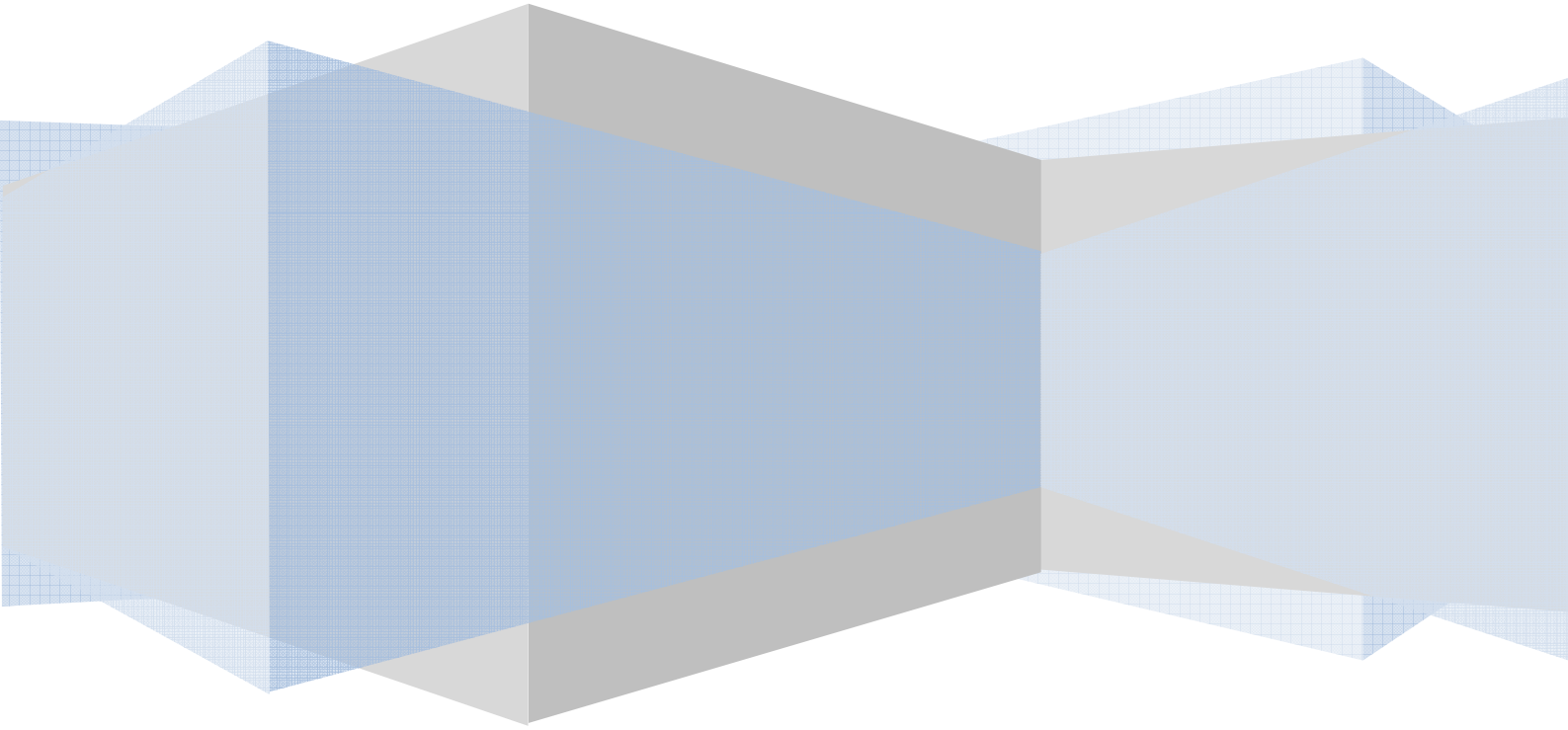
The Rotherham NHS Foundation Trust

Quality Account

2012-2013



1 Message from the Chief Executive

2012-13 has been a challenging year for TRFT, one which has seen significant changes – not least of which being the retirement of the previous Chief Executive, Brian James, and the appointment of myself as interim Chief Executive.

Since then there have been numerous changes to the Board structure, the current version of which is smaller, and forms a strong foundation for moving towards a healthcare management model which will exceed expectations of the Rotherham residents whom we serve.

The Trust Electronic Patient Record system – Meditech v6, has been implemented; this has led to numerous operational issues which could not have been overcome without the hard work and dedication of our staff, which in the short time I have been here, I have been convinced – are our number one asset.

It has been widely reported in the press that the Trust is in a situation referred to as 'significant breach' of its terms and conditions of operating; the Trust was informed of this by Monitor – the NHS Foundation Trust regulators, early in 2013. This is a deeply regrettable situation for the Trust to be in, however, I must stress that the reasons for this were based on Trust financial situation as it was then – and in no way is a reflection of the high quality clinical care which we, as a Trust, continue to provide.

The trust continues to be in the upper quartile Nationally, for having the lowest waiting times for surgery; we have some of the lowest C.Difficile and MRSA infection rates in the Country, have had zero never events and continue to meet all of our CQC standards. The myriad of clinical quality indicators continue to reflect improvements against previous years.

Our performance against Nationally and locally agreed Commissioning for Quality and Innovation (CQUIN) targets have been good – particularly in the area of Venous Thromboembolism (VTE) assessment and prophylaxis. Our nominated improvement programmes also show significant progress against areas where improvement was sought.

The Trust has again been awarded a 'Top 40 Hospital' award by CHKS, an organisation specialising in benchmarking Acute Trusts against clinical quality and efficiency indicators; we are delighted to receive this award once again.

The Trust Care Coordination Centre has opened early in 2013, a new initiative to ensure that patients are signposted to the most appropriate service to meet their needs – but also aiding in improving our operating efficiency by reducing avoidable admissions to hospital beds.

In summary, in spite of the many challenges faced by TRFT in 2012-13, we have taken significant interventional actions to address these – whilst maintaining high standards of service to those in need. These were the right things to do and, in doing so – I remain convinced that the Trust is now in a much stronger position than it was, to safeguard it's future for the benefit of the populace it serves.

The Trust Quality Account for 2012-13 outlines some of the challenges we have faced in relation to delivering quality care, alongside many of the successful outcomes we have achieved in this respect. In consultation with my Board members and other colleagues, I am confident that the information reflected in this report represents an accurate picture of our activity throughout 2012-13.

I look forward to providing the Trust with the direction and strategy it requires in delivering further success in 2013-14.

Yours faithfully

Michael Morgan

Interim Chief Executive

Statement of director's responsibilities in respect of the Quality Report

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 trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012-13
- the content of the quality report is not inconsistent with the internal and external sources of information including:
    - Board minutes and papers for the period April 2012 to June 2013
    - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
    - Feedback from commissioners dated 8th May 2013
    - Feedback from Governors dated 11th April 2013
    - Feedback from Local Healthwatch organisations (previously LINks) dated 27th March 2013
    - The Trust complaints report published under regulation 18 of the local Authority Social Services and NHS Complaints Regulations 2009, dated 21st May 2013
    - The latest national patient survey 16th April 2013
    - The latest national staff survey 20th March 2013
    - The draft Head of Internal Audit's annual opinion over the trust's control environment dated 21st May 2013
    - CQC quality and risk profiles data 15th May 2013
- the Quality Report represents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported 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 they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to 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-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.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 Report.

By order of the Board

28/05/2013	Peter Lee	Chairman
28/05/2013	Michael Morgan	Interim Chief Executive

2A Our Priorities for improvement and progress last year (2012-13)

Our focus on quality

The Rotherham NHS Foundation Trust continues to focus on quality of care, driving forward integrated care services for the benefit of patients, relatives and carers. Progress towards achieving many of the aims set out in our Quality Strategy 2012-215 remains on track, whilst a review of Service Delivery Strategy 3 is underway to ensure that it continues to support our long term vision in what remains a very challenging environment for the whole of the NHS.

Emphasis on patient experience

Throughout the year we have continued to review patient feedback and our patient experience strategy in response to this; we have achieved success in increasing the volume of complaints to obtain more feedback (up by 43% on 2011-12) whilst also reducing the overall severity of complaints. In 2012-13 we received 4 complaints rated "red" according to our Red, Orange, Amber, Green (RAG) classification system, against 7 "red" complaints in 2011-12. Overall for 2012-13 – 6.1% of our complaints were rated "Red" or "Orange", against 11.0% rated at that level of severity in 2011-12.

There has been a shift in themes of complaints for 2012-13, whilst the principal theme relates to medical care, there has been a significant increase in complaints relating to administration and appointments from 6.9% in for the two themes in 2011-12, to 30.7% for the two themes in 2012-13. This shift has been largely attributed to issues surrounding outpatient appointments and associated administration, which were incurred due to issues arising soon after the implementation of Meditech Electonic Patient Record v6.

In addition to complaints review and analysis, two other sources contribute to our monitoring of this area – the National Inpatient Survey and Meridian's Optimum Contact patient experience tracking system. During the year, the decision was made to move to Meridian OC from Dr Foster Patient Experience Tracker, as it was proven to provide a greater degree of flexibility in terms of its analysis functionality, combined with more options for review of feedback by relevant users. The same questions and response options were used on the new system, enabling continuity of performance monitoring.

Patient experience capture, using Meridian OC, is now captured directly from patients using handheld 'tablet' devices, rather than proprietary units – these are proving popular with both staff and feedback providers – as well as providing opportunities for the same device to be used for a number of uses.

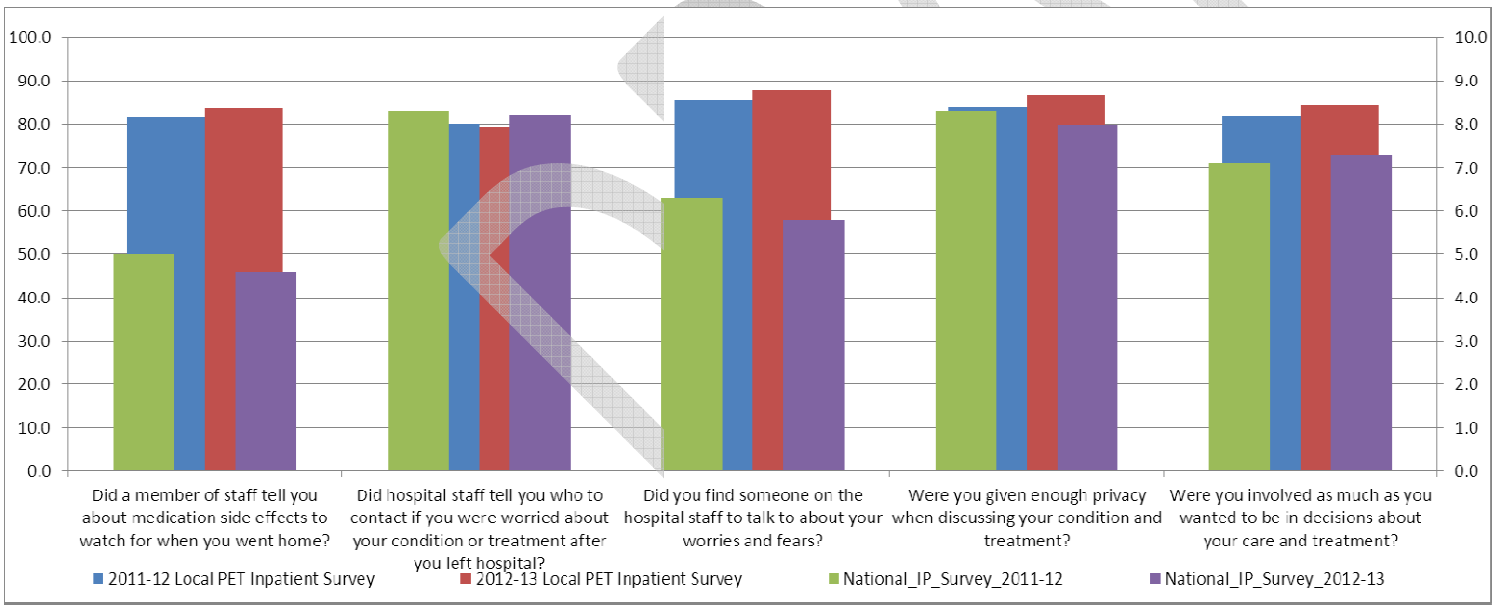
The national inpatient survey is coordinated and published by the CQC on an annual basis. Performance in this survey forms part of our CQUINs target for the acute element of the Trust, monitored by local surveys throughout the year (via Dr Foster/Meridian OC) whilst CQUIN performance targets for the community element of

the Trust are based entirely on results from our local patient experience surveys (no national community patient survey is performed by CQC). Questions asked by the local inpatient surveys are the same as those which the national survey is based upon.

The chart below reflects how we have performed in the national inpatient survey in 2011 and 2012, as well as results from our local patient experience surveys for both years for CQUIN related questions. Local surveys take place throughout the year and capture considerably more responses than the national survey (1,545 and 2,881 local survey responses for 2010-11 and 2012-13 against 432 and 331 for the national surveys respectively); the extra level of response received from local surveys is only set to increase – given that patients are now given the option to provide feedback after their time in hospital, by the use of a weblink to capture data.

In terms of the national inpatient survey, 2 questions in which the Trust was rated comparatively as being 'worse than most other Trusts' were concerning "being offered a choice of food" and "being given printed information about what you should or should not do on leaving hospital". The Trust was rated 'better than most other Trusts' in 5 of the 70 questions asked. Data available from the national inpatient survey does not go to a sufficiently granular level (i.e. ward or specialty) so as to enable corrective or improvement action to be taken; on that basis local surveys will continue to be used to identify potential improvement actions for these specific issues. This is in addition to a programmatic review of all patient experience related initiatives, led by the Chief Nurse, in light of the Francis report recommendations.

National & local inpatient surveys: CQUIN results 2011-12 vs 2012-13



National Staff Survey results

2012 Response rates	2012-13		2011-12			
	TRFT	National Avg (Acute Trusts)	TRFT	National Avg (Acute Trusts)	TRFT variance	National Avg variance
Response rate	264	395	408	427	-35%	-7%
Response %	32%	49%	49%	53%		

Top 5 ranking scores 2012 (2012-13 vs 2011-12)	2012-13		2011-12				
	TRFT	National Avg (Acute Trusts)	TRFT	National Avg (Acute Trusts)	TRFT variance	National Avg variance	Previous indicator ID*
Percentage of staff experiencing discrimination at work in last 12 months (KF28)	6%	11%	11%	13%	-45.5%	-15.4%	*KF38*
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (KF19)	17%	24%	14%	16%	21.4%	50.0%	*KF26*
Percentage of staff experiencing pressure in last 3 months to attend work when feeling unwell (KF20)	22%	29%	20%	26%	10.0%	11.5%	*KF29*
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (KF13)	22%	34%	27%	35%	-18.5%	-2.9%	*KF20*
Percentage of staff experiencing bullying, harassment or abuse from patients, relatives or the public in the last 12 months (KF18)	22%	30%	14%	15%	57.1%	100.0%	*KF24*

Bottom 5 ranking scores 2012 (2012-13 vs 2011-12)	2012-13		2011-12				
	TRFT	National Avg (Acute Trusts)	TRFT	National Avg (Acute Trusts)	TRFT variance	National Avg variance	Previous indicator ID*
Staff motivation at work (KF25)	3.73	3.84	3.80	3.82	*-1.8%*	0.5%	*KF35*
Percentage of staff suffering work related stress in last 12 months (KF11)	41%	37%	29%	29%	*41.4%*	27.6%	*KF18*
Staff recommendation of the Trust as a place to work or receive treatment (KF24)	3.35	3.57	3.50	3.51	*-4.3%*	1.7%	*KF34*
Percentage of staff agreeing that their role makes a difference to patients (KF2)	88%	89%	91%	90%	*-3.3%*	-1.1%	KF2
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (KF1)	74%	78%	74%	74%	*0.0%*	5.4%	KF1

**Italics* indicate the the KF# has changed relative to the previous comparative year

The National Staff Survey is an annual initiative, commissioned by the Department of Health for all NHS trusts; it provides us with a useful means of benchmarking our staff perceptions of the Trust as an employer, against those of other Trusts.

The response rate for TRFT, for the 2012-13 survey, is significantly lower than that in 2011-12; this decrease is mirrored by the national average for Acute Trusts but to a greater extent. This correlates with some of the key findings for 2012-13 which highlighted that staff engagement and motivation are both in the lowest 20% of Acute Trust outcomes. The reasons for these outcomes are no doubt multi factorial, but the impact of Electronic Patient Record implementation cannot be overlooked as a contributory factor to these issues; local staff surveys will continue to provide a more timely measure of staff satisfaction and the most recent results are reflected below.

Aspects which can be seen in a positive light include the fact that levels of staff experiencing discrimination (in the last 12 months) are almost half of that reflected in the previous survey and the National average. Staff witnessing potentially harmful errors, near misses etc. have also reflected a significant reduction – well under the National average by approximately one third. Whilst 2 of the top 4 ranking scores have shown an increase (harassment, bullying etc. from staff & feeling

pressure to attend work) –this must be taken in the context that they remain well under the National averages for these Key Findings, which have increased by a far greater extent.

Short and medium term actions to be taken by the Trust as a result of these outcomes include:

- A formalised means for staff to communicate queries, comments and concerns directly to the Chief Executive – and receive feedback within 7 days
- The Human Resource function coming under the direct supervision of the Chief Executive
- Human Resources and staff centric issues being made a key focus in the upcoming strategic planning process (due for release in September 2013)

Local Staff Survey results

Response category	2011-12 Adjusted score by Category	2012-13 Adjusted score by Subject area
Feeling valued	7.2	7.2
Learning and Development	6.0	5.4
Performance	6.1	5.6
Health and Wellbeing	7.3	7.4
Communication from managers	6.6	6.4
Job satisfaction	5.7	5.6
Conflict resolution	7.0	7.1
Overall score	6.5	6.4

The overall score for the staff survey has varied little in comparison to that carried out in April 2012, decreasing by only 0.1 - where 10 equates to the most positive result possible and 1 being the most negative result possible.

The main areas of concern remain the same as last year – staff opinions on learning & development, performance (feedback & development reviews) and job satisfaction having scored the lowest of all categories. Of these low scoring areas, 2 of 3 reflect the most decreased score against last year (learning & development and performance) – with communication from managers reflecting the third largest decrease.

Areas of strong performance remain the same as last year, increasing in 2012-13 by 0.1 at most; some of the most encouraging individual scores in the conflict resolution category relate to staff feeling able to handle conflict appropriately – although this is to be tempered by the fact that many staff agree that they have experienced some form of conflict within their role.

Actions to be taken in relation to local survey results, in addition to those mentioned in response to national survey outcomes, include the introduction of a more participative management style - involving employees more in decision making and establishing the future direction of the Trust; alongside this, TRFT is exploring the implementation of a staff engagement strategy to enhance commitment, motivation and inclusion during a time of significant organisational change.

Quality Governance

The Quality Governance Framework process includes:

- Standard Operating Procedure for the Quality Governance Framework – covering the assurance and reporting process
- Executive and non-executive sign off
- Monthly reporting to the Board
- Quality Governance Standards database provides evidence to assure executive members that assigned RAG ratings are appropriate
- Quarterly agreement by the Board prior to Monitor sign off

Currently our status is a score of 3, most areas are green/amber (rated at 0-0.5), one area we are continuing to declare as red (rated at 1), is data quality; this issue is anticipated to be resolved as part of our data quality/EPR recovery programme by the end of the year.

Looking back: Achievements against our quality priorities for 2012-13

How did we prioritise our quality improvement initiatives?

During the year we have been monitoring our progress against the targets we set in last year's quality report. Due to progress made against our improvement programmes (outlined below), the Trust has chosen to set new targets in areas which are current priorities. Our main focusses this year reflect this and sets out new targets in areas we maximum benefit will be achieved.

In making these decisions we have also consulted and received feedback, through various methods from our key stakeholders - including patients, public, carers, governors, LINks members, the Health Scrutiny Commission and our commissioners. The majority agreed with the further development of topics and continued links to our CQUIN priorities. The initial agreement stage of the process was conducted by the Corporate Safety and Experience Committee and then reported to the Board for final approval in March 2013.

