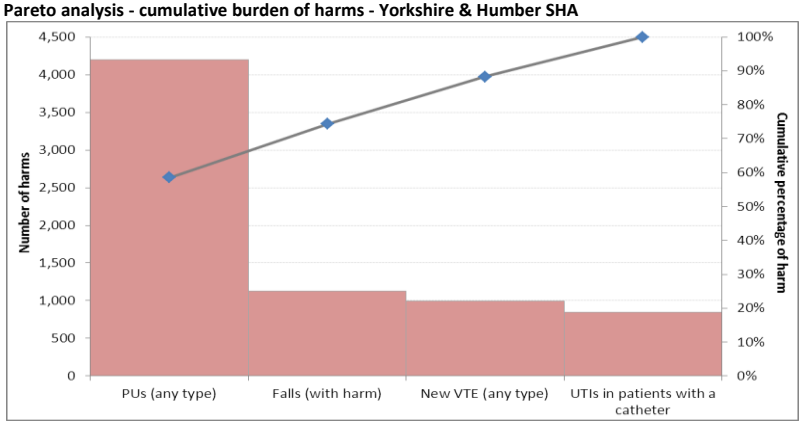
'Harm free' care



Pareto analysis - cumulative burden of harms - TRFT



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



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