Our overarching strategic objectives for the next 3 years as set out in our Quality Strategy, against Safety, Experience and Effectiveness are

Key Aims:

SAFE
•Reduce mortality: achieve a position in upper quartile of organisations with the lowest Summary level Hospital Mortality (SHMI)
•Reduce harm: 95% of patients to receive 'harm free' care
CARING
• Improve the patient/staff experience: achieve a position in the top 20% for patient and staff experience surveys
RELIABLE
• Provide reliable care: ensuring that evidence based practice is followed by meeting 90% compliance with all NICE quality standards

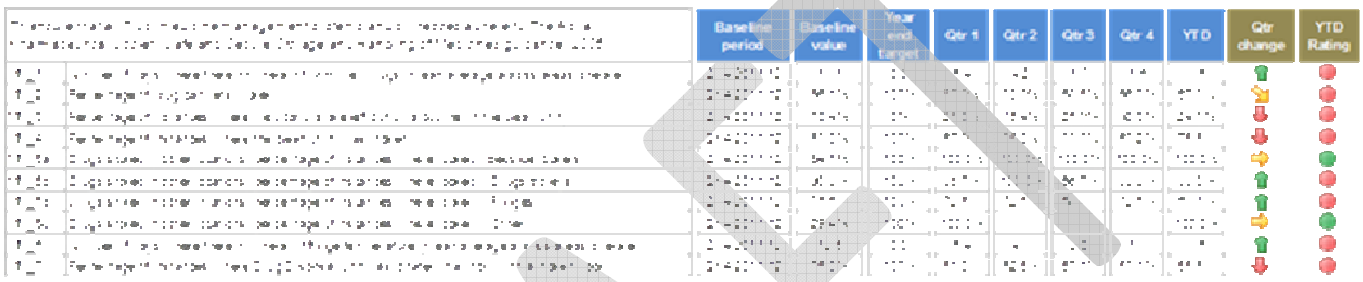
- The Trust Risk Adjusted Mortality Index (RAMI) score for 2011-12 was 87, indicating that mortality at the trust was 'lower than expected' according to the model parameters. This has increased in 2012-13 to 89, although still remains lower than the expected level of mortality as calculated by the methodology. RAMI is no longer the methodology promoted by the DoH – instead Summary level Hospital Mortality Index (SHMI) is the preferred comparator, this is reported in the mandatory indicator table later in the report.
- The Trust has achieved its aim of achieving 95% patients receiving 'harm free care', as measured and reported by the NHS Safety Thermometer initiative. The year end outcome for 2012-13 in respect of this indicator was 95.7%; CQUIN targets for 2013-14 will incentivise further improvements in performance. Which will be measured against the 2012-13 baseline.
- The Trust has reflected improvement in some aspects of the National inpatient surveys – with 2 out of 10 sections scoring 'better than most other trusts' in 2012-13, against 1 out of 10 scored in that category in 2011-12. 1 section was scored as 'worse than most other trusts' for 2012-13 – this section was related to 'the hospital and ward'; where the Trust was scored 'worse than most other trusts' in relation to offering a choice of food.
- The Trust has improved its position in relation to staff surveys, compared to the previous year. For 2012-13, the Trust has achieved 53.6% (n=28) of key findings where the response was in the upper quintile or 'better than average' – against 44.7% (n=38) in 2011-12.

- 21 of 24 published NICE standards are applicable to TRFT, we have a process in which we assign a clinical lead for each of the standards, these standards are monitored via a self assessment process reporting to the Clinical Effectiveness team and Clinical Effective and Research Group (CEG). We have introduced a random sampling process this year, which assesses the evidence against the self assessment process to ensure that full compliance has been achieved. The standards are RAG rated and we currently only have on element of one standard that is rated red (1 out of 210 standards) – this relates to the link between GPs and the Trust for patients discharged on VTE prophylaxis.

Our detailed quality improvement projects for 2012/13

Priority 1a: Compliance with medications management guidelines (Royal Pharmaceutical Society)

"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)".



What the results mean for the Organisation

The Organisation has made *huge* strides forward in increasing compliance against Royal Pharmaceutical Society (RPS) guidelines in relation to storage and handling of medications. We can take great pride in having vastly improved safety and security of our drug stocks in wards and departments where medication is used (this excludes Pharmacy main stores).

However, the setting of absolute targets for these indicators (i.e. 100%, 0% incidences or 'zero days' without checks) has meant that in many cases these 'stretch' targets have not been met.

What the results mean for our patients

Patients can be assured that the organisation is handling medications appropriately, and that they are being kept in good condition (at the right temperature) as well as being secured against potential tampering or adulteration – assuring against incidents such as that which was reported in a Manchester hospital in 2011.

Given the significant level of improvement against this programme (notwithstanding the achievements against the challenging targets set), this will not be set as an improvement programme in the coming year.

Further improvements identified

Although improvement is evident in all areas; aspects where most room for improvement still exists are the locking of drug fridges and cabinets – alongside the siting of Drug Disposal Units. Whilst this will not be set as an improvement programme for the coming year, performance against the RPS standards will continue to be reviewed in the nursing accreditation scheme and monthly nursing forum to ensure meeting these standards remains a priority.

Priority 1b: Introduce data collection for NHS 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."

Introduce and improve data collection in relation to falls, pressure ulcers, UTIs and VTE assessments in acute and community setting from April 2012 baseline		Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating
ST_1	No Harm - Falls	April 2012	97.7%	Increase	97.9%	98.9%	99.0%	98.7%	98.6%	↘	
ST_2	No Harm - New pressure ulcer	April 2012	96.8%	Increase	97.2%	97.6%	97.8%	97.9%	97.6%	→	
ST_4	No Harm - VTE	April 2012	97.7%	Increase	98.5%	98.9%	99.6%	99.5%	99.2%	→	
ST_5	No Harm - UTI	April 2012	93.9%	Increase	94.1%	95.4%	96.4%	96.3%	95.6%	↗	
ST_7	No Harm - Old pressure ulcer	April 2012	97.3%	Increase	92.6%	92.3%	93.0%	95.2%	93.4%	↗	

NB. Other areas of clinical effectiveness were measured during this process, but not required by Safety Thermometer – hence the number sequence is not sequential

What the results mean for the organisation

As a National CQUIN also, a significant amount of funding could be withheld by commissioners if the Trust fails to achieve its targets for this improvement programme. The Trust has achieved all the in-year targets in relation to this initiative, and hence will receive in the region of £300,000 when year-end review of CQUINs performance is finalised.

The Trust has not only achieved targets set, it has exceeded them significantly – by instigating a robust method for capturing and providing data to the NHS Information Centre as per the formal objectives, but at the same time evidencing improvement against most of the mandated performance indicators.

It must be borne in mind that the specific CQUIN goals are not related to improvement in performance, *but evidencing improvement in the data capture and submission process itself*. This has been achieved by using a robust in-house developed solution, utilising SNAP™ optical character recognition software in combination with SQL Server 2008™ to provide not only timely, accurate data submission to the NHS Information Centre – but the same data source seamlessly updates the Trust intranet where ward managers etc can view their own performance, 'drilling down' into the data to identify where problems are occurring.

The benefits from this programme are principally securing CQUINs funding for this programme, alongside maintaining an extremely useful online data source for clinical staff (also reflecting many other quality metrics).

The main dis-benefit for the Trust, in some respects – is it's *over achievement* in terms of performance outcomes, rather than simply managing to submit data on time. Next year the targets will be based on this year's performance, with a view to improving it. As the Trust has already performed extremely well this year – we have made targets even more challenging to achieve against next year.

What the results mean for our patients

Patients can be assured that the Trust is already performing strongly in the 'Harm Free Care' domains mandated by NHS Safety Thermometer, both against National, SHA Cluster and other peer groups.

Not only is TRFT performing well against peers, but in terms of day to day management – patients can feel safe in the knowledge that appropriate staff – from Ward Managers to Heads of Specialty, are able to review and rapidly respond to any issues affecting patient care if they are identified.

Funding from the CQUINs ring fenced budget will be released in due course – which will be ploughed back into the Trust to support and further develop patient care.

Further improvements identified

CQUIN Safety Thermometer goals have been developed further for the coming year. The CQUIN goal for 2013-14 is to not only continue data collection in respect of these indicators, but to evidence improvement against the actual outcomes from 2012-13. Having set a challenging target by performing strongly this year – striving to exceed that will result in even higher levels of care for our patients.

Priority 2a: End of Life care

"Increasing compliance to 65% for 5 key measures of the Liverpool Care of the Dying Pathway (LCP) by April 2013"

		Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating
Number of deceased (mortality DB - excludes deaths occuring in Accident & Emergency)		2011-12	1,055	Reduce	261	234	267	309	1071	↓	
Proportion of those deceased, who were on the LCP		2011-12	47.0%	Increase	58.2%	56.8%	49.1%	44.3%	51.6%	↓	
LC_1	Has the patient had the opportunity to discuss what is important to them and their wishes? (Q5)	2011-12	42.7%	65%	43.0%	93.2%	86.3%	96.4%	78.6%	↑	
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%	44.4%	91.0%	85.5%	97.1%	78.4%	↑	
LC_3	The patient has medication prescribed on a PRN basis for the following:	2011-12	35.6%	65%	41.1%	88.3%	80.8%	89.6%	73.9%	↑	
	Pain (Q7a)	2011-12	40.9%	65%	45.0%	91.7%	84.0%	92.7%	77.4%	↑	
	Agitation (Q7b)	2011-12	38.7%	65%	42.4%	90.2%	80.9%	92.7%	75.5%	↑	
	Respiratory tract secretions (Q7c)	2011-12	36.1%	65%	41.1%	88.0%	80.2%	87.6%	73.2%	↑	
	Nausea/vomiting (Q7d)	2011-12	31.9%	65%	39.7%	86.5%	77.9%	88.3%	72.6%	↑	
	Dyspnoea (Q7e)	2011-12	29.6%	65%	37.1%	85.0%	80.9%	86.9%	71.4%	↑	
LC_4	Has a full explanation of the current care plan been given to the relative/carer? (Q13)	2011-12	41.9%	65%	45.0%	94.0%	86.3%	97.1%	79.5%	↑	
LC_5	Has the LCP 'Coping with death' leaflet been given to the relative/carer? (Q14)	2011-12	39.5%	65%	44.4%	90.2%	85.5%	97.1%	78.3%	↑	
Average across 5 key measures		**2011-12**	**38.4%**	**65%**	**42.5%**	**90.0%**	**83.0%**	**92.8%**	**76.0%**	↑	

What the results mean for the organisation

The Trust has exceeded the targets set for 2012-13 across all areas of the 5 key measures. The main achievement arising from this programme is an increased application of the Liverpool Care Pathway (up to 51.6% in 2012-13, from 47.0% in 2011-12). Of similar importance, is the vast improvement made in careful documentation of provision of five of the crucial measures listed in the Liverpool Care Pathway document.

Whilst crude mortality (raw numbers of deaths) is extremely difficult to influence, the Trust did not achieve a reduction in the number of deaths occurring on wards, by 16 cases.

The organisation can be assured that a step change has occurred, not only in the provision of care to those nearing death and their relatives – but that this is being more carefully recorded in patient notes. It has long been the view that these elements of care are provided, by reference to the volume of work performed by the Palliative Care Team (for example); but also it is acknowledged that completeness of nursing documentation could have been improved in this respect.

What the results mean for our patients

Patients nearing or on the End of Life care pathway (and their relatives), can be assured that their last days will be as comfortable as possible, that their wishes in relation to death will be discussed and – wherever possible, acted upon.

This could be anything from wishing to hear particular music, or receive any blessing that they wish to take part in, according to their culture and religious belief. Relatives can also take comfort in knowing that pain relief for their loved ones will be provided carefully, to not only minimise any pain or discomfort – but to reduce anxiety also.

Support to relatives, in respect of keeping them informed of the patients care plan, and in the form of information leaflets regarding 'Coping with death' (signposting where to go for further support and assistance)

have in the past, been regarded as useful, practical support at a time of great distress and loss for relatives of those recently passed away.

Further improvements identified

Whilst all areas of the Liverpool Care Pathway improvement have achieved against their target, some areas (notably provision of medication as required and explanation of care plans to relatives) have shown variable performance through the year. It is the aim of the on-going monitoring to bring focus to these areas to attain a greater level of consistency; this will be achieved by inclusion of the indicators as part of the nursing accreditation scheme initiative.

Priority 2b: Responsiveness to patient's needs

"Increasing our responsiveness to our patients needs using a composite indicator of care, from April 2012 baseline"

Increasing our responsiveness to out patients needs using a composite indicator of care, from April 2012 baseline		Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating
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	79.8	87.6	83.7	↑	
PR_1b	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hc	April 2012	68.9	Increase	72.2	77.4	82.9	87.8	79.3	↑	
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	87.8	89.8	87.8	↗	
PR_1d	Were you given enough privacy when discussing your condition and treatment?	April 2012	80.5	Increase	83.0	81.4	91.4	93.8	86.8	↗	
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	80.0	89.0	92.2	84.6	↗	
PR_1	**Inpatient CQUIN template overall score**	**April 2012**	**79.1**	Increase	**80.9**	**81.4**	**86.5**	**90.4**	**84.4**	↗	
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	93.6	94.2	93.0	→	
PR_2b	Were you given enough time to discuss your condition with healthcare professionals?	April 2012	96.3	Increase	87.1	91.6	92.3	93.1	92.0	→	
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	85.1	81.4	86.8	↘	
PR_2d	Overall, have staff treated you with dignity and respect?	April 2012	99.6	Increase	95.5	97.8	96.4	97.3	96.9	→	
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	95.5	96.7	96.1	↗	
PR_2	**Community Health Adult Services overall score**	**April 2012**	**97.2**	Increase	**91.8**	**94.5**	**92.7**	**92.9**	**93.1**	→	
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	96.0	97.9	96.3	↗	
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	98.1	98.3	97.2	→	
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	84.8	89.2	92.4	88.0	↗	
PR_3d	Overall, have staff treated you and your family with dignity and respect?*	April 2012	97.6	Increase	98.4	98.8	98.9	98.4	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	98.7	98.7	97.8	→	
PR_3	**Community Health Universal Services**	**April 2012**	**94.7**	Increase	**95.1**	**94.8**	**96.3**	**97.2**	**95.8**	→	

What the results mean for the organisation

The Trust has broadly achieved its aims in respect of improving the positivity of patient feedback in a variety of care settings. Where increased scoring by patients has not been achieved this year – it is acknowledged (as in the case of Community Adult Health Services) that the baseline to evidence improvement against, was already extremely high – hence not attaining this level is in no way a sign of poor performance.

Midway through the year, the Trust switched to a different patient experience capture system – Meridian Optimum Contact. Some of the new features of the system enable appropriate staff to review feedback relevant to their areas, online and in a variety of different means – with increased functionality to identify trends in feedback according to day of the week etc.

The new system also provides more ways in which to provide feedback – via a weblink (for example), which can be used after the patient has left the hospital itself. This increased flexibility means it is even easier for patients to provide feedback about the service they have received – which in turn means TRFT captures more feedback, this can then be used to formulate actions for improving our services further.

What the results mean for our patients

Patients and relatives can be assured that the Trust not only seeks feedback from service users regularly – but that we seek to take action on this feedback.

Further patient experience initiatives have been introduced during this year, by mandate from the DoH; this new 'friends and family' test seeks the view of every patient that has attended Accident & Emergency,

alongside inpatients – to ascertain whether they would recommend the Trust to their family and friends as a place to be treated. Responses to this 'test' are captured utilising the same technology used to administer our in-house feedback surveys, hence enabling relevant staff to view feedback in real time, identifying trends at department level with a view to taking corrective action where necessary.

Further improvements identified

Continued use of our new patient opinion capture solution, in combination with deployment of the DoH mandated 'friends and family' test, will provide TRFT with a wealth of data that can be used to inform service improvement initiatives throughout the Trust. This information will continue to be monitored at Patient Experience Committee meetings, and reported in summary level to the Board via quarterly Quality Account updates.

2c: Dementia screening, assessment and referral

"To deliver the locally agreed improvement targets for early identification of patients with dementia – Find, Assess/Investigate and Refer (F.A.I.R) - in relation to all admitted patients aged 75 years and older by April 2013"

		Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating
DE_1a	Percentage of emergency admissions aged **over 75** (minus exclusions), who are asked the case finding question within 72 hours of admission (FIND)	-	-	90%				56.7%	56.7%	-	
DE_1b	Percentage of emergency admissions aged **over 65** (minus exclusions), who are asked the case finding question within 72 hours of admission (FIND)	-	-	90%				53.8%	53.8%	-	
DE_2a	Percentage of emergency admissions aged **over 75** (minus exclusions), scored positively by case finding OR having a clinical diagnosis of delirium, who are recorded as having a dementia diagnostic	-	-	90%				76.2%	76.2%	-	
DE_2b	Percentage of emergency admissions aged **over 65** (minus exclusions), scored positively by case finding OR having a clinical diagnosis of delirium, who are recorded as having a dementia diagnostic	-	-	90%				75.5%	75.5%	-	
DE_3a	Percentage of emergency admissions **over 75** (minus exclusions), with a 'positive' or 'inconclusive' outcome from a dementia diagnostic assessment, who are referred for further diagnostic advice or follow	-	-	90%				16.7%	16.7%	-	
DE_3b	Percentage of emergency admissions **over 65** (minus exclusions), with a 'positive' or 'inconclusive' outcome from a dementia diagnostic assessment, who are referred for further diagnostic advice or follow	-	-	90%				16.7%	16.7%	-	

What the results mean for the organisation

Unfortunately the organisation has not achieved its target for this year, which is also a CQUIN goal agreed with our commissioners. The target was to achieve 90% for each element of the process, for at least 3 months in the year.

The Trust acknowledges that it did not begin the data capture and screening processes early enough in the year, to affect changes in performance which would have led to achievement of this goal. Part of the reason for this was the anticipation that data capture for this target would be performed via the new EPR system – although difficulties experienced through implementation meant this was not possible. The introduction of a paper pro forma and associated administration processes therefore led to delays in starting the process.

Whilst not achieving this goal, it must also be recognised that the Trust did not simply intend to perform dementia screening for 75 year olds and over, but to achieve against our own locally imposed 'stretch' target – for 65 year olds and over.

What the result mean for our patients

Patients and relatives can take some comfort in the knowledge that this programme will 'roll over' into 2013-14 – with increased resource and effort applied to attain these goals.

Patients and relatives should also be aware of the benefits of TRFT's 'stretch' target of achievement for all 65 plus year olds – *so a larger group of people will be screened than originally mandated by the DoH*. This is very much to our patients' advantage, as early identification of dementia – with appropriate intervention, leads to much better outcomes for patients in terms of longevity and quality of life.

Newly developed drug treatments for dementia can slow (and in some cases, slightly reverse) the onset of dementia – it is clinically proven that these are most effective when administered as soon as possible after dementia is diagnosed. Early diagnosis, for a wider age range – can only have a positive impact on the lives of older adults served by TRFT.

Further Improvements identified

As targets have not been met by the Trust this year, they will continue to be an area of focus. Sustained resource is to be applied to achieving these goals – which will also remain a CQUIN target; it is highly probable that they will be achieved prior to mid 2013-14, now that a robust monitoring system is in operation.

Performance information will be provided to a number of Trust committees – including the Dementia Strategy Committee, Patient Experience Committee and, on a quarterly basis, to the Corporate Safety & Experience Committee and Board via the Quality Account report.

3a: Health Assessments for Looked After Children

"Increasing the number of assessments carried out for looked after children and young people, from the April 2012 baseline"

Increasing the number of assessments carried out for looked after children and young people, from the April 2012 baseline		Baseline period	Baseline value	Year end target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Qtr change	YTD Rating
HA_1a	Percentage of under 5's receiving a health assessment within timeframe (every 6 months) - In area	Qtr4_2012-13	100.0%	Increase				100.0%	100.0%		-
HA_1b	Percentage of under 5's receiving a health assessment within timeframe (every 6 months) - Out of area	Qtr4_2012-13	55.6%	Increase				55.6%	55.6%		-
HA_2a	Percentage of 5-18's receiving a health assessment within timeframe (every 12 months) - In area	Qtr4_2012-13	75.0%	Increase				75.0%	75.0%		-
HA_2b	Percentage of 5-18's receiving a health assessment within timeframe (every 12 months) - Out of area	Qtr4_2012-13	61.5%	Increase				61.5%	61.5%		-
HA_3a	Percentage of under 5's receiving a health assessment within timeframe (every 6 months) - Total	Qtr4_2012-13	78.4%	Increase				78.4%	78.4%		-
HA_3b	Percentage of 5-18's receiving a health assessment within timeframe (every 12 months) - Total	Qtr4_2012-13	71.7%	Increase				71.7%	71.7%		-

Unfortunately the Trust has not delivered the aims of this programme during the financial year. In quarter 2, as part of the Trust's data assurance review for Quality Account indicators – issues were identified with the reliability of the data.

This led to a revised process being implemented to track health assessment activity, utilising SystmOne. This is now working well, but the anticipated baseline and on-going operational performance data was not available until the beginning of quarter 4.

As no progress, other than quality assurance of data sources, has been made with this initiative – it will continue to be monitored as part of Quality Accounts 2013-14 (Quality at a Glance) metrics, and reported to the appropriate forums on that basis.

Further improvements identified

On-going performance will be discussed, alongside other indicators, at regular meetings with the relevant clinical service units and the Healthcare of Tomorrow Programme Board (CQUINs module) and reported quarterly via the Quality Account Report to the Board.

Looking forward: Our quality improvement priorities for 2013-14

The Board agreed the strategy and the improvement programme priorities for the year 2013-14. NHS Safety Thermometer and patient responsiveness will continue to be monitored in the Quarterly Quality Accounts, as part of our quality reporting framework.

The priorities for improvement for TRFT in the year 2013-14 are set out below. Each of the programmes supports, directly or indirectly, many of the recommendations arising from the outcomes of the Francis report – following issues highlighted surrounding the quality of care provided at the Mid Staffordshire NHS Foundation Trust.

In selecting these programmes, the views of staff were also sought as part of our annual Quality Account staff survey. The views of patients and the wider public, encouraged to contribute at the Trust annual general meeting, were also taken into account - as were those of our Governors and other agencies.

The improvement projects will support our aims to provide 'safe, caring and reliable' care, and are summarised as:

Quality Projects: 2013-14 (and on-going 2012-13) Improvement Programmes

Topic	**New or On-going**	**Objectives : 2013-14**
1. SAFE		
Never Events	On-going	Zero Never Events
Death certification process	New	To increase the number of recorded causes of death in the electronic discharge summary, from April 2013 baseline.
2. CARING		
Dementia	New/on-going	To deliver the locally agreed improvement targets for early identification of patients with dementia – Find, Assess and Refer (F.A.I.R) - in relation to all admitted patients aged 75 years and older by April 2014
3. RELIABLE		
NICE Quality Standards Dementia	New/on-going	Meeting NICE quality standards for Dementia (as part of programme above)
Intra Operative fluid management	New	To increase the number of patients receiving IOFM to the standards stipulated in National guidance, from baseline April 2013.
Improving data quality	New	Improve from our current position on the National and Regional benchmarking statistics by April 2014.

Priority 1: Patient Safety: (CQUIN pre-qualification indicator), Intra-operative Fluid management (IOFM)

How and who collects the Data?

The data for this programme will be collected via the patient administration and electronic patient record codes and collated by the information department. Additional data involving the NHS Safety Thermometer will be collected via our monthly data collection method.

Why is it important to us?

Intra-operative fluid management is an important aspect of care for patients who are at high risk during certain operative procedures. Although we have implemented specific management for patients undergoing colorectal surgery we now need to expand this to other high risk operations as set out in the national IOFM standards framework and as part of our pre-qualification for CQUINs payment.

Over the previous years we have also included a fluid management performance indicator within the ward quality monitoring regime, to ensure that the care of patients undergoing surgical and medical procedures is optimal. Although we have shown significant improvement in our assessment of fluid balance on patients we still feel we have areas that we can improve further. We have therefore included the whole care pathway for patients undergoing surgery for inclusion in our improvement programmes this year and in addition fluid balance in the ward setting.

What are we going to do?

We will initially carry out a baseline assessment of procedures against the national standards and set out an improvement trajectory and gain agreement from our Clinical Commissioning Group (CCG) on the target. Following agreement we will ensure that we have the correct equipment to undertake the monitoring of all relevant surgical patients and also put in place data collection methods to ensure we can monitor progress during the year. We will also assign and resource a project lead, working within the anaesthetics and surgical clinical service unit to ensure implementation of activities.

In addition we will continue to monitor fluid balance assessment and actions as part of the additional monitoring we undertake whilst conducting our NHS Safety Thermometer surveys. A project team will be established to ensure that all aspects of the work are reported and any non-compliance, issues or good practice is feedback to relevant wards and surgical areas.

How and where will the progress be reported?

The patient safety committee will have this as a standard agenda item for monitoring issues via the project group. Progress will be reported as per our usual quarterly quality accounts monitoring report all information and any escalations will be reported to the Board via these mechanisms.

Board Sponsor:

Chief Nurse

Implementation Leads:

Lynne Betts Theatres Manager - Quality Improvement Lead: Patient Safety Team

Ian Wigley - Governance Lead: Anaesthetics and Theatres

Programme manager: Fiona Middleton - Associate Director of Patient Safety and Risk

Priority 2: Supporting the Quality Agenda: Improving Data Quality

How and who collects the Data?

All of our commissioning targets, including 18 week cancer targets, will form the basis for monitoring the outcomes of our data quality improvement programme, in addition we will also aim to improve our depth of

coding and take forward the action plan based on the outcomes from our PbR audit (Audit Commission), see the Data Quality section in part 2b for details.

Why is it important to us?

During the year the implementation of the Electronic Patient Record (EPR) has brought significant challenges in terms of data quality. Many of the data quality issues relate to user error and training issues in entering data into the system. Other errors have occurred because of the way in which the system has been configured. This has clearly had an impact on our financial activity payments from the commissioners and has limited the amount of information we have in terms of some of our performance indicators, i.e. 18 week waits, cancer targets.

Given heightened public scrutiny of the Trust, as a result of some high profile press coverage during the year in relation to EPR implementation – the Trust believes that focussing attention on publicly available data quality indicators will aid in restoring confidence in the Trust's administrative support systems.

What are we going to do?

Following a review of the system and identification of the issues affecting data quality we have developed within our new Health Informatics Directorate a Data Quality function. This team will develop an improvement plan against all data quality issues. This will involve training of users, changes in the system configuration and improved feedback reports to users and to the team to enable actions to be taken in a timely manner.

We will monitor this situation closely during the year in our progress report s to CCG and Monitor.

How and where will the progress be reported?

We will report via our Quality accounts quarterly report. The reports will also be discussed at the monthly Corporate Informatics Committee and also be provided to CCG and to Monitor on a monthly update report.

Board Sponsor:

Dr Patricia Bain - Executive Health Informatics Officer

Implementation Leads:

TBC - Director of Informatics & Intelligence

Programme managers:

Ian Stinson **-** Business Intelligence Development Manager

Leilei Zhu – Clinical Information Development Manager

Priority 3: Clinical Effectiveness: Review of death certification

How and who collects the Data?

The death certification process is managed via two main teams, the patient service department who are responsible for registration of deaths and the Chief Medical Officer in terms of overall responsibility for the clinical directors of each clinical service unit clinical effectiveness leads. The coding department also have a role to play in ensuring the cause of death is coded accurately on the system

Why is it important to us?

Death certification is important in terms of making sure that for the patient's family and carers the accurate cause of death is recorded. It is also important to ensure that our mortality statistics reflect accurately what our patient mortality is caused by, to enable us to focus on areas that may be outliers to ensure that there are no clinical reasons for this. In terms of the coronial process it is also important that we ensure all deaths are recorded accurately to assist the coroner.

During the year we had a Care Quality Commission (CQC) alert requesting information in relation to what appeared to be a higher than expected death rate for septicaemia. Following investigation, junior doctors recording of cause of death was found to be inaccurate and in some instances the coding of the cause of death was inaccurate. This brings reputational issues to the Trust as well as focusing our efforts in areas that do not appear to be clinically significant.

What are we going to do?

All clinical directors will be asked to review their process for death certification, in particular the supervision of junior doctors. The PGME department will be asked to review their training programmes in relation to death certification. In addition, the electronic discharge summary has already been amended to ensure we collate the cause of death in addition to the primary diagnosis to ensure that coders can more accurately record this information.

How and where will the progress be reported?

The quarterly Quality Account report will be used to show improvements with this programme, the report is shared with CSUs and the Board. In addition the death certification programme will be included as a standard agenda item for the Clinical Effectiveness & Research Group (CEG), progress on this programme will be reported by the Clinical Effectiveness lead. Any escalations will be via CSEC.

Board Sponsor:

Executive Medical Officer

Implementation Leads:

Clinical Effectiveness leads in all CSUs, Clinical Directors, Coding Manager, PGME Director

Programme managers: Clinical Effectiveness lead identified to lead on programme, Coding Manager

Priority 4: Patient Experience - Dementia

How and who collects the Data?

The data for this programme will be collected via the Chief Nurse senior nursing group as part of the requirement under our CQUINs programme.

Why is it important to us?

Improving the care of patients who suffer Dementia and ensuring that they are assessed and signposted to the appropriate care pathway is vitally important for these patients quality of experience and treatment. During the year we have made good progress in setting up data collection methods to ensure we have a much better understanding of where we need to improve our care. This information and the additional information required under our CQUIN target will be used to identify improvement programmes during the year.

What are we going to do?

On establishing a baseline position we will then develop appropriate improvement programmes and continued monitoring via our various mechanisms e.g. Nurse Walk arounds, Nursing Accreditation Schemes.

How and where will the progress be reported?

Progress will be reported to the Patient Experience Committee and any escalations to CSEC. The information will also be reported via the quarterly Quality Account report and to the Board.

Board Sponsor:

Chief Nurse

Implementation Leads:

Group Nurses, Matrons

Programme managers: Named Senior Group Nurse

2B Statement of assurance: The quality of services provided

Review of services and income generated

During 2012-13 The Rotherham NHS Foundation Trust provided and/or sub-contracted 25 Acute and 40 Community relevant Health Services.

TRFT has reviewed all the data available to them on the quality of the care in 65 of these relevant health services.

The income generated by the relevant health services reviewed in 2012-13 represents 68.6% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2012-13.

Clinical Audit Activity

During 2012-13, 38 national clinical audits and 6 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation Trust provides. During 2012-13 TRFT participated in 97.4% national clinical audits and 100.0% 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 2012-13 are as follows:

	Number of audits relevant to services provided by The Rotherham NHS Foundation Trust	Percentage of audits participated in
National Clinical Audits	38	97%
National Confidential Enquiries		
National Confidential Enquiries into Patient Outcome & Death (NCEPOD)	4	100%
Confidential Enquiries into Maternal & Child Health	2	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	0	NA

The national clinical audits and national confidential enquiries that TRFT participated in during 2012-13 are as follows:

Title	Eligible	Participation	% Cases submitted	Report published 2012 (calendar year)	Report Reviewed	Action (s) to improve quality of care
Acute						
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes	Data collection ongoing until May 2013	Yes	Yes	Incorporate into junior doctor teaching sessions the importance of chest x-ray prior to giving antibiotics, calculating CURB65 score; considering the need for critical care involvement where CURB65 4-5; and giving antibiotics promptly on confirmation of diagnosis.
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%	Yes	Yes	Following review of the audit report, no actions were required.

Title	Eligible	Participation	% Cases submitted	Report published 2012 (calendar year)	Report Reviewed	Action (s) to improve quality of care
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100%	Yes	Yes	Following review of the audit report, no actions were required.
National Joint Registry (NJR)	Yes	Yes	98% (2012) 100% (2013 to date)	Yes	Yes	TRFT are currently using the recommended implants for hip and knee replacements and are in line with other Trusts regarding the levels of types of implant used. Therefore no further actions are required.
Non-invasive ventilation - adults (British Thoracic Society)	Yes	Yes	Data collection ongoing until May 2013	Yes	Yes	Develop a patient information leaflet to improve engagement with patient and carers in treatment plans. Redesign the BiPAP referral form and update the hospital CPAP policy to include all CPAP patients to be transferred to a level 2 care facility within 1 hour of request.
Patient Outcome and Death (NCEPOD)	Yes	Yes	100%	Yes	Yes	The Resuscitation Committee is to set a formal target for the number of cardiac arrests leading to CPR attempts. The trust is taking forward work on the recommendation for Consultant review of all acute admissions within 12 hours of admission. Patient location is not routinely recorded on the medical history sheets in the patient case notes – to discuss at the Clinical Effectiveness & Research Group.
Renal colic (College of Emergency Medicine)	Yes	Yes	100%	No	NA	NA
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	100%	Yes	Yes	Improve adherence to the fractured rib pathway through reminders in newsletters and training for junior doctors. Review and amend the Trust chest trauma guideline specifically for A&E. Update local guidelines for head injury in line with NICE guidelines for patients on Warfarin/Low Molecular Weight Heparin.
Blood and Transport						
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
National Comparative Audit of Blood Transfusion: a) O neg blood use	Yes	No data collection 12/13	No data collection 12/13	No	NA	NA
b) Medical use of blood	Yes	Yes	95%	No	NA	NA
c) Bedside transfusion	Yes	No data collection 12/13	No data collection 12/13	Yes	Yes	Review Patient Identification policy. Develop Patient information leaflet 'Do you know who I am' and discharge information so that areas other than haematology ward can provide patients with contact

Title	Eligible	Participation	% Cases submitted	Report published 2012 (calendar year)	Report Reviewed	Action (s) to improve quality of care
d) Platelet use	Yes	No data collection 12/13	No data collection 12/13	No	NA	details in the event they feel unwell after a transfusion. Ensure new EPR system uses the same core set of patient identifiers as all other IT systems. NA
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	100%	Yes	Yes	Complete and ratify all organ and tissue donation policies. Develop a teaching programme accessible to all clinical staff involved in care of the dying patient.
Cancer						
Bowel cancer (NBOCAP)	Yes	Yes	100%	Yes	Yes	Ensure patients with rectal cancer are made aware of the impact and length of time they may have a stoma pre-operatively. Review radiotherapy rates for patients with rectal cancers.
Head and neck oncology (DAHNO)	Yes	Yes	100%	Yes	Yes	Discuss the feasibility of increasing the working hours of the Clinical Nurse Specialist.
Lung cancer (NLCA)	Yes	Yes	100%	Yes	Yes	Work with neighbouring trusts to improve the data completeness for treatment activity. Review records of patients who did not have a CT scan prior to bronchoscopy. Improve access to a dedicated thoracic surgeon at the Rotherham MDT to ensure equitable access to surgery.
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%	Yes	Yes	Following review of the audit report, no actions were required.
Heart						
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100%	Yes	Yes	Work is required to improve referrals of NSTEMI patients to Cardiology.
Adult cardiac surgery audit (ACS)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Cardiac arrhythmia (HRM)	Yes	Yes	100%	No	NA	NA
Congenital heart disease (Paediatric cardiac surgery) (CHD)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Coronary angioplasty	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Heart failure (HF)	Yes	Yes	78.8% based on HES data 100% based on primary ICD10 codes	Yes	Yes	Ensure patients are given a follow up appointment and contact numbers for heart failure specialist nurses both in hospital and community.
National Cardiac Arrest Audit (NCAA)	Yes	No	NA	NA	NA	Non participation due to cost.
Peripheral vascular surgery (VSGBI Vascular Surgery Database, NVD)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Pulmonary hypertension (Pulmonary Hypertension Audit)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*

Title	Eligible	Participation	% Cases submitted	Report published 2012 (calendar year)	Report Reviewed	Action (s) to improve quality of care
Long term conditions						
Adult asthma (British Thoracic Society)	Yes	Yes	100%	Yes	Yes	Respiratory Clinical Nurse Specialist to train link nurses on wards B1 and A2 and work with A&E to develop training programme. Develop an asthma protocol.
Asthma Deaths (NRAD)	Yes	Yes	100%	No	NA	NA
Bronchiectasis (British Thoracic Society)	Yes	Yes	100% (sample agreed)	Yes	Yes	Establish a specialist bronchiectasis clinic at Breathing Space and develop a local protocol to support clinical practice.
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	100%	Yes	Yes	Introduce new pathways for patients attending A&E and Medical Admissions Unit. Provide education for nurses on diabetes ward and consider rolling this out to staff on other wards following evaluation. Implement the Think Glucose programme. Recruit an inpatient specialist nurse, and ensure specialist diabetes team attend ward rounds on a regular basis. Ensure referrals into the MDT are triaged by the whole team, and reviewed by a diabetes consultant daily. Specialist podiatrist to provide education on the diabetes ward.
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	Yes	Yes	The proposal to implement service changes relating to the Best Practice Tariff are being worked towards and appointments will continue to be managed within CYPHS. Investigate the use of SystmOne for data collection.
Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services	Yes	Yes	Data collection ongoing until December 2013	Yes	Yes	Investigate increased allowance for IBD Dietitian and increased access to counsellors and psychologist. Provide education to IBD clinicians on rescue therapy, bone protection system and referrals for smoking cessation. Provide education to ward staff on referrals to IBD nurse, to increase input for inpatients.
Pain database	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Renal replacement therapy (Renal Registry)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Renal transplantation (NHSBT UK Transplant Registry)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Mental Health						
National audit of psychological therapies (NAPT)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Prescribing in mental health services (POMH)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Suicide and homicide in mental health (NCISH)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*
Older people						
Carotid interventions audit (CIA)	*No*	*NA*	*NA*	*NA*	*NA*	*NA*

Title	Eligible	Participation	% Cases submitted	Report published 2012 (calendar year)	Report Reviewed	Action (s) to improve quality of care
Fractured neck of femur	Yes	Yes	100%	No	NA	NA
Hip fracture database (NHFD)	Yes	Yes	100%	Yes	Yes	Following review of the audit report, no actions were required.
National dementia audit (NAD)	Yes	Yes	100%	No	NA	NA
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100%	Yes	Yes	Ensure information packs are available and medical teams make appropriate referrals to the Nurse Specialist. All patients to receive a sitting standing blood pressure measurement in clinic. Education for Nurse Specialist with regards to identifying and referring those at risk of osteoporosis to the Bone Health Team. Occupational Therapist's to investigate the use of standardised assessments and trial these. Make greater use of the Quick Reference Cards for Physiotherapy and trial new outcome measures. Speech and Language Therapists to consider making audio recordings and documenting whether the patient is assessed during an 'on/off' period.
Sentinel Stroke National Audit Programme (SSNAP) a) Sentinel stroke audit b) Stroke improvement national audit project	Yes	Yes	100%	Yes	Yes	Ensure Stroke Unit beds are used and prioritised, and adopt a policy that non-stroke patients on the Stroke Unit should be managed as any other medical outlier. Discuss with Radiology regarding providing CT scans for those patients meeting NICE criteria for urgent imaging, and the importance of imagining within 1 hour. Collect and review data on patients missing the 1 hour target.
Other						
Elective surgery (National PROMs Programme)	Yes	Yes	59.1% (data to September 2012)	Yes	Yes	Review participation rates and circulate results to relevant nursing staff who are involved in recruiting patients. Ensure patients are aware of the requirement to complete a follow up questionnaire post discharge. Investigate obtaining access to and the analysis of local data.
Women's & Children's Health						
Maternal infant and perinatal (MBRRACE-UK)*	Yes	Yes	100%	No	NA	NA
Child Health (CHR-UK)	Yes	Yes	Data collection ongoing until April 2013	No	NA	NA
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	100%	Yes	Yes	Referrals to the Epilepsy Nurse Specialist need to be increased – all staff are to be reminded of this requirement and referral criteria to be circulated. A checklist is being developed for first clinical assessment and a

Title	Eligible	Participation	% Cases submitted	Report published 2012 (calendar year)	Report Reviewed	Action (s) to improve quality of care
						protocol for children with convulsive seizure disorder. Work is taking place to ensure all children are seen within a dedicated Epilepsy clinic wherever possible.
Neonatal intensive and special care (NNAP)	Yes	Yes	100%	Yes	Yes	Investigate patient experience and opinion in relation to breastfeeding and ensure all staff are appropriately trained on the importance of breastfeeding (particularly for pre-term babies). Look at the possibility of earlier discharge for pre-term breastfeeding babies where the only need to stay in hospital is occasional tube feed. Work closely with Ophthalmology colleagues to increase the number of ROP screens at the appropriate time. Improve data completeness by liaising with junior doctors and community colleagues to raise awareness of the audit requirements, in particular data relating to encephalopathy and follow up.
Paediatric asthma (British Thoracic Society)	Yes	Yes	100%	Yes	Yes	Continue to work with EPR team to ensure all relevant audit data is routinely recorded.
Paediatric fever (College of Emergency Medicine)	Yes	Yes	100%	No	NA	NA
Paediatric intensive care (PICANet)	*No*	*No*	*NA*	*NA*	*NA*	*NA*
Paediatric pneumonia (British Thoracic Society)	Yes	Yes	100%	Yes	Yes	Teaching sessions will be delivered to ensure the continued implementation of the new BTS guidelines on the management of Paediatric Pneumonia.

The national clinical audits and national confidential enquiries that TRFT participated in, and for which data collection was completed during 2012-13, are listed in the table above alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 28 national clinical audits were reviewed by the provider in 2012-13 and TRFT intends to take the actions as listed in the table above to improve the quality of healthcare provided.

The reports of 214 local clinical audits were reviewed by the provider in 2012-13 and TRFT intends to take the following actions to improve the quality of healthcare provided:

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action to improve quality of care
A&E	Anaphylaxis	Yes	Write anaphylaxis guidelines including the use of tryptase. Discuss referrals to Allergy Clinic with Paediatrics. Produce a leaflet for patients following an anaphylactic reaction. Update Emergency Department guidelines.
A&E	Audit of child protection questions	Yes	Ensure complete and accurate completion of the mandatory questions for the paediatric patients.

A&E	Audit of Emergency admissions from Falls	Yes	No actions required.
A&E	Re-audit of admissions following Fall	Yes	No actions required.
A&E	Sedation Checklist audit	Yes	Highlight the importance of correctly completing the checklist, particularly the discharge information. Increase documentation of evidence that verbal consent has been obtained.
Adult	Audit of Key Performance Indicators for the Diabetes Specialist Team	Yes	Feedback the results to staff to ensure all patients receive an annual HbA1c, Microalbumin, eGFR and smoking status check and urine dipstick at every appointment. Ensure all sections of the annual review template are completed. Investigate the feasibility of using an electronic system (SystmOne) for recording patient contacts.
Adult - CASH	Prescribing of oral contraception	Yes	No actions required.
Adult - Community Dental	An audit of clinical record keeping for dental treatment under general anaesthesia at Doncaster Royal Infirmary (DRI)	Yes	Produce standardised dental General Anaesthetic form. Pilot General Anaesthetic form locally (DRI). Use form throughout Rotherham Foundation Trust Community Dental Service.
Adult - Community Dental	Audit into Rotherham Residential Dental Screening Service 2008-2012	Yes	Continue to increase percentage of residents screened by reinforcing the importance of screening to care home staff. Develop fluoride varnish programme.
Adult - Community Dental	Audit into the inclusion of FP17DC form in the patient's notes	Yes	Ensure surgeries are stocked weekly with all relevant documentation to make the consent process easier. A copy of the FP17 DC form along with the consent form should be given to the patient/parent/carer at the appointment when treatment moves into band 2 or 3.
Adult - Community Dental	Audit of compliance with NICE CG112 for sedation in children and young people	Yes	Modify current proforma to include a tick box to record that verbal information has been provided regarding the technique, alternatives and risks/benefits. Provide all staff delivering inhalation sedation with update on the technique, including the need for pre-assessment, every two years. Check all clinics have a set of functional weighing scales and if not these to be ordered. Develop a proforma to record pre-inhalation sedation information for all patients. Develop written patient/carer information leaflets regarding inhalation sedation technique, alternatives and risks/benefits.
Adult - Community Dental	Clinical audit of the quality of radiographs taken in Doncaster Community Dental Service 2011	Yes	Introduce a new system to ensure consistency of justification and reporting, such as when and how to record. In view of the use of digital radiographs at the Flying Scotsman Centre, modify the method of audit, particularly relating to developing problems. A named Radiation Protection Supervisor should be designated to oversee a number of specific operators.
Adult - Community Dental	Compliance with referral protocol for extraction of lower wisdom teeth in the dental sedation service	Yes	Write to referring dentists informing them of the results of the audit and the requirement to include a good quality radiograph with their referral letter of the wisdom teeth that require extraction.
Adult - Community Dental	Pre-assessment of children prior to dental extractions under GA	Yes	Present findings and discuss options for changes to current practice to improve service and comply with current guidelines
Adult - Community Dental	Retention and discharge of Paediatric Dentistry Patients within Barnsley CDS	Yes	Discussion at next departmental meeting to ensure all members are adhering to protocol. Amend local protocol for correspondence to ensure referrer receives letter of acceptance and discharge and NHS Constitution letter pledge is met.
Adult - Community Dental	Service review of outcomes and treatment provided for patients referred by General Dental Practitioners under the behaviour management category	Yes	Provide targeted training to General Dental Practitioners regarding diagnosis of dental caries in paediatric patients.
Adult - Ear Care & Audiology	Treatment of Chronic Otitis Media	Yes	Discuss the findings and recommendations with the specialist nurses at the clinical supervision meeting in order to: standardise patient assessment and diagnosis; ensure appropriate treatment is prescribed with accurate documentation; and ensure referrals to ENT are arranged appropriately according to clinical need.
Adult - Nursing	Audit of home delivery of continence products and service user experience	Yes	Standardise telephone response to patient requests for products.
Adult - Nursing	Audit on NICE Guidance on the use of long acting analogue insulins for the treatment of diabetes	Yes	Present findings at Clinical Network meeting to agree further action required in order to improve compliance with the guidance.
Adult - Nursing	Liverpool Care Pathway Audit End of Life Care	Yes	Share findings with staff to ensure they are aware of the information that should be recorded on the end of life template - disseminate end of life template and results of audit to all Matrons and District Nurses who will discuss with other team members.
Adult -Community Dental	Antibiotic prescribing habits of community dentists in Doncaster	Yes	Consider reviewing diffuse swellings after 2-3 days and discontinuing the antibiotic if the swelling has resolved and the temperature is normal.

Anaesthetics	An audit of pain relief following hip and knee replacement - what is happening now?	Yes	Investigate the usefulness of the infiltration in hip replacement. Theatres to have a folder with all pain team policies and guidelines including the hip and knee guideline. Investigate how much influence the spinal diamorphine has on post-operative nausea and vomiting. Look at pre-printed analgesia drug cards. All surgeons who use a local anaesthetic block to use the premixed syringes.
Anaesthetics	Audit of information received on analgesia and anaesthesia in labour	Yes	Information leaflets to be provided to all women antenatally in all areas - leaflets to be ordered and distributed. Development and production of DVD. Display posters in all clinical areas with details of Obstetric Anaesthesia Association website/App available to download free of charge.
Anaesthetics	Audit of thromboprophylaxis given to surgical patients compared to NICE guidelines	Yes	Discussion regarding whether Anaesthetists should be considering VTE risk as part of peri-operative care. Feedback results to VTE steering group.
Anaesthetics	Awake shoulder Surgery	Yes	Feedback the audit information to the orthopaedic surgeons. Make GPs aware of this service. Reduce waiting on all day lists by staggering the admission times for some patients on the all-day list.
Anaesthetics	Day case ACL reconstruction (ACLr)	Yes	Anaesthetists who do lists with ACLr need to be aware of potential to use Prilocaine spinal. Ensure ACLr are listed on morning lists, scheduling needs to do this with the surgeons support. Explore being able to support ACLr surgery being done later in the day, Physiotherapy have revised their rotas to offer later reviews.
Anaesthetics	Day case interscalene blocks	Yes	Consider the use of ice packs post operatively. Discuss TTO regime and consider guideline.
Anaesthetics	Delayed discharges from theatre recovery	Yes	No actions required.
Anaesthetics	Emergency drug use audit	Yes	Increase awareness among Anaesthetists through audit presentation - highlight the expense to draw multiple drugs with similar actions.
Anaesthetics	Enhanced recovery for hip and knee arthroplasty	Yes	No actions required.
Anaesthetics	Fasting times in children	Yes	Inform maxillo facial team that IV fluids should be considered if the patient has oral injuries / dental abscess. Inform Children's Ward Manager and Day Surgery Ward Manager that clear fluids should be actively offered up to 2 hours before surgery, for both urgent and scheduled children. Ensure clear communication from theatre to the wards if there is going to be a delay in the emergency/trauma lists - Emergency Coordinator and Trauma Coordinator to do this in discussion with concerned Anaesthetist. Review pre-assessment/instructions given for inpatient dental patients - speak to Debbie Timms and Jocelyn Lee.
Anaesthetics	Fracture neck of femur (#NOF) study to improve care of #NOF	Yes	No actions required.
Anaesthetics	Post Partum Haemorrhage & cell salvage audit	Yes	Purchase 2 cell salvage machines: 1 for Delivery Suite, and 1 for main theatre - discuss purchase at CSU
Anaesthetics	Preoperative testing and its compliance with NICE	Yes	Local guidelines for pre-assessment nurses on Perioperative Blood Tests and ECGs. Regulate testing of patients against the recommendations of NICE. Increase awareness of the importance of accurate documentation of Perioperative Tests requested in Surgical Care Pathway
Anaesthetics	Preoperative testing the routine use of pre-operative tests for elective surgery	Yes	Increase awareness of the importance of accurate documentation of perioperative tests requested in Surgical Care Pathway. Regulate testing of patients against the recommendations of NICE. Produce Local guidelines for pre-assessment nurses on perioperative blood tests and ECGs
Anaesthetics	Re-audit of Compliance of RFT with the National NAP4 project for airway management in theatres.	Yes	Stock obstetric recovery with basic airway equipment - discuss with Operating Department Practitioners who cover Labour Ward. Ensure availability of Oxford Pillow for A&E - liaise with A&E Liaison Anaesthetist. Consider the need for Manujet/Aintree catheter in A&E.
Anaesthetics	Review of patients re-routed to day surgery due to bed pressures	Yes	Continue to collect and analyse data.
Anaesthetics	The frequency and extent of hypotension following a subarachnoid block, for elective surgery, in the Recovery room.	Yes	Ensure primary anaesthetics are informed when their patients become hypotensive by introducing a new protocol for Recovery staff. Ensure Anaesthetics complete the recovery section on the anaesthetic chart.
Anaesthetics	Unplanned Admissions from Day Surgery 2011	Yes	Anaesthetists should ensure post-operative analgesics and antiemetics are prescribed and review patients. Data forms to be completed for patients who go to ward straight from main theatre. Data on patients who are rerouted to inpatient on admission to TAU to be collected. Consider later opening times for day case. Review of Urology Day cases undergoing stent/stone surgery Review of Day case laparoscopic cholecystectomies.
CYP Service	An Audit of Health Assessments for Looked After Children	Yes	Compile Practice Guidance for Health Practitioners in order to ensure the completion of Health Assessments within acceptable timeframes. Compile a training programme specifically around Review Health Assessments and their quality/completion in relation to the Practice Guidance and provide training regarding the health needs of Looked After Children and Young

			People to support the completion of Review Health Assessments.
CYP Service	Audit of compliance with speech therapy programmes in special schools	Yes	Contact the school to recommend that they have a team of staff that are responsible for raising the profile of the fundamental nature of communication across all learning environments and to recommend that Speech and Language Therapy (SLT) are part of this. Develop a new care pathway and offer formal training on this. Meet with school management staff to illustrate the new care pathway and recommend that information is cascaded to all staff members. Recommend that all children known to SLT have a communication target that has been agreed with the Therapist and is delivered across the curriculum as part of their Individual Education Plan.
CYP Service	Audit of Consent (2012)	Yes	Amend current generic food challenge document and ensure this is distributed at time of consent. Re-audit performance - add SCBU consent audit to 2013-14 audit plan.
CYP Service	Audit of data input into BadgerNet for the National Neonatal Audit Programme	Yes	Quick reference guidance to be made easily accessible. Raise awareness of importance of data entry and how to enter data by using a short hand out guide at induction. Liaise with the NNAP nurse for the network regarding a training session for the junior doctors.
CYP Service	Audit of documentation	Yes	Improve record keeping - Doctors to sign front sheet on records.
CYP Service	Audit of Handover (NCEPOD)	Yes	Explore updating computer in sigma room. Speak to radiology regarding the availability of a PACS box on children's ward to view images. Consider implementing an 'education book/log' where topics are noted to be presented at a later date.
CYP Service	Audit of Lumbar Puncture/Infection Screening Guidelines	Yes	Improve documentation of informed consent by developing lumbar puncture pack for doctors to use when lumbar puncture is planned. Pack to include information sheet to be given to parents at time of consent. Weekly feedback to be initiated regarding antibiotics duration.
CYP Service	Audit of NICE Guidance on Looked After Children	Yes	Remind Social Care of the need for paperwork to be sent prior to/for Looked After Children medicals
CYP Service	Audit of Paediatric Resuscitation (NCEPOD)	Yes	Recommend dedicated Paediatric Resus trolley, clearly labelled and based on model in HDU. Check availability of drug kardex. Discuss availability of ENT staff. Junior doctors to visit A&E during induction walk-around to ensure familiarity with A&E resus environment. Circulate information on best practice to improve documentation. Emphasise the importance of completing audit forms and update the current de-briefing guidelines to ensure includes the requirement to complete resus audit forms.
CYP Service	Audit of Paediatric Resuscitation (NCEPOD) - Aug 2012	Yes	Implement immediate debrief regarding any issues from Resus/Fast Bleep. Prostin to be kept on neonatal unit and made up on neonatal unit for use in A&E and other areas. Ensure audit proformas are completed to ensure a comprehensive record is available. Improve orientation of staff joining mid post (F2 and other Registrars). Ensure availability of EMBRACE drug kardex within A&E.
CYP Service	Audit of safeguarding referrals to social care	Yes	Specific training to be incorporated into induction programme for areas where high volumes of social care referrals originate. Training to include informing parents in the process. Seek clarification regarding a proposed multi-agency form. Consider the use of the form used on SystmOne if multi –agency documentation not imminent
CYP Service	CAU Re-audit	Yes	Conduct a monthly prospective audit for 2013. Feed back audit results to nursing staff and action plan. Review notes for ward attenders to CAU to reduce numbers of routine attenders. Explore use of Rapid Access Clinic for child protection to reduce number sent to the ward.
CYP Service	Consultant allocation - audit of pathway and guidelines of patients	Yes	Ward based Consultant to check allocation on ward round. Retraining on consultant allocation for staff, especially out of hours.
CYP Service	Epilepsy a re-audit of outpatient clinic services	Yes	Ensure children are seen within 2 weeks of referral - advise all Consultants to review Choose and Book for suspected Epilepsy and change appointment date and time to ensure appropriate priority has been given. If Anti Epileptic Drugs are prescribed the decision to initiate treatment should be made in consultation with the individual and family and/or carers - remind all Consultants that this discussion should be clearly recorded in the notes.
CYP Service	Intubation and early ventilation guideline audit (Network audit)	Yes	Explore possibility of changing to volume guided ventilation. Produce simple guidelines for the use of volume guided ventilation. Explore training needs for nursing staff and investigate network training available. Reduce time needed to administer pre-meds by exploring the costs for pre-filled syringes.
CYP Service	Mental Health Admissions re-audit	Yes	Liaise with CAMHS regarding the high percentage of patients admitted that were already known to mental health services. Ensure alcohol misuse awareness and questions training and core planning has been undertaken.
CYP Service	Processes followed by School Nurses and Health Visitors prior to and subsequent to MARAC meetings	Yes	Develop standards for HV/SN for sharing information prior to and following MARAC. Review existing MARAC and DASH risk assessment training to ensure it clearly addresses issues identified from this audit (identification, assessment and referral). All HV, SN and Area Manger to attend MARAC and DASH Risk Assessment Training Circulate Domestic Abuse Practice Guidance 2007 to all Band 6&7 HV/SN and Area Managers. Review use of SystymOne Alert Protocol and Risk Assessment as result of MARAC. Create rolling programme which allows for HV/SN to attend and observe MARAC meeting. Training for band 6&7 HV/SN to explore their role and responsibility supporting women and children

			discussed at MARAC. Develop SystmOne templates to improve and support information gathering and sharing pre and post MARAC meeting. Promote names, roles and responsibilities of TRFT MARAC representatives. Re-audit.
CYP Service	Re audit of NICE Feverish Child guidelines	Yes	Parents of children with red/amber classification or any for whom clinical feels is indicated should have follow-up contact visit from Community Children's Nurse as necessary. Open access for 48 hrs leaflet should be developed and given to any child with fever who is discharged from CAU Leaflet on Temperature Control should be revised to include all parent information advised by NICE CG47. Discharge checklist to be revised to include tick box for leaflet given. All Staff to be reminded about importance of documentation of all basic observations, discussions and reasons to do / not do investigations
CYP Service	Re-audit of NICE guidelines on urine infections in children	Yes	Raise awareness of departmental guidance -print and laminate copies of the guidance and flow diagram and display. Circulate guidance electronically. Raise at staff meeting that when seeing and assessing children on ward rounds - there should be a clear plan for children in terms of age, time of infection and documentation of what has been done. Contact Medical Physics regarding the cancellation of DMSA investigations without Consultant liaison.
CYP Service	RRR015/2010 Prevention of over infusion of intravenous fluid and medicines in neonates	Yes	Consider whether local guidance on fluid management and feeds needs to be aligned to network guidance, in conjunction with available evidence
CYP Service	School Nurse involvement with children subject to child protection plans	Yes	Review School Nurse Service in conjunction with current guidance/documentation, meet with partner agencies and explore current practice in surrounding areas. Ensure School Nurse case conference reports identify health actions which are specific, measurable, achievable, realistic and delivered in a timely way (SMART) and develop audit of compliance with "Guidance for Writing Report for Case Conference". Standardise School Nurse record keeping prior to and following case conference to evidence assessment, analysis and action planning - review document "Report for Initial/Review Case Conference". Improve quality of health actions in decisions and recommendations to make them SMART - work with Independent Case Conference Chairs to update them on the role of School Nurse and universal service.
CYP Service and O&G	Hepatitis B 2010	Yes	Improve documentation of discussions antenatally and referrals to Hepatologist - emphasise the importance of this to all relevant staff. Raise staff awareness of standards and the need to improve compliance - consider providing an education day. Update internal protocol and brief nurses, doctors and ward clerks to ensure notifications of vaccinations is correct. Explore pharmacy electronically notifying the Child Heath. Consider setting up a new system where the immuniser notifies Child Health electronically (in addition to red book). Reconsider pathway for administering 1st Hep B vaccinations in hospital. Ensure complete repeat course recalls can be arranged through SystmOne
CYP Service and O&G	RDS and Early Care Audit	Yes	Ensure saturations and heart beat are monitored, monitor to be available for every resuscitation on trolley
Dermatology	Audit of Consent (Dermatology)	Yes	Circulate a copy of the report and remind everyone to include information on anaesthesia and consent for additional use of tissue samples
Dermatology	Audit of monitoring of patients on Cyclosporin in Dermatology dept	Yes	Design local departmental guidelines. Keep a copy of the newly implemented departmental guidelines in every clinic room as well as being accessible via the trust intranet. Produce an A4 pro-forma for the patient to keep and bring to each clinic appointment and also when they see GP. Educate stakeholders -relay audit results to all staff in dermatology department. To re-audit the same standards once the guidelines and pro-forma has been implemented to assess for improvement in clinical practice.
Dermatology	Audit of timeliness of notification to GPs of a diagnosis of skin cancer	Yes	All members of skin cancer MDT to ensure the stamp is put in post MDT and filled in when the patient receives diagnosis. Reinforce the need to inform GPs within 24 hours - Clinical Nurse Specialist to track when patients coming for diagnosis, Outpatient Assistants to alert clinicians. Identify more rare cancers on diagnosis and ensure the GP is notified of diagnosis discussion.
Endoscopy	Consent audit	Yes	Procedure specific consent forms to be developed - a small working group to be established and examples from other departments and trusts to be considered.
Endoscopy	Number of procedures	Yes	No actions required.
Endoscopy	OGD	Yes	No actions required.
Endoscopy	OGD – GI bleed	Yes	No actions required.
Endoscopy	PEG Audit	Yes	Use InfoFlex for data on all PEG placements and note review properly. Continue education programme
Endoscopy	Unplanned admissions, operations within 8 days, ventilation, perforation, bleeding & 30 day mortality (30/7 & 8/7)	Yes	No actions required.
ENT	Audit of Consent (ENT)	Yes	Improve documentation of when information is given to patients - reminder given to all to document when booklet or information sheet given to patient

ENT	Correlation between free-hand and ultrasound guided thyroid FNA	Yes	Discuss the use of a dedicated thyroid cytology request form. All cyst fluid to be sent, not just a representative sample. Discuss findings with pathologists and change preparation technique.
General Surgery	Annual audit of Consultant Reviews within 24hrs of admission (An Acute Problem)	Yes	Remind staff at the next Clinical Effectiveness meeting regarding the documentation of timing of reviews. Ensure that evening ward rounds on SAU and the new EGS procedures have reduced the number of patients not reviewed by a Consultant within 24 hours - re-audit with a larger sample.
General Surgery	Antibiotic prescribing in General Surgery	Yes	MRSA swabs need to be taken immediately on admission or as soon as possible thereafter, if it is not possible to obtain an MRSA swab and result, this should be documented in the notes and microbiology advice sought when prescribing antibiotics. If a previous MRSA status is known, this should be documented in the meantime. It should become standard practice for all prescribing doctors to document the indication for treatment on the drug card - encourage all doctors to document this on ward rounds. Update any doctor who misses August induction with audit findings. F1 doctor to repeat audit 6 monthly.
General Surgery	Audit of Consent (General Surgery)	Yes	Ensure Patient information leaflets are given and documented for common procedures such as OGD. Ensure doctors know which leaflets available and where they are stored. Encourage juniors to consent for photography and tissue samples when appropriate - distribute standards handbook. Establish correct procedure for Endoscopists asking about photography during their consent process (discuss at the endoscopy users meeting). Re-audit, including whether patients' consent has been re-confirmed if procedure undertaken on a different date and where consent has been withdrawn.
General Surgery	Comparative audit of Sheffield & Doncaster Surgery cases for Oesophagectomy & Gastrectomy.	Yes	No actions required.
General Surgery	Documentation Audit (General Surgery)	Yes	Update junior handbook to include a copy of the standards and a copy be uploaded to the department shared drive. Investigate the feasibility of having the booklet printed.
General Surgery	Re-audit of Accuracy of endo-rectal ultrasound in rectal cancer staging	Yes	Offer Trans-rectal ultrasound service to Rotherham Patients and monitor accuracy.
General Surgery	Re-audit of Antibiotic prescribing in General Surgery	Yes	MRSA swabs need to be taken immediately on admission or as soon as possible thereafter, within 12-24 hours. It should become standard practice for all prescribing doctors to document the indication for treatment on the drug card - disseminate standards, include information at induction and randomly spot check completion at every audit meeting. Upload into the department of surgery intranet the relevant guidelines and standards expected of antibiotic prescribing documentation into the drug kardex for ease of access to all trainees. Discuss possible changes to the kardex layout for antibiotic prescribing:-5 days only, requiring update there after. Re-audit in 4 months.
General Surgery	Re-audit of trans-rectal ultrasound scans	Yes	No actions required.
General Surgery	Timely management of acute gallstone pancreatitis	Yes	Revise Glasgow Pancreatitis Scoring sheet to incorporate time to operate
General Surgery	Use of negative pressure wound therapy in the management of open abdomen	Yes	Designate one named consultant to take the lead on cases of open abdomen. Draft guideline for good practice and discuss at Clinical Governance and Effectiveness meeting.
GU Med	Outpatient Documentation Audit	Yes	History sheets have been changed to include time, and at follow-up appointments the notes are stamped ‘time’ as a reminder.
GU Med	Uptake of HIV testing and reasons for declining tests in GU Medicine	Yes	All staff to be made aware that reasons why patients decline tests and risk factors should be documented. Ensure patients who are at high risk and decline HIV testing see a health advisor.
GU Medicine	Asymptomatic screening by nursing staff in GU Medicine department	Yes	All patient notes to include date and time of consultation and signature and designation of health care professional - staff to be reminded of this requirement. Nursing staff seeing asymptomatic patients to record the same information in Diary.
GU Medicine	Audit of GU med department offering hepatitis B immunisation	Yes	Amend clinic proforma - insert a box in which the consulting clinician must specify whether Hepatitis B immunisation is necessary and if it has been offered.
GU Medicine	Audit of PGD use of Clotrimazole pessary	Yes	Amend inclusion criteria to be able to treat symptomatic patients when microscopy is negative. Amend PGD to include Clotrimazole as second line treatment, in the event of patient declining pessary. Include or develop PGD for Clotrimazole vaginal cream. Discuss the documentation of leaflets and advice given at Clinical Governance and Effectiveness. Remind nurses, health advisors and doctors to sign if medication is given and record in the notes and on the drug treatment sheet. Re-audit the administration via a PGD within 12 months to re-assess compliance and use of PGD.
GU Medicine	Management of HIV in Pregnancy	Yes	Devise new Obstetric data collection proforma of the mother after delivery at MDT meeting. Repeat the audit using British HIV Association 2012 guidelines.

GU Medicine	Patient Group Direction Audit for the use of Azithromycin in the Department of G U Medicine	Yes	Amend exclusion criteria adding any known allergy to peanuts to use alternative PGD.
GU Medicine	Patient Group Direction Audit for the use of Doxycycline in the Department of G U Medicine	Yes	Continue with documenting in PGD audit book – raise awareness at Clinical Governance. Send a copy of the recommendations to the Drugs & Therapeutics Committee. Discuss the following at Clinical Governance: documentation that verbal and written information has been provided; whether referrals have been made to health advisors; medication given under PGD; whether allergy status has been checked; last menstrual period, contraception and pregnancy risks. Further audit of the administration of Doxycycline via a PGD to be carried out in 12 months.
GU Medicine	Patient Group Direction Audit for the use of Erythromycin in the Department of G U Medicine	Yes	Remind nursing staff regarding the need to document in the PGD audit book when a PGD is given. 1:1 with every nurse prior to signing signature list. Staff to be reminded of the need to document the following: Last Menstrual Period, Contraception and Pregnancy risks; whether they have referred the patients to health adviser; any medication given (within the main body of notes and drug kardex); whether a leaflet or verbal information has been provided; advice regarding no sex until both treated and 7 days after completion of medication; the need for Test of Cure (TOC) at 6 weeks after completion of medication and at 36 weeks of pregnancy. The following will be discussed at Clinical Governance/Effectiveness: the need for Erythromycin to be kept as a safe option for the use in pregnancy or suspected pregnancy; and diagnosis coding of PNC/C4. A re-audit of the administration of Erythromycin via a PGD is to be carried out within 12 months to re assess compliance.
Haematology	Documentation Audit	Yes	Ensure that deletions and alterations are appropriately documented Improve recording of time of entry
Haematology	Documentation Audit (Haematology)	Yes	Improve documentation of patient first and last names on both sides of the page - request ward clerk to use sticker on both sides of each page. Improve documentation when errors are made - discuss with the incoming SpR and current CT2 doctors the importance of using a single line to cross out, and adding a signature and date to any amendments
Haematology	Infective episodes of neutropenic sepsis audit (For Better, For Worse?)	Yes	Train staff in the use of PGDs to enable delivery of antibiotics by nursing staff whilst awaiting medical review. Collect Trigger to needle times prospectively as a Haematology Quality Indicator. Make pre-emptive 'antibiotic plan' formal part of ward rounds - add to formal ward round prompt list.
Integrated Medicine	Adult community acquired pneumonia	Yes	Reinforce importance of chest x ray prior to giving antibiotics (unless severe disease), calculating CURB65 score, considering the need for critical care involvement where CURB65 4-5, and giving antibiotics promptly on confirmation of diagnosis.
Integrated Medicine	Alcohol Management	Yes	Audit alcohol screening on Surgical wards. Provide education/teaching sessions to raise staff awareness. Ensure easier access to withdrawal guidelines by uploading to the intranet. Re-audit performance.
Integrated Medicine	An audit of the pacemaker remote monitoring service 2012	Yes	To extend the use of remote monitoring to a greater number of patients requiring a premium dual chamber pacemaker, subject to funding by the PCT. Continue to redesign working practices to optimise service provision. Audit a larger sample of patients who have a remote monitor in Summer 2013.
Integrated Medicine	Anti-pyschotic usage in the elderly	Yes	Continue education of medical and nursing staff regarding anti-psychotic usage in elderly patients by incorporating into teaching sessions for junior doctors and Grand Round. Monitor anti-psychotic usage in elderly patients - re-audit in one year.
Integrated Medicine	Application of TED stockings for medical inpatients who cannot have prophylactic LMWH	Yes	Provide education to junior doctors through their induction programme on the importance of correct TEDs prescribing. Provide education to medical and nursing staff on the importance of TEDs application. Provide education to medical and nursing staff on the importance of correct documentation of TEDs application, and how this should be recorded on the Drug Kardex.
Integrated Medicine	Audit of atrial fibrillation	Yes	All patients with new onset of atrial fibrillation should have echocardiogram. All Patients should be offered a rate or rhythm control strategy and be involved in decision-making process. All Patients should be assessed for risk of stroke & given thromboprophylaxis according to the stroke risk stratification algorithm. The reason for not giving appropriate thromboprophylaxis should be clearly recorded. All Patients with atrial fibrillation should be followed up at 1 month and 6 months. On each visit rhythm should be reassessed by electrocardiogram and the need for anticoagulation.
Integrated Medicine	Audit of Consent	Yes	Present audit to those involved in delivering thrombolysis - Acute Thrombolysis MDT Meeting and Stroke Specialist Nurses. As the completion of the documentation is the responsibility of both the Doctor and Thrombolysis Nurse it would be good practice to jointly ensure all sections of the required documentation are completed once treatment has commenced therefore all clinicians involved in delivering Thrombolysis need to agree to this recommendation and a re-audit needs to be completed when a sufficient number of Stroke patients have been thrombolysed.
Integrated Medicine	Audit of handover	Yes	To discuss with Trust regarding funding an electronic handover system. Discuss with trust management regarding availability of a screen and telephone in A1/A2.

Integrated Medicine	Audit of Handover	Yes	Look at the feasibility of electronic handover. Ensure the Haematology SpR and Consultants are aware of their responsibilities with regards to handover when the CT doctors are absent - circulate audit report to all concerned, and raise the issue at the Haematology Clinical Effectiveness Meeting. Re-audit.
Integrated Medicine	Audit of MAU	Yes	No actions required.
Integrated Medicine	Audit of Tuberculosis services in Rotherham	Yes	To look at adapting cohort review form to simplify data collection and re-audit.
Integrated Medicine	Cardiac Arrhythmia	Yes	Continue to improve the identification of candidates for CRT and ICD implantation through providing an education session for primary care doctors about devices and reminders for secondary care physicians in grand round and Consultant Physicians forum.
Integrated Medicine	Diagnostic Pathway review	Yes	No actions required.
Integrated Medicine	GLP-1 Agonists for the treatment of Type 2 Diabetes	Yes	The patient should be aware of targets at commencement, there should be a 3 month review, and an alert at 6 months for a medication review. Produce a laminated information sheet for doctors in the clinic reminding them of all indications, side effects and criteria for continuing therapy.
Integrated Medicine	Management of Paracentesis	Yes	Re-educate junior doctors regarding drains being removed within 24 hours. Continue to monitor against standards using re-audit.
Integrated Medicine	Management of Severe Sepsis	Yes	No actions required.
Integrated Medicine	Management of status epilepticus in adults	Yes	No actions required.
Integrated Medicine	NICE CG130 Hyperglycaemia in ACS	Yes	Ensure follow up treatment for patients with hyperglycaemia - discharge letters to GP need to state in patients not known to be diabetic if they had glucose greater than 11 in association with Acute Coronary Syndrome to do fasting glucose within 1 week, and annual screen for Diabetes Mellitus thereafter. Ensure patients with glucose greater than 11 are treated with insulin within first 48 hours of Acute Coronary Syndrome, whilst avoiding hypoglycaemia - consider either sliding scale insulin or twice daily subcutaneous insulin to get glucose 7-11.
Integrated Medicine	Performance indicators in Acute Medicine	Yes	Incorporate the audit as an annual Trust Clinical audit.
Integrated Medicine	Stroke Mortality from SHMI	Yes	Provide training for doctors and nurses: a) A&E doctors teaching on Acute Stroke assessment/management; b) Medical doctors teaching; c) Nurses training. Revise the acute stroke and TIA pathway and related protocols.
Integrated Medicine	Trent Cancer Registry Lung Outcomes	Yes	No actions required.
Integrated Medicine	What happens after AMT on admission	Yes	Ensure all patients admitted to B1 with a history of memory problems are screened using the Abbreviated Mental Test - screening questions to all >65 years, memory clinic referral to all who score less than 8 on the test.
Neuro-rehabilitation	Re-audit of Spasticity Service	Yes	Get hoist in the clinic to allow treatment of patients with severely restricted movement. Need to acquire an EMG machine for injections.
Nutrition & Dietetics	Audit of appropriateness of referrals into obesity services	Yes	Continued communication to GP's to explain criteria for GPs to refer to Reshape: admin team to continue to write to highest referrers monthly and to all surgeries tri monthly. Reshape admin team to send out information regarding new developments as requested. Electronic referrals for Reshape once SystmOne use is established. Review Reshape referral form to include offers and incentives available. Target GPs who refer inappropriately to raise awareness of Reshape - arrange meeting with GPs who refer patients for 1:1 intervention when Reshape would have been appropriate. Develop a telephone script for communications with prospective referrals to ensure motivation is assessed and patients are aware of what will be involved through attending Reshape. Review departmental policy to consider offering one clinic appointment to assess and triage to Reshape if appropriate (or GP to refer directly as per above) if Reshape declined despite patient being deemed appropriate to discharge. Clearer advice for Dieticians on discharge and maximum number of appointments- protocol e.g. four months, monthly appointments for those not appropriate for Reshape but still to be seen in clinic
Nutrition & Dietetics	Audit of Care Home Referral System	Yes	Roll out to other 40 homes e.g. learning disabilities/mental health & under 65's, train homes and communicate to GP/other referrers Target homes with no referrals or inappropriate referrals for training To share results and discuss with GP staff asking if possible for care home to refer direct
Nutrition & Dietetics	Audit of home visit review times	Yes	Categorise patients into low, medium and high risk. Review caseloads regularly and consider splitting into geographical areas.
Nutrition & Dietetics	Audit of Nursing Staff Adherence to the Action Plan detailed in the Nutritional Screening Tool	Yes	Ongoing MUST training to ensure all patients are accurately screened on admission to hospital. Ensure all staff are aware of what snacks are available on wards and when they should be offered - information to be disseminated to Patient Experience Committee. Ensure literature is available to carers/relatives so they can bring in appropriate snacks. MUST training to emphasise the importance of accurate food record charts.
Nutrition & Dietetics	Audit of Nutriprem 2 Pathway.	Yes	Update health visitors and GP's on the guidelines for prescribing vitamin drops and Iron supplementation for pre-term infants in relation to Nutriprem 2. Liaise with dietetic prescribing team to format guidelines on how to

			prescribe last prescription for Nutriprem 2 infants.
Nutrition & Dietetics	Biochemical monitoring in patients receiving home enteral nutrition	Yes	Amend the Home Enteral Feeding Dietetic Standards, to take account of the review of the evidence, the results of this audit and the information from the feed companies on the nutritional completeness of feeds
Nutrition & Dietetics	Documentation audit (Nutrition & Dietetics)	Yes	Admin Team will check letters prior to typing to ensure all relevant details are included. All content must be legible - Admin staff to read through prior to typing – if any more than 3 words are illegible, will be returned. Clinical staff to take care when writing out letters for typing. If letters are not at final stage, and may require a re-write, staff should specify draft copy so further amendments can be made.
Nutrition & Dietetics	Documentation audit for Nutrition & Dietetics	Yes	Errors should not exceed more than 2 per month, to meet with those Dieticians identified as having most errors and discuss issues with them. All handwritten information should be written legibly and accurately and checked before being handed in against the record card.
Nutrition & Dietetics	Is MUST being completed accurately on the wards in Rotherham General Hospital?	Yes	Change MUST tool to make it easier to complete, contact BAPEN re process needed to implement changes, and then implement indicated changes. All wards should have the facilities to weigh and height patients. Disseminate audit findings to the dietetic department to highlight the need for further training for all dieticians and ward staff. Offer MUST training to all wards that were highlighted as having the most discrepancies
Nutrition & Dietetics	Reshape Audit	Yes	Consider SMS text reminders. To meet with weight management team leader to review lists of missing data and to plan for delegating follow up of this data to team. Statistics flow chart forwarded to managers each month and shared with weight management team where appropriate. Performance team to be involved in the data review to improve accuracy and presentation. To try and increase the number of successes by more specialised dietetic input for complex conditions. Consider introducing system of daytime and evening follow up for DNAs
Nutrition & Dietetics	Use of STAMP (screening tool) on the wards	Yes	Consider building the tool into current documentation to avoid duplication of documentation. Raise paediatric doctor awareness of STAMP to help support the roll out of the tool. Re- train children's ward staff on the use of STAMP
O&G	Audit of Consent	Yes	Reminder on labour ward notice board regarding retrospective entry of verbal consent and confirmation of consent for all elective caesarean sections. Reminder on notice board in doctors office in Green Oaks regarding recording of information leaflets on consent form and offering a copy of the consent form to patients. Present audit to those involved in delivering thrombolysis - Acute Thrombolysis MDT Meeting and Stroke Specialist Nurses.
O&G	Audit of counting and recording of swabs, strings, instruments and needles used for vaginal procedures	Yes	Ensure improvements embedded in practice by use of spot checks. Analysis of audits to go to labour ward forum. Issues to be escalated to clinical governance and risk management meeting. Anyone not complying with PEP will be referred to labour ward midwifery/obstetric lead as appropriate.
O&G	Audit of emergency gynae unit	Yes	To open up the service for GPs, and then monitor the effectiveness over the next three months. To ensure that there is always medical cover for the Emergency Gynae unit. To allocate one scan slot per day to the Emergency Gynae Unit.
O&G	Audit of Gestational Diabetes	Yes	Review local guideline. Consider documenting blood glucose monitoring in the care plan booklet when this is reviewed. Consider covering feeding options at visits if possible - discussion with Service Manager required.
O&G	Audit of Letz done under GA	Yes	No actions required.
O&G	Audit of Medical Management of ectopic pregnancy	Yes	Ensure all patients have documentation of the risk of possible need for surgery in the notes or consent form - add this risk (may need surgery) in the New Methotrexate consent form and booklet. Ensure all patients have their Methotrexate dose calculation according to Body Surface Area as in the guidelines - design a Dosage table in cooperation with the pharmacy to reduce errors and user friendly. Make Methotrexate treatment available over the weekends - stock new prefilled syringes in B11. Improve coding for Ectopic pregnancy and Pregnancy of Unknown Location (PUL) to facilitate future audits - create a 'favourite' list for all Early Pregnancy Assessment Unit diagnostic cases - add PUL on SNOMED list.
O&G	Audit of Ward attenders to B10	Yes	More effective use of ANDU & Guidance: (Staffing, Logistics, Guidance) - to be discussed at Consultant Obstetrician meeting and CSU meeting. Co-ordinator for every shift: (Deal with transfers, referrals from CMW, allocation of roles, social services issues etc) - to discuss with ward manager and head of midwifery. Data collection: (Accurate filling of form, Review of form to reflect docs workload, where patient is seen – Triage, ANDU) - redesign form. Spread elective admissions onto quieter days and monitor this - to discuss at obstetrics meeting and send a memo to all doctor, to discuss with ward manager. Investigate whether wound care can be dealt with elsewhere - discuss further with head matron. Allocate an SHO solely to B10 for the day.
O&G	Audit on Gynaecology Discharge Letters	Yes	Ensure 100% Accuracy in operation performed and diagnosis. Raise awareness of all doctors in Obstetrics and Gynaecology about the importance of documentation of operation date - send a memo to all consultants and registrars. Re-audit, to include looking at admission date inaccuracy which should be resolved when migrating to Meditech discharge.

O&G	Caesarean section audit	Yes	Surgeon to take cord bloods to help improve the percentage of cord bloods done - discuss at Labour Ward Forum. To avoid General anaesthesia as much as possible for women with BMI >40 who require a crash caesarean section even if it requires the baby being delivered after 30 minutes - to communicate this to medical staff to counsel patients in clinic. Incorporate the grade of Anaesthetist into the audit form. Improvement required in recording of prophylactic antibiotics and correct dose and timing of thromboprophylaxis - surgeon carrying out the operation to check documentation. 'Full dilation and extension' slide to be taken to Labour Ward Forum. Findings to be included in teaching sessions for new house - difficult births.
O&G	Correlation between Scan Findings and Hysteroscpy Findings in PMB Patients	Yes	No actions required.
O&G	Feasibility of laparoscopic surgery in obese patients in a district general hospital	Yes	No actions required.
O&G	Infection post Caesarean Section	Yes	Change the antibiotics used in accordance with NICE guidance. Disseminate updated guidance to all anaesthetists and obstetricians. Caesarean section guideline in development. Training of Community midwives on surgical site infection. Theatre etiquette to be reviewed by Infection Control to include bare below the elbows compliance, adherence to hand hygiene regulations and aseptic technique for catheterisation. Consider the use of a coloured solution as an alternative to the current colourless solution. Update training for all midwives in aseptic technique. Antibiotics should be given before the skin incision. Timing of antibiotics monitored by WHO checklist & timing required on theatre white board for each case.
O&G	IPG239 - Laparoscopic subtotal hysterectomies	Yes	No actions required.
O&G	Returns to theatre	Yes	Review returns to theatre cases prospectively in order to identify trends - implement new process to identify patients prospectively, and to act on any findings.
O&G	Swab findings for patients with menorrhagia for Mirena insertion	Yes	If patients are low risk, do not screen unless specifically requested by patient.
O&G	TA156 - Audit of routine anti D prophylaxis	Yes	Provide evidence based information leaflets to patients - contact the company that supplies Anti D for further information. Update the Anti-D guidance and discuss at audit meeting. Re-audit when the guidance has been updated and in use for 6 months. Introduction of new Anti D clinic - as a means of solving the problem of incorrect labelling of samples.
OMFS	Annual audit of Consultant Reviews within 24hrs of admission (An Acute Problem)	Yes	No actions required.
OMFS	Audit of Consent	Yes	Documentation of leaflets given at clinic appointment.
OMFS	Audit of Consent for treatment of Fractured Mandibles	Yes	OMFS teaching session on risks to be documented on consents for mandibular fractures.
OMFS	Audit of investigations done for patients admitted with acute oro-facial infections	Yes	All patients admitted under the care of OMFS Surgeons with orofacial infections should have a full blood count, urea and electrolytes, glucose, with a CRP in more complex cases. If a patient is thought to have an infection of dental origin they should have an OPT. If pus is drained as part of the patients treatment, a pus sample must be sent to microbiology - this is to be communication to all relevant staff with any necessary explanation/education required. Re-audit.
OMFS	Audit of temporal artery biopsy service provided by OMFS	Yes	Share audit results with Rheumatology.
OMFS	Microbiology - why bother?	Yes	Send a memo to all SHOs informing them that a microbiology sample should be sent to pathology for all abscesses where pus is drained and for all wound infections where there is concern about infection.
OMFS	National Prospective Audit on Bisphosphonate Related Osteonecrosis of the Jaw	Yes	No actions required.
Ophthalmology	Audit of Accuracy of Referrals from Optometrists for wet age related macular degeneration	Yes	Develop a new education programme for optometrists to optimise correct use of referral pathways, to include: visiting local optometrists and liaising with them to ensure they are aware of wet Age Related Macular Degeneration rapid access referral pathway; collaborating with the head optometrist of the establishment to ensure locum optometrists are also educated before they start; and to ensure all optometrists referring patients are given feedback on the referral.

Ophthalmology	Audit of Consent	Yes	Ensure documentation of whether leaflet/tape has been provided - considering use of patient survey to supplement this. Remind everyone to tick photography for all patients on the Consent form in case the desire to record arises using the microscope. Check intention to photograph is recorded in the history sheet during the next audit, also check operation notes as to whether video recording took place.
Ophthalmology	Audit of Ptosis Surgery Results	Yes	Prospective documentation to be kept on the database: information from Eye log book will be added to Excel. Staff to document the amount of resection done (a column to be added to the spreadsheet to capture this information).
Ophthalmology	Barnsley Consent Audit	Yes	Distribute scanned copy of consent form highlighting areas which need to be filled in to improve compliance. Re-audit.
Ophthalmology	BDGH Trabeculectomy Audit	Yes	No actions required.
Ophthalmology	Cataract Audit (Rotherham)	Yes	Improve documentation of complications in theatre - encourage theatre nurse to document complications and check complication theatre book regularly. Ensure all consultants are customising A constants. Circulate Biometry guidelines. Check post-operative refraction feedback from opticians at 6 weeks. Document pre and post op refraction and target of refraction. Use RCO electronic record (Eye log book). Devise method for recording late complications.
Ophthalmology	Clinical Audit of cataract for year 2011	Yes	No actions required.
Ophthalmology	Consent audit - Barnsley	Yes	Leaflet/e-mail with advise on best practice to be e-mailed to colleagues
Ophthalmology	Diabetic Blindness	Yes	Continue to collect data for next audit. Start recording patients who have vision loss due to their diabetes. Develop standard form for feeding back to Screening Service.
Ophthalmology	Diabetic Macular Laser Audit	Yes	Follow up appointment should be arranged 3-4 months after laser. Patients having FFA should have a copy in notes, photographers to be informed. Laser appointment should preferably be arranged within 8 weeks of listing. Patient with a VA 0.0 or better should be thoroughly explained risks before listing
Ophthalmology	Documentation Audit	Yes	Adherence to trust recommendations regarding alterations to records namely, crossing with one line, dating and signing.
Ophthalmology	Follow up against Discharge Guidelines	Yes	Ensure firm adherence to discharge guidelines - discuss and explain to colleagues, place details in all clinic rooms and ensure new starters are made aware.
Ophthalmology	Initial management of patients in Glaucoma clinic at Rotherham & Barnsley	Yes	Glaucoma proforma sheet to be used in subspecialty clinic. Further attention to improve documentations in sheet to raise the standard of care.
Ophthalmology	New Paediatric referrals Barnsley	Yes	Ensure all referrals are received and appointments booked. Better referral information for patients attending from screening, information leaflet to be typed.
Ophthalmology	Outcome of Glaucoma Surgery	Yes	Refer cases which need glaucoma surgery earlier.
Ophthalmology	Phaecotrabectuletomy	Yes	Repeat the audit with increased numbers & record visual acuity later than 1 month. Define the types of complications to be included. Look into routine use of antibiotic cover post operatively and infection rates.
Ophthalmology	Post-Operative Vision Loss in Non-Ocular Surgery	Yes	Broaden spectrum of surgical procedures for data .Revise data collection tool for re-audit to include screen for ischaemic optic neuropathy risk factors and patient positioning.
Ophthalmology	Premature Clinic Rotherham	Yes	Ensure distribution of information sheets to parents prior to 1st ROP screening and documentation that this has been given. Share results with Paediatricians to avoid screening breaches - if risk, Paediatrician to contact Consultant Ophthalmologist. Ensure that when babies are transferred to RDGH discharge summaries are reviewed and ROP screening booked within the time frame set out by the guidelines.
Ophthalmology	Rapid Access Wet Macular Degeneration Outcomes	Yes	No actions required.
Ophthalmology	Wet age related macular degeneration Lucentis peruke audit	Yes	To check visual outcome and number of Lucentis injections required
Orthopaedics	A patient-related outcome measure audit of Hand Surgery	Yes	No actions required.
Orthopaedics	Annual audit of Consultant Reviews within 24hrs of admission (An Acute Problem)	Yes	No actions required.
Orthopaedics	Audit of Consent	Yes	Correct use of consent 4 form, document reason for lack of capacity and ensure form signed by consultant. Document discussions with patients/ families, families are now routinely asked to attend the ward for the morning ward round to discuss risks etc. also improving on documentation of all meetings. Senior doctor to obtain consent, encouraging all consultants to check/ countersign consent forms if not taken by them. Clarify what risks

			need to be documented, lists of risk factors are likely to become more consistent if consent is taken by more senior surgeons. Document capacity to consent & mental test score, AMT score added to clerking book. Staff educated about capacity and need to document.
Orthopaedics	Audit of Consent (Orthopaedics)	Yes	Try to clarify precise risk/benefits and make stickers with generic risks for each operation. Clearly document patients' capacity if form 4 used. Educate medical and nursing staff regarding the timely deliver of the hip fracture booklet.
Orthopaedics	Documentation	Yes	Ensure signed as well as having clear name/ designation of person making note entry. Educate staff to ensure labels placed on both sides of page. Educate all staff to document time in all entries
Orthopaedics	Emergency readmissions to hospital within 28 days of orthopaedic admission	Yes	Continue active monitoring of medical problems before discharge e.g. for DVT, chest infection, anaemia
Orthopaedics	IPG271 - Audit of wrist arthroplasty	Yes	No actions required.
Orthopaedics	IPG43 - Percutaneous palmar fasciotomy for Dupuytren's contracture	Yes	No actions required.
Orthopaedics	NJR - DePuy implants	Yes	No actions required.
Palliative Care	Audit of Acute Management of Hypercalcaemia of malignancy at Rotherham General Hospital	Yes	Standardise the pre and post treatment blood tests for patients undergoing treatment of hypercalcaemia of malignancy/standardise the medical treatment of hypercalcaemia of malignancy. Adopt the central guidelines issued, with any locality modifications on bisphosphonate choice. Standardise the intravenous bisphosphonate used in the management of hypercalcaemia of malignancy.
Radiology	DATSCAN audit (National) British Nuclear Medicine Society	Yes	No actions required.
Radiology	Diagnostic reference level audit	Yes	No actions required.
Radiology	Paediatric trauma CT head: Dose limit (DLP) values - are we heading towards the target?	Yes	Review CT Protocols with reference to SCH protocols and NRPB guideline. Improve staff training in Paediatric Scanning and ensure regular training sessions with input from SCH CT department. Ensure Protocols for CT chest and abdomen in paediatric population are appropriate.
Radiology	Request card details and patient checks audit	Yes	All staff to be reminded about the 28 day rule and breast feeding status. Staff to be reminded about request justification and ARSAC details.
Radiology	WHO Checklist (RFT adaptation) for Radiology procedures	Yes	Adapt form to include more information about allergies. Move date box and procedure name so not covered by sticker. Add base observations to form. Remind staff to complete form fully.
Radiology - medical physics	Audit of MUGA scan analysis 2011-12	Yes	No actions required.
Resuscitation	Annual suction audit	Yes	All areas where problems have been highlighted must: replace/report all faulty units to Estates, ensure correct tubing attached, ensure Yankauer attached, ensure all Suction equipment ready for use in an emergency.
Resuscitation	Audit of daily emergency equipment checks	Yes	Continue to stress the importance of checking emergency equipment in all resuscitation training sessions.
Resuscitation	Audit of defibrillator (MRx) operational checks (weekly)	Yes	Operational check should be completed weekly to comply with manufacturer's recommendations for defibrillator. Resuscitation status should be documented in patients who are at risk of deterioration. Encourage Consultants/Registrars/Middle Grades to discuss decisions with relatives wherever possible and document discussion. If relatives have not been spoken to, document why in the case notes
Resuscitation	Audit of documentation of DNACPR decisions	Yes	The regional DNACPR should be filled in correctly, in particular the areas relating to discussion with relevant others and patient - this will be discussed with Resus Committee chair to agree an appropriate plan of action. Consider amending the regional form to make it more user-friendly - this will be discussed with the regional DNACPR lead.
Resuscitation	Emergency Equipment Audit	Yes	All clinical areas should ensure emergency equipment is checked daily, email out to all group nurses/matrons/heads of department to emphasise importance of checking emergency equipment.
Rheumatology	Audit of Adherence to Trust Temporal Arteritis Pathway	Yes	Establish Consultant of the week rota so that one Consultant Rheumatologist handles all Temporal Arteritis referrals. Discuss the results with Ophthalmologists. Ensure all consultants are aware to provide personal feedback on inappropriate referrals to GPs and send copy of pathway. Make Integrated Care Pathway available centrally.
Rheumatology	Audit of biological treatment of RA after failure of 1 anti TNF medication	Yes	Improve DAS 28 monitoring - ensure monitoring done at least every 6 months. Establish Nurse led biologic clinic. Consider Rituximab for all patients who have failed to improve on 1st anti-TNFdrug. Continue and improve data entry into biologic database. Emphasize DAS 28 monitoring in rheumatoid arthritis patients to joining and temporary medical staff.
Rheumatology	Audit of department practice against BSM PMR guidelines	Yes	Spot survey of how many PMR patients are currently under ongoing care in the department, in order to determine the need and feasibility of providing this care differently – i.e. via nurse lead clinic, or via shared care with GPs. Develop a departmental pathway to support shared care of PMR patients with GPs. Re-audit in 2 years time, using notes in order to determine whether urine dip being performed in new patients.

Rheumatology	CG79 - Audit of department adherence to NICE for management of Rheumatoid Arthritis	Yes	Improved referral rates of patients newly diagnosed with RA to therapy team, or documentation of why not if not appropriate. Quicker escalation of treatment where symptoms not adequately controlled through implementation of Departmental Treat to Target Pathway. All clinicians to use DAS or alternative to describe disease activity in patients with newly diagnosed RA
Rheumatology	Ethnic minority RA audit (National)	Yes	No actions required.
Theatres & Anaesthetics	Audit of HDU documentation	Yes	Handover proforma needed. Discussion regarding whether HDU be incorporated into a Critical Care Unit managed by the Intensivists. Change HDU documentation form.
Therapy Services	Audit of NICE guidance on Rheumatoid Arthritis	Yes	No actions required.
Therapy Services	Therapy Records Audit	Yes	Standardise the use of the audit tool and develop specific standards of what should be measured. Deliver training sessions prior to the next round of audit.
Trust wide	Annual audit of Cardiac Arrests	Yes	Resuscitation status should be documented in patients who are at risk of deterioration - continue to stress the need to document decisions at Consultant mandatory Resuscitation training sessions. Examine DNACPR audit to determine if there is a trend with either specialities or individuals and provide targeted training.
Trust wide	Audit of evaluation of Ionising Radiation Examinations	Yes	*Haematology* - discussion with current junior medics on A7 and add to A7 ward Clinical Effectiveness agenda. *OMFS* - raise awareness within department, review at Clinical Effectiveness meeting. *O&G* - raise awareness among doctors, discuss in a CSU CE meeting and also inform new doctors at Induction. Disseminate information to Gynae nurses and midwives - inform B11 ward manager, B10 and Labour Ward managers and clinic manager. *Urology* - review cases where x-rays are not being recovered. *CYP Service* - remind junior medical staff and investigate cases with non-compliance. *Rheumatology* - alter future audit methodology (CE team), ensure all x-ray results are signed and communicated.
Trust wide	Audit of Patient Identification	Yes	Re-educate regarding the wrist band being on the dominant arm - ensure as part of the re-launch of the reviewed Patient Identification policy that re-education is provided.
Trust wide	Consultant to Consultant Referrals	Yes	No actions required.
Trust wide	Medication storage audit & re-audits	Yes	Actions are being taken at specialty level to ensure: Controlled drugs are checked daily; fridge temperatures are checked daily; clean utilities are locked securely; drugs cabinets are locked securely; no medication is left on the side in the clean utility; and drugs fridges are locked securely.
Urology	Audit of effectiveness of intravesical botox for sensory urinary urgency	Yes	Inform all consultants in Urology that Onabotulinumtoxin A should be offered to all patients with sensory bladder so that there is reduced delay in a patient receiving their treatment.
Urology	Documentation Audit	Yes	Improve use of identifying data on history sheets.
Urology	Rigid and flexible ureterscopy audit	Yes	Ensure patients for URS are listed as true day cases as appropriate - Consultants to list as day cases in young and solitary stones.
Urology	The effect of TVTO on the maximal urethral closure pressure in women	Yes	No actions required.
Workplace Heath & Wellbeing	National audit of back pain management by NHS Occupational Health Services	Yes	Improve recording of enquiry about barriers to return to work and yellow flags. Training for occupational health technicians is to be provided.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by TRFT in 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 654.

Table 1 illustrates the number of studies currently reported as active within the Trust. The studies are further broken down into their relevant funding categories. Table 2 shows the number of Rotherham patients recruited to portfolio studies where the Trust is either hosting a study, or acting as a Participant Identification Centre (PIC), the total number was 732 patients. Table 3 also shows the number of studies currently undergoing approval within the Trust.

Table 1: Active Studies

Study Type	Number of Studies
Commercial	**26**
Portfolio	**128**
Own Account	**55**
EC Funded	**0**

Table 2: Recruitment

Study Type	Patient Recruits
Hosted Portfolio Study	654
PIC Registered Portfolio Study (Cancer Research Network)	78

Table 3: Studies currently undergoing approval

Study Type	Number of studies
Commercial	0
Portfolio (inc PIC registered)	15
Own Account	3

NB. Recruitment study figures are correct at time of publication, final figures are not usually available until the middle of June the following year.

Goals agreed with commissioners: CQUIN Framework

A proportion of TRFT income in 2012-13 was conditional upon achieving quality improvement and innovation goals agreed between TRFT and any person or body the entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012-13 and for the following 12 month period are available at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The value of income dependent on achieving CQUIN goals by TRFT for 2012-13 was £4.1m, this represents an increase on the previous year where the value was £2.5m (this refers to NHS Rotherham CQUINs).

Progress made against last year's CQUIN goals can be found at appendix 2a, alongside 2013-14 goals in appendix 2b.

CQC Registration and periodic/specialist reviews

TRFT is required to register with the Care Quality Commission and its current registration status is fully compliant. TRFT has no conditions on registration.

The Care Quality Commission has not taken enforcement action against TRFT during 2012-13.

TRFT has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012-13:

- Acute Services Review – 13th August 2012

- Mental Health Act – 7th March 2013

TRFT intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

- To agree and finalise the Memorandum of Understanding with Rotherham Doncaster and South Humber NHS Foundation Trust.
- To facilitate Mental Health Act training for identified staff.

TRFT has made the following progress by 31 March 2013 in taking such action:

- The Memorandum of Understanding is currently with the Mental Health Act Manager at RDaSH and is being amended following legal advice. Once the amendments are made the Memorandum of Understanding will be returned to TRFT for final approval.
- Training arranged for 23rd April 2013, further date in June 2013 to be confirmed.

Septicaemia alert

During 2012-13 TRFT received an alert from CQC regarding an above average outcome for mortality in relation to septicaemia, highlighted as a result of the Summary Hospital Mortality Indicator (SHMI) for the range of conditions which are classified under the septicaemia group.

This led to a review of cases involved, with a response to CQC accordingly. The review found that the reasons for higher than expected mortality for this condition group were related principally to poor documentation in patient notes by junior doctors. This skewed the recording of primary diagnoses for the deaths which occurred – inaccurately relating them to septicaemia rather than other causes.

The responses to CQC was correspondingly made, the current mortality for septicaemia is now showing a downward trend. We have also included in one of our improvement programmes for 2013-14 Quality Accounts, review of death certification and cause of death to be included in the outcome summary of deceased patients. It is anticipated that these changes will reduce the potential for issues such as this to occur again.

Serious Incidents/ Coroner's inquests

During the year we had fewer serious incidents declared than the previous year. However, we did have a cluster of missed opportunities for Downs Syndrome screening incidents, which were declared as serious incidents.

This led to the main issues related to how the recording and handover of information from parents to community midwives, and from community based midwives to hospital based midwives. Following the analysis, and working with the Strategic Health Authority, we introduced a health community approach to electronically recording all screening requirements. The new reporting system will significantly mitigate the risks of this type of incident re-occurring in future.

CQC Quality & Risk Profile

QUALITY & RISK PROFILES ROTHERHAM FOUNDATION TRUST April 2012 - March 2013											
		April	May	June	July	Sept	October	November	January	February	March
Section 1	**Involvement and Information**										
Outcome 1 (R17)	Respecting and involving people who use services	Low Green	Low Neutral	Low Neutral	High Green	High Green	High Green	High Green	High Green	High Green	High Green
Outcome 2 (R18)	Consent to care and treatment	Low Green	High Green	High Green	High Green	High Green	High Green	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Section 2	**Personalised care, treatment and support**										
Outcome 4 (R9)	Care and welfare of people who use services	High Green	Low Neutral	Low Neutral	Low Neutral	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Outcome 5 (R14)	Meeting Nutritional Needs	Low Neutral	Insufficient data	Insufficient data	Insufficient data	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Outcome 6 (R24)	Cooperating with other providers	Low Neutral	Low Neutral	High Neutral	High Neutral	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Section 3	**Safeguarding and safety**										
Outcome 7 (R11)	Safeguarding people who use services from abuse	High Amber	Low Amber	High Neutral	High Neutral	High Yellow	High Yellow	High Yellow	High Yellow	High Yellow	High Yellow
Outcome 8 (R12)	Cleanliness and infection control	High Green	Low Neutral	Low Neutral	Low Green	Low Green	High Green	High Green	High Green	High Green	High Green
Outcome 9 (R13)	Management of medicines	Low Neutral	High Neutral	High Neutral	High Neutral	High Yellow	High Yellow	High Yellow	High Yellow	High Yellow	High Yellow
Outcome 10 (R15)	Safety and suitability of premises	Low Neutral	Insufficient data	Insufficient data	High Green	High Green	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Outcome 11 (R16)	Safety, availability and suitability of equipment	Low Neutral	Insufficient data	Insufficient data	Low Green	Low Green	High Green	High Green	Low Yellow	Low Yellow	Low Yellow
Section 4	**Suitability of Staffing**										
Outcome 12 (R21)	Requirements relating to workers	Low Neutral	Low Neutral	Low Neutral	Low Neutral	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Outcome 13 (R22)	Staffing	Low Neutral	Low Neutral	Low Neutral	Low Neutral	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Outcome 14 (R23)	Supporting Staff	Low Neutral	Low Neutral	Low Neutral	Low Neutral	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow	Low Yellow
Section 5	**Quality and Management**										
Outcome 16 (R10)	Assessing and Monitoring the quality of service provision	Low Green	Low Green	Low Green	Low Green	Low Green	Low Green	Low Yellow	Low Green	Low Green	High Green
Outcome 17 (R19)	Complaints	High Green	High Green	High Green	High Green	High Green	High Green	Low Green	Low Green	Low Green	Low Green
Outcome 21 (R20)	Records	Low Green	Low Green	Low Green	Low Green	Low Green	Low Green	Low Green	Low Green	Low Green	Low Green

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2012-13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was 98.6% for admitted patient care, 99.1% for outpatient care and 79.5% for accident and emergency care (April 2012 – February 2013 data only).

The percentage of records which included the patient's valid General Practitioner Registration Code was 100.0% for admitted patient care, 100.0% for outpatient care and 99.9% for accident and emergency care (April 2012 – February 2013 data only). At the time of publication of this report, the Health & Social Care Information Centre had not yet published full year comparative date in respect of SUS datasets for 2012-13.

TRFT Information Governance Assessment Report overall score for 2012-13 was 65.0% and was graded red. This rating was due to the Trust not achieving attainment level 2 in 1 of the 45 requirements of the Information Governance Assessment – "Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained".

	Overall score	Grade
Information Governance Management	60%	Not satisfactory
Confidentiality and Data Protection Assurance	66%	Satisfactory
Information Security Assurance	66%	Satisfactory
Clinical Information Assurance	66%	Satisfactory
Secondary Use Assurance	66%	Satisfactory
Corporate Information Assurance	66%	Satisfactory
Overall	65%	Not satisfactory

Achieved Attainment Level 2 or above on all requirements	Satisfactory
Not achieved Attainment Level 2 or above on all requirements	Not satisfactory

TRFT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published draft audit for that period for diagnoses and treatment coding (clinical coding) were 7.7% and 15.4% respectively.

In respect of clinical coding audits, the results should not be extrapolated further than the actual sample audited; a limited number of services were reviewed in respect of patients admitted with specific problems as per the above performance - pneumonia and falls.

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

- One of our improvement programmes for this year is specifically focussed on data quality – this is also a CQUINs target; Regional and National benchmarking on data quality will be reviewed as part of this CQUIN
- Data quality responsibilities continue to be included as a standard element of staff job descriptions
- Following consultation, a new Health Informatics Directorate is to be formed, bringing together IT, Information Services & Performance Management, Information & Clinical Systems Development, Clinical Coding and an Assurance function. A specific, focussed data quality team will be a part of this Directorate, taking a lead role in improving TRFT centric data quality issues

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

Table 4: Department of Health Mandatory Quality Indicators for Acute Trusts

The table below sets out the Trust position, against Acute Trust peers, for applicable indicators mandated for reporting in Quality Accounts by the Department of Health. Given the time lag associated with availability of data from the mandated source for peer comparison (the Health & Social Care Information Centre), which on occasions can be *over a year* - these are monitored through the year using a proxy data source which enables corrective actions to be implemented in a more timely fashion, commentary on those indicators is included in part 3.

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
P01544 (12)	Summary Hospital Mortality Indicator – Value	Oct 2011- Sept 2012/Jul 2011- Jun 2012	1.08	1.06	1.00	1.00	1.21	1.26	0.68	0.71
P01544 (12)	Summary Hospital Mortality Indicator – Banding	Oct 2011- Sept 2012/Jul 2011- Jun 2012	2 ("As expected")	2 ("As expected")	2.06 (n=142)	2.03 (n=142)	1 ("Higher than expected")	1 ("Higher than expected")	3 ("Lower than expected")	3 ("Lower than expected")
P01544 (12)	SHMI: Percentage of patient deaths with palliative care coding at diagnosis level	Oct 2011- Sept 2012/Jul 2011- Jun 2012	27.55%	25.10%	18.75%	18.22%	43.28%	46.26%	0.20%	0.34%
P01551 (18)	Patient Reported Outcome Measure: Groin hernia surgery	April2012 - Dec2012/ April2011- March2012	0.080	0.067	0.090	0.087	0.310	0.249	-0.115	-0.084
P01551 (18)	Patient Reported Outcome Measure: Varicose vein surgery*	April2012 - Dec2012/ April2011- March2012	-	0.101	0.089	0.094	0.271	0.240	-0.089	-0.134
P01551 (18)	Patient Reported Outcome Measure: Hip replacement surgery	April2012 - Dec2012/ April2011- March2012	0.540	0.415	0.429	0.416	0.791	0.716	0.207	0.282
P01551 (18)	Patient Reported Outcome Measure: Knee replacement surgery	April2012 - Dec2012/ April2011- March2012	0.343	0.307	0.3212	0.302	0.621	0.541	0.111	0.114

P00911 (19)	Readmissions within 28 days (same trust) 0-14 years old (Standardised % - medium acute for comparison)	April 2010-Mar2011/ April2009-Mar2010	10.46%	10.87%	9.87%	10.21%	14.56%	14.70%	5.22%	6.35%
P01552 (19)	Readmissions within 28 days (same trust) 15 & over (Standardised % - medium acute for comparison)	April 2010-Mar2011/ April2009-Mar2010	12.78%	12.04%	11.16%	11.05%	12.94%	13.17%	7.64%	7.30%
P01553 (20)	CQUIN: Responsiveness to patients personal needs	April2011-Mar2012/ April2010 - Mar2011	69.9	71.5	67.4	67.3	85.0	82.6	56.5	56.7
P01554 (21)	Staff who would recommend the Trust to their family or friends	National Staff Surveys 2012 & 2011	50.6%	61.1%	61.7%	62.3%	85.7%	89.5%	35.3%	33.1%
P01556 (23)	Percentage of patients admitted to hospital and risk assessed for VTE	Qtr3 2012-13/ Qtr3 2011-12	92.0%	91.3%	94.1%	90.7%	100.0%	100.0%	84.6%	32.4%
P01557 (24)	Rate per 100,000 bed days of cases of C. Difficile amongst patients aged 2 or over	April2011-March2012/ April2010-March2011	20.5	29.3	21.8	29.6	51.6	71.8	0.0	0.0
P01558 (25)	Patient safety incidents: rate per 100 bed days	April2012-Sept2012/Oct2011-Mar2012	7.15	6.91	6.87	6.56	14.44	10.54	3.11	2.21
P01558 (25)	Patient safety incidents: % resulting in severe harm or death	April2012-Sept2012/Oct2011-Mar2012	0.10%	0.43%	0.57%	0.79%	3.56%	3.49%	0.12%	0.10%

* NB – PROMS data for varicose vein surgery is not available for TFRT in 2012-13 as no procedures have been carried out.

In terms of indicator P01558 – % of patient safety incidents resulting in severe harm or death - due to the nature of this indicator it is difficult to be certain that all incidents are identified and reported and that all incidents are classified consistently within the organisation and nationally. One individual's subjective view of what constitutes severe harm can differ from another's. As a Trust we work very hard to ensure all our staff are aware of and comply with internal policies on incident reporting and standardisation in clinical judgements.

Part 3 Other Information

Quality at a Glance Commentary

This section deals with outcomes and commentary for those indicators which are not a summary indicator for improvement programmes, progress against which was covered in section 2A. Where available, historical data from the previous year has been used as a baseline from which appropriate targets have been set – enabling a view as to whether improvement in these indicators has occurred over time; in addition to this, national performance of peers (where available) has been included in the commentary to provide additional context.

Performance against Acute & Community 'Quality at a Glance' indicators has generally been strong for 2012-13, although some opportunities to further optimise performance remain. The data table is available for review at Appendix 1. The rationale for maintaining and introducing indicators is covered in table 5, following the detailed commentary, alongside details of indicators which will no longer be covered as part of Quality Accounts in table 6.

Patient Safety

Never events

The Trust has achieved its target for 'never' events, having had no such incidents throughout the year – these events are drawn from a list mandated by the DoH and include such incidents as wrong site surgery, falls from unrestricted windows etc.

Reporting of incidents and severity of incidents

The Trust has achieved targets for increasing incident reporting per 1,000 admissions, alongside reducing the severity of incidents (any incidents where semi-permanent/permanent harm or death occur) as recorded on the Datix risk management system and reported to the National Reporting and Learning System. This is in line with Trust aims to enhance its 'no blame' reporting culture, as well as reducing the impact of harm to patients.

In terms of benchmarking for context, the most recent published data by the National Reporting & Learning System (NRLS – April 2012 to September 2012) reflects TRFT incident reporting to be above the medium acute average per 100 admissions at 7.15 against 6.87. In terms of severity – 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%

Healthcare Acquired Infections (HCAI's)

Targets for reducing incidents of C. Difficile have been achieved by a comfortable margin, and TRFT is known to have one of the lowest HCAI rates in the UK. Unfortunately, the target for zero MRSA bacteraemia (blood infection) has not been achieved, due to one bacteraemia occurring during quarter 1; this was in a patient transferred from another trust, however blood cultures were not taken within the required timescale to discharge responsibility for this incident from TRFT.

Complaints

The Trust has achieved its target for increasing complaints, which reflects our focus on gaining feedback on our services – whether positive or negative, with a view to continuously improving

them. Year on year - the seriousness of complaints has also reduced, with complaints rated as orange or red (the more serious classifications of complaint) falling from 10.9% in 2011-12, to 6.3% for 2012-13.

Clinical Effectiveness

Reducing the number of hospital readmissions from care homes within 30 days

Significant improvements have been achieved against baseline for this indicator up to the end of Qtr3, with a decrease from 19.7% in 2011-12 to 11.0% (YTD – Qtr3), in line with the Trusts core value of 'right first time'. Data for this indicator is provided by NHS Rotherham. Due to a change of organisation for the Information Team to a regional Commissioning Support Unit – they are currently legally precluded from accessing patient level data, hence Qtr4 and full year data in relation to this indicator may not be available until after this report is published.

Reducing emergency readmissions to hospital within 28 days of discharge

The Trust has made significant improvements in this respect, with a 2012-13 value of 5.8% against 7.3% the previous year. Our performance this year is also significantly better than the HES peer average of 6.8%.

Reduction in mortality – Summary Hospital Mortality Index value (SHMI) – CHKS Live

The Trust has not attained a SHMI value of lower than the baseline period, with a rate of 79.2 for 2012-13; whilst this is above HES peer value of 68, care must be taken in drawing conclusions from this indicator in isolation.

The SHMI methodology is known to be influenced by not only mortality rates against an expected value (calculated by taking into account 'relative risk' of death, per patient, given a large number of factors such as age, primary diagnosis, co-morbidities etc) – but by methods of service provision. Also note that whilst more proximate in terms of availability, and therefore more useful in operational management terms - the CHKS Live version of this indicator excludes 'out of hospital' deaths, due to the length of time taken to match this data to Office for National Statistics mortality data. As reflected in the mandated HSCIC version of SHMI (including out of hospital deaths) – our SHMI banding is in the 'as expected' range.

Reduction in weekend mortality rates

The Trust has not achieved against target in this respect, albeit by a relatively small margin, at 27% for the year. Appropriateness of baselines will be reviewed, as the value for 2011-12 was higher than April 2012 at 28.4% - hence year on year improvement is evident.

Patient Experience

Increasing our responsiveness to patients needs using a composite indicator of care

Our target for increased responsiveness to patient needs has been achieved. The overall index for patient satisfaction has increased from 82.9 in 2011-12, to 89.9 for 2012-13. Our new patient experience opinion capture system will continue to support monitoring of this initiative.

Occupational Therapist (OT) and Health Visitor attendances

The Trust has achieved its target of >95% and improved upon its baseline for OT visits for assessment within 28 days, ending the year with performance of 99.4%; exceeding this level of performance for 2013-14 will be very challenging indeed. Health Visitor attendances within 10-14 days of childbirth target of 97% has not been achieved by a small margin, monitoring of this target will continue under Community performance reporting.

Proportion of patients assessed using the MUST nutritional tool every 7 days

The Trust has not achieved its target to improve base line; monitoring of this indicator across all wards, alongside implementation of corrective actions, will be progressed as part of the trust improvement programme for Intra Operative Fluid Management (IOFM).

Proportion of patients with completed (and calculated) fluid balance charts

Whilst the Trust has achieved its target by significant improvement against base line; monitoring will be continued as part of Service2Board indicators, given the importance of this issue in relation to the impact on patient recovery. Outcomes against this indicator will be progressed as part of the trust improvement programme for Intra Operative Fluid Management (IOFM).

Culture

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

The Trust has improved slightly against baseline, albeit not achieving this in the final quarter of the year. YTD performance in respect of this indicator is above baseline, but this is of limited value given the rolling nature of the target as due dates for review occur throughout the year.

IR1 reporting

The target for increased reporting of incidents via Datix (IR1 form) has been achieved, this enables action to be taken to mitigate the risk of future incidents, the impact and likelihood of which is captured – therefore ensuring that incidents are reported to the most appropriate level of seniority, according to its risk rating.

Compliance against Mandatory and Statutory Training (MAST)

The Trust broadly achieved improvements against baseline for this indicator, although slipping slightly at the end of quarter 4.

Employee sickness rates

The target for reducing sickness absence was not achieved by the Trust for 2012-13, this will continue to be monitored.

Data Quality

Data Quality Index (HRG4 based)

The Trust has not achieved against its target of increasing our index score against 2011-12 for data quality; currently the Trust value for 2012-13 is 94.6 against HES peer value of 95.5. At the time of report publication a number of uncoded episodes remain for March data, 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 not achieved against target for 2012-13, mainly due to a high number of blank primary diagnoses in the last quarter. The rate for the Trust of 2.7% blank primary diagnoses against 5.1% for HES peers in quarter 4 remains favourable however. 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 remains unchanged against last year at 3.2 diagnoses per coded episode. Our performance against HES peers is lower than the 4.2 national average. It is anticipated that outcomes from the data quality and death certification improvement programmes will positively influence this situation in the coming year.

SystmOne Data Quality

The Trust has not achieved its target of a 97% rate for SystmOne, by a very narrow margin at 96.9%, this will continue to be monitored.

Table 5: Key Quality Indicators for Quality Account monitoring report 2013-14 - New and remaining indicators

Domain	ID	Indicator name	Rationale for monitoring
Patient Safety	PS_1	Have zero 'Never Events'	Zero target not achieved for 2012-13, monitoring to continue
	PS_2	Rate of patient safety incidents/1000 admissions	Linked to 'no blame' reporting culture
	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)
	PS_4a	Number of patients with C. Diff	On-going infection control surveillance
	PS_4b	Number of patients with MRSA	On-going infection control surveillance
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
	PE_2	Increase in the number of patients assessed using the MUST nutritional tool	Target not achieved for 2012-13, 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
	PE_4	Increase in number of complaints	On-going Patient Experience indicator
Clinical Effectiveness	CE_1	Reducing emergency re-admissions to hospital within 28 days of discharge	Target not achieved for 2012-13, monitoring to continue
	CE_2	Reducing weekend mortality rates as at April baseline 2012	Reduction target not achieved in 2012-13, monitoring to continue
	CE_3	Dementia Find, Assess/Investigate, Refer (F.A.I.R)	Summary indicator to reflect progress against Improvement Programme **(NEW)**
	CE_4	Looked After Children's assessments	Target not achieved for 2012-13, monitoring to continue
Culture	C_1	All applicable staff to have in year PDR	Links to 'caring' objectives
	C_2	Increase in IRI reporting	Linked to 'no blame' reporting culture
	C_3	All staff to maintain compliance against MAST training	Links to supporting staff objectives
	C_4	Employee sickness rates	Proxy marker reflecting morale/wellbeing of staff
Data Quality	DQ_1	Data Quality index (CHKS Live -HRG4 based)	On-going Trust requirement – links to DQ Improvement Programme
	DQ_2	Blank or invalid or unacceptable primary diagnosis rates (CHKS Live -HRG4 based)	On-going Trust requirement – links to DQ Improvement Programme
	DQ_3	Depth of coding average diagnosis per coded episode (CHKS Live)	On-going Trust requirement – links to DQ Improvement Programme

	DQ_4	Data quality summarised indicator – TBC	Summary indicator to reflect progress against Improvement Programme **(NEW)**

Notes

- Baselines for *new* indicators will be established in quarter 1 of 2013-14, for remaining indictors, 2012-13 outcomes will be used.
- DoH mandated Quality Account indicators, based on HSCIC publications, will be reported in the Quality Account as a distinct dataset due to the time lag associated with data availability

Table 6: Indicators to be removed from Quality Account monitoring report 2013-14

Domain	ID (if applicable)	Indicator/programme name	Rationale for removal
Patient safety	PS_1	To ensure that we are meeting 90% compliance against all of the standards set out in relation to safe and secure storage of medications	Due to the significant improvements associated with these indicators, on-going audits will be carried out by the Clinical Effectiveness team and included in the annual audit plan. These will be reported via the Clinical Effectiveness group
Patient Experience	PE_2	Increasing compliance to 65% of 5 key measures on the Liverpool Care of the Dying Pathway (LCP) by April 2012	Targets achieved for 2012-13, hence no longer an improvement programme and as such will no longer be reported at summary level. On-going monitoring is to be undertaken as part of the nursing accreditation scheme
	PE_3	Increase the proportion of community OT visits for assessment within 28 days from April 2012/13 baseline to 95% by April 2013/14	Quality at a Glance to be streamlined - Indicator more appropriately monitored via Community performance reporting
	PE_4	Increase the number of Health Visitor first visit within 10-14 days of birth from 90% to 97%	Quality at a Glance to be streamlined - Indicator more appropriately monitored via Community performance reporting
	PE_6	PROMS data	Quality at a Glance to be streamlined - reported in the DoH mandated indicator dataset
Clinical Effectiveness	CE_1	Reducing the number of hospital re-admissions from care homes within 30 days from April 2012 baseline	Quality at a Glance to be streamlined - Indicator more appropriately monitored via Community performance reporting
	CE_3	Reduction in Mortality: SHMI value and banding	*Quality at a Glance to be streamlined - reported in the DoH mandated indicator dataset*
	CE_4	% patients admitted treatment inc palliative care	Quality at a Glance to be streamlined - reported in the DoH mandated indicator dataset
	CE_5	% patients whose death inc in SHMI treatment palliative care	Quality at a Glance to be streamlined - reported in the DoH mandated indicator dataset

Improvement Programmes	-	Medications Management – Compliance with RPS guidelines	Rationale for removal as per PS_1 above
	-	Communication	Monitoring to be continued via the CQUIN programme
	-	NHS Safety Thermometer – Harm Free Care	Process established for monitoring, to be reported under CQUINs
	-	End of Life care – Liverpool Care Pathway 5 key measures	Improvement Programme goals achieved, on-going monitoring to be undertaken as part of the nursing accreditation scheme
	-	Responsiveness to patient's needs	Process established for monitoring, to be reported under CQUINs
	-	Looked After Children's assessments	Progress now to be reported under Quality at a Glance

National Priorities and Regulatory Requirements 2012-13

In addition to our quality indicators, the Trust is also assessed through the submission of the following 'national priorities' which are set by different organisations:

National Priorities 2012/13						
Measure	DOH	MON	2011/2012		2012/2013	
			Year end position	National Target	Year end Position	National Target
Access to Genito Urinary Medicine Clinic (%)			100%	100%	100%	100%
Number of cases - Clostridium Difficile Infection (Cdiff)	✓	✓	35 cases	42 cases	21 cases	31 cases
Number of cases - MRSA	✓	✓	1 case	2 cases	1 case	0 cases
Delayed transfers of care	✓		1.5%	3.5%	1.6%	3.5%
Infant health & inequalities: breastfeeding initiation	✓		62.0%	64.0%	60.5%	66.0%
VTE - percentage of all adult inpatients who have had a VTE risk assessment on	✓		90.1%	90.0%	92.3%	90.0%
Nobody waits more than 18 weeks from GP referral to treatment	✓	✓	98% Admitted Patients 98% Non Admitted Patients	90% Admitted Patients 95% Non Admitted Patients	Indicator changed from April 1st 2012	Indicator changed from April 1st 2012
95th Percentile Time - RTT Pathway - The 95th Percentile time waited for admitted (adjusted) and non-admitted patients whose clocks stopped during the period and for incomplete pathways at the end of the period.						
Admitted	✓	✓	16.1 weeks	23 weeks	Indicator changed from 1st April 2012	Indicator changed from 1st April 2012
Non-Admitted	✓	✓	10.6 weeks	18.3 weeks	Indicator changed from 1st April 2012	Indicator changed from 1st April 2012
Incomplete	✓	✓	16 weeks	26 weeks	Indicator changed from 1st April 2012	Indicator changed from 1st April 2012
Median Time - RTT Pathway - The median time waited for admitted and non-admitted patients completing an RTT pathway, and for incomplete pathways.						
Admitted	✓	✓	5.2 weeks	11.1 weeks	Indicator changed from 1st April 2012	Indicator changed from 1st April 2012
Non-Admitted	✓	✓	2.4 weeks	6.6 weeks	Indicator changed from 1st April 2012	Indicator changed from 1st April 2012
Incomplete	✓	✓	3.0 weeks	7.2 weeks	Indicator changed from 1st April 2012	Indicator changed from 1st April 2012
RTT Pathway - The percentage of patients seen within 18 weeks in respect of Consultant led services to which the 18 weeks referral to treatment standard applies.						
Admitted	✓	✓	Not Applicable	Not Applicable	93.9%	90%
Non-Admitted	✓	✓	Not Applicable	Not Applicable	98%	95%
Incomplete	✓	✓	Not Applicable	Not Applicable	93.7%	92.0%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	✓		Not Applicable	Not Applicable	1.3%	less than 1%
Patients waiting less than 4 hours in A&E (%)	✓	✓	95.57%	95.0%	95.30%	95%
Cancelled Operations (%)	✓		0.93%	0.8%	0.79%	0.8%
Patients with new onset chest pain thought to be angina seen in a RACPC within 2 weeks of referral (%)	✓		99.0%	100%	Indicator removed	Indicator removed

National Priorities 2012/13						
Measure	DOH	MON	2011/2012		2012/2013	
			Year end position	National Target	Year end Position	National Target
Women who have seen a midwife or a maternity healthcare professional by 12 completed weeks of pregnancy (%)	✓		87.8%	90.0%	87.3%	90%
Patients who spend at least 90% of their time on a stroke unit (%)	✓		87.3%	80.0%	85.6%	80%
Higher risk TIA cases who are scanned and treated within 24 hours (%)	✓		68.9%	60.0%	87.4%	60%
Access to healthcare for people with a learning disability', based on recommendations set out in Healthcare for All 2008 * *collected with special data collection*		✓	Compliant	Compliant	Compliant	Compliant
Mixed Sex Accommodation - The number of breaches of sleeping accommodation	✓		19 breaches	0 breaches	0 breaches	0 breaches
Patients waiting no more than 31 days for second or subsequent cancer treatment						
Anti Cancer Drug Treatments - Chemotherapy (%)	✓	✓	100%	98.0%	100%	98.0%
Surgery (%)	✓	✓	98.3%	94.0%	99.2%	94.0%
Radiotherapy (from 1 January 2011) (%)	✓	✓	Not Applicable	94.0%	Not Applicable	94.0%
62-Day Wait For First Treatment (All cancers)						
Patients treated within two months of consultant upgrade (%)	✓	✓	96.8%	Not yet available	97.4%	Not yet available
From Consultant Screening Service Referral (%)	✓	✓	98.2%	90.0%	95.3%	90.0%
Urgent GP Referral (%)	✓	✓	93.7%	85.0%	93.3%	85.0%
31-Day Wait For First Treatment (Diagnosis To Treatment)						
All cancers	✓	✓	99.3%	96.0%	99.3%	96.0%
Two week wait from referral to date first seen						
All cancers (%)		✓	97.1%	93.0%	95.2%	93.0%
For symptomatic breast patients (cancer not initially suspected) (%)		✓	95.0%	93.0%	91.6%	93.0%
Health visitor numbers against plan	✓		Not Applicable	Not Applicable	41.2	49 Wte

National Priorities Commentary

Performance by the Trust against National Priorities has been good in 2012-13, with 20 of 26 (76.9%) relevant priorities being achieved against target; compared to 2011-12 where 22 of 28 (78.5%) of relevant priorities being achieved against target.

C. Difficile performance remains strong, although the MRSA bacteraemia target was not achieved – 'ownership' of this incidence was disputed by the Trust, but due to failing to obtain blood samples within the relevant timescale of acceptance of a transfer from another Trust, this has been recorded against TRFT performance. TRFT performance for infection prevention and control remains amongst the best in the country. Breastfeeding initiation performance has slipped by 1.5% against last year – failing to achieve against the national target which increased by 2% for 2012-13; TRFT continues to strive to drive up performance against this target.

All applicable Referral To Treatment (RTT) targets have been achieved, bar the target for nobody waiting 6 weeks or over for a key diagnostic test (1.3% vs 1.0% target). Stroke, learning disability access and mixed sex accommodation targets have all been achieved.

Cancer 31 and 62 day targets for first and second/subsequent treatments, including the 31 day diagnosis to treatment, have all been achieved – with half reflecting increased improvement on the previous year, the remainder still performing above target having slipped slightly.

Two week wait from referral to date first seen target has been achieved for 'all cancers' – although 'symptomatic breast' in isolation, fell just short of the national target by 1.3%. A new target for maintaining Health Visitor numbers against plan has not been achieved – falling short by 7.3 whole time equivalents (WTEs).

ANNEXE: Statement on behalf of Local Involvement Networks

LINkrotherham has continued to strengthen partnership working with the Rotherham Foundation Trust Hospital during 2012.

LINkrotherham supported by NHS Rotherham and Rotherham Foundation Trust to undertake a review of Rotherham's emergency/out of hours health services. LINkrotherham arranged and facilitated focus groups to provide further understanding as to why people choose the service they do. The information gathered from the focus groups is part of a much wider piece of work around unscheduled care services.

In LINkrotherham's analysis, no patterns or consensus emerged about why and when certain people accessed specific services. There was a lot of confusion from service user perspective, about which was the 'right' service and participants weren't therefore always able to make informed decisions about accessing the appropriate health service.

LINkrotherham Board members' response to Quality Accounts improvements 2012-13 included the view that the standards should be regularly reviewed with respect to rates of incidents reporting, where higher numbers of reports indicate a positive patient safety culture. With respect to the Francis report recommendations LINkrotherham believe that patient experience, family and friends' satisfaction is paramount and pressures with respect to targets should not distort clinical priorities. Neither should it ignore the duty of candour nor override shared decision making.

From the end of March 2013, LINkrotherham will end and its work will transfer to Healthwatch Rotherham which will be Rotherham's consumer champion for patients, service users and the public across health and social care. Healthwatch Rotherham will have additional functions and funding to LINkrotherham for supporting individuals to exercise choice and control and provide a local health complaints advocacy service. LINkrotherham Governing Board wish Healthwatch Rotherham every success.

Diana Swanson
LINkrotherham Chairperson
27th March 2013

Annexe: Statement on behalf of Council of Governors

As Lead Governor and Chair of the Patient Safety & Experience Governor & Member Group, a sub-committee of the Council of Governors, I would like to acknowledge the unique contribution that individual elected Governors and the Council of Governors as a whole are able to make to the future development of The Rotherham NHS Foundation Trust and specifically to the development of the key quality indicators.

During the year, Governors have monitored levels of quality in relation to Care Quality Commission standards, actively participated in Senior Nurse Walkarounds, contributed to the development of the quality strategy and also the programme of work planned for 2013-14.

Information on the quality of care is shared with Governors on a regular basis and we challenge and question progress against targets. The additional work undertaken by the Patient Safety & Experience Governor & Member Group ensures we stay close to the quality of care provided to the patients and the people of Rotherham.

As a Council of Governors we have seen the content of the Quality Account, and have been involved in defining the quality indicators and priorities for the coming year. The Governors specifically support the on-going work in relation to patients with symptoms of dementia, aligned to CQUIN targets, which will be reported regularly on by the Patient Safety and Experience Committee Governor's meeting.

Jean Dearden

Public Governor/Lead Governor

Chair, Patient Safety & Experience Governor & Member Group

11th April 2013

Annexe: Statement from Rotherham Clinical Commissioning Group (Commissioners)

The maintenance of high quality care while delivering efficiencies has remained a priority and key challenge up to 31st March 2013. Rotherham PCT ceased to exist on 31st March 2013 and Rotherham Clinical Commissioning Group (RCCG) came into full existence on 1st April 2013. The groundwork for the relationship between the Trust and the CCG has been firmly laid during the transition and lead up to this major change in NHS commissioning.

The Trust has engaged with the PCT and emerging CCG on many work streams involving service delivery/provision regarding referrals management and unplanned care. This work involving the Trust Medical Director and Chief Nurse, along with other key senior clinicians and officers, working with PCT/CCG clinicians and officers has resulted in improved pathways of care and a series of top tips for referring GPs. The Trusts senior clinicians have also engaged with a programme of learning events for Primary Care to support work on pathways.

The involvement of senior clinicians from the Trust in the on-going commissioning and contract management remains strong; for example the Chief Nurse and Executive Medical Director both attend Contract Quality Meetings and have been involved in the negotiations relating to the 2013-14 CQUIN scheme.

There has been a flurry of negative publicity in relation to the Trust's financial balance and operational issues during replacement of their defunct Patient Administration System with a much more comprehensive Electronic Patient Record (EPR) System. These have been largely resolved as a result of 'bug' fixes, collaborative work between TRFT and Meditech to create system enhancements, increased staff training and changes to administrative SOPs. Maintaining the quality of data submitted for the Commissioning Data Set has been a challenge for the Trust during the implementation of the Meditech EPR. This had an impact on the Trust's ability to get the correct amount of Payment by Results funding. Notwithstanding these challenges, the Trust maintained an open and honest relationship with the PCT/CCG about the problems and their plans to resolve them. While there have been problems, the CCG are reasonably assured that the data included in the quality account is accurate.

Whilst there have been issues as outlined above, the Trust have made solid achievements in terms of providing safe, quality care as evidenced by the findings of the NHS Safety Thermometer and the programme of clinically led visits to the Trust. These visits will continue throughout 2013-14 together with PCT/CCG representation on the unannounced senior nurse visits to wards and clinical areas where patient/GP feedback has raised questions.

RCCG believe that the data received for the purpose of contract performance monitoring and management purposes during 2012-13 has not always been accurate given the issues with the EPR system. However, RCCG welcome the Trust's focus on improving data quality through the CQUIN scheme and other programmes of work. The combined effect of remedial activities undertaken by TRFT, alongside the open and honest communication with the PCT/CCG and regional and national benchmarking data, is that the CCG can take assurance that the submissions that are now being made are suitably robust and accurate, as to form the basis of PbR (Payment by Results) fund provision.

Dr Phil Birks

GP Executive Lead – TRFT Contract: Rotherham Clinical Commissioning Group

8th May 2013

RFT Quality Accounts – formal response from the Rotherham Health Select Commission

The Quality Accounts were presented to members at their meeting in December 2012. Members appreciate being presented with this information and having considered and discussed these; they are fully supportive of the accounts and feel happy with the work which has taken place for 2012-13.

During the meeting, scrutiny members raised a number of queries in relation to the accounts and future sharing of information between the Trust and the Health Select Commission. I am pleased with the way in which the Trust has responded to this and continues to work in a positive manner with Scrutiny in Rotherham.

Following a recent scrutiny review of Autistic Spectrum Disorder, a number of recommendations were made which are specific to the Trust and I look forward to receiving responses to these recommendations and hopefully how they have further improved quality in the coming year.

The Health Select Commission feels happy with the willingness of the Trust, from both officers and directors, to attend their meetings and present information to them, as well as taking on board their comments and concerns. The commission members look forward to working much more closely with the Trust with on-going matters in the future.

Cllr Brian Steele
Chair of Rotherham Health Select Commission

[For insertion at an appropriate point in the NHS Choices (Graphics Team version) document]

Case study: Business Intelligence initiatives continue to support trust staff in driving forward 'Harm Free Care' – in line with Francis Report recommendations, also gaining nationwide recognition as best practice for NHS Safety Thermometer reporting

NHS Safety Thermometer was instigated as a National CQUIN for NHS Trusts for 2012-13. Replacing NHS QUEST, it covers many of the same areas including falls/pressure ulcer reduction, VTE assessment/ prophylaxis and Urinary Tract Infection reduction.

The overarching concept of the initiative is to drive upwards the prevalence of 'harm free care' – echoing the sentiment of Florence Nightingale in that "the very first requirement of a hospital, is that it should do the sick no harm".

Reducing patient harm is also stated as a key objective arising from the Francis report on the public inquiry into poor quality outcomes and patient care at Mid Staffordshire – which was published in February 2013. In this sense, the CQUIN is well aligned to the latest findings and recommendations for future improvement in NHS patient care.

The CQUIN targets for 2012-13 were simply designed to start Trusts performing the snapshot audits against all patients in an acute bed (or treated by District Nurses) on a given day – and submitting the results, on a monthly basis, in an appropriate format to the NHS Information Centre for publication and peer comparison.

The use of SQL Server 2008TM technology, in combination with SNAPTM optical character recognition software enabled seamless data flow from the point of capture, to its availability online on the Trust intranet – with 'drill up' and 'drill down' capability, to enable comparison of results at specialty and ward level. The submission to NHS Information Centre is also performed via SQL Server 2008TM technology – ensuring error free transmission of data, in a timely fashion.

Given that the Trust was already performing a similar audit based approach for Ward Nursing Quality Indicators – the decision was made to align NHS ST data requirements with that system. The key benefits of this were an already well-established data validation process (linked to Datix incident reporting) and the ability to enable a 'self service' approach for ward and specialty managers to rapidly see their results online – and take corrective action where necessary.

This capability has resulted in several core ST metrics reflecting consistent improvement throughout the year. The validation and technological approach taken by TRFT, in achieving the aims of this CQUIN, have been widely acclaimed as National best practice in a variety of Safety Thermometer forums; it also embodies the Trust core value of 'right first time'.

Appendix 1: Quality at a Glance indicators 2012-13 progress

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
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%	64.0%	64.2%	64.3%	→	🔴
	PS_2a	Have zero 'Never Events'	2011-12	1	0	0	0	0	0	0	→	🟢
	PS_2b	Rate of reported patient safety incidents per 1,000 admissions	2011-12	78	Increase	84	93	89	92	89	↗	🟢
	PS_2c	Percentage of patient safety incidents resulting in serious harm (semi permanent/permanent) or death (Datix)	2011-12	3.1%	Reduce	2.3%	2.2%	1.6%	2.3%	2.1%	↓	🟢
	PS_3	Number of patients with attributable C. Difficile	2011-12	35	=<31	5	7	6	3	21	↑	🟢
	PS_4	Number of patients with attributable MRSA bacteraemia	2011-12	1	0	1	0	0	0	1	→	🔴
	PS_5	Number of complaints	2011-12	653	Increase	213	259	278	188	938	↓	🟢
Patient Experience	PE_1	Increasing our responsiveness to our patients needs using a composite indicator of care (Patient Experience Tracker)	April 2012	82.9	Increase	85.0	89.1	91.0	92.4	89.9	↗	🟢
	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%	42.5%	90.0%	83.0%	92.8%	76.0%	↑	🟢
	PE_3	Increase the proportion of community OT visits for assessment within 28 days	April 2012	98.9%	95%	98.7%	99.8%	99.7%	99.6%	99.4%	→	🟢
	PE_4	Increase the number of Health Visitor first visit within 10-14 days of birth	April 2012	97.0%	97%	96.8%	95.2%	95.8%	96.1%	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%	81.6%	84.7%	83.6%	↗	🔴
	PE_5b	Increase in the proportion of patients with completed (and calculated) fluid balance charts	April 2012	61.1%	Increase	73.8%	83.1%	77.9%	78.3%	78.2%	→	🟢
Clinical Effectiveness	CE_1	Reducing the number of hospital re-admissions from care homes within 30 days	2011-12	19.7%	Reduce	17.2%	9.0%	7.0%	-	11.0%	-	🟢
	CE_2	Reducing emergency re-admissions to hospital within 28 days of discharge (CHKS Live)*	2011-12	7.3%	Reduce	6.0%	6.3%	5.8%	5.1%	5.8%	↑	🟢
	CE_3a	Reduction in Mortality: SHMI value - in hospital deaths only (CHKS Live)	2011-12	74.1	Reduce	78.7	74.3	76.6	86.3	79.2	↓	🔴
	CE_6	Reducing weekend mortality rates	April 2012	24.7%	Reduce	23.8%	29.5%	25.6%	29.1%	27.0%	↘	🔴
Culture	C_1	Applicable staff to have in year PDR (end of Qtr snapshot)	Qtr4 2011-12	49.0%	100%	50.1%	53.7%	50.9%	46.4%	n/a	↘	-
	C_2	IR1 reporting (all types)	2011-12	7512	Increase	1878	2097	2140	2049	8164	↘	🟢
	C_3	Staff to maintain compliance against MAST training (end of Qtr snapshot)	Qtr4 2011-12	75.0%	100%	77.0%	77.3%	77.1%	70.1%	n/a	↓	-
	C_4	Employee sickness rates	2011-12	4.3%	Reduce	4.2%	4.5%	4.7%	5.3%	4.7%	↗	🔴
Data Quality	DQ_1	Data Quality index - CHKS Live (HRG4 based)*	2011-12	95.9	Increase	95.4	94.7	95.0	93.3	94.6	↘	🔴
	DQ_2	Blank, invalid or unacceptable primary diagnosis rates - CHKS Live (HRG4 based)*	2011-12	0.2%	Reduce	1.0%	0.4%	0.8%	2.7%	1.2%	↓	🔴
	DQ_3	Depth of coding: average diagnosis per coded episode - CHKS Live (excludes Breathing Space)	2011-12	3.2	Increase	3.2	3.1	3.1	3.1	3.2	→	🟡
	DQ_4	SystmOne Data Quality	2011-12	97.4%	>97%	96.6%	96.7%	97.0%	97.1%	96.9%	→	🔴

Appendix 2a: CQUINs 2012-13 year end position

No.	Indicator Name	Target and Monitoring	Quarter 1 Finance			Quarter 2 Finance			Quarter 3 Finance			Quarter 4 Finance			Full Year Financial Outcome		
			Financial Plan Qtr1	Finance Actual Qtr1	% Achieved Qtr1	Financial Plan Qtr2	Finance Actual Qtr2	% Achieved Qtr2	Financial Plan Qtr3	Finance Actual Qtr3	% Achieved Qtr3	Financial Plan Qtr4	Finance Actual Qtr4	% Achieved Qtr4	Full Year Plan	Full Year Actual	% Actual
1	VTE Risk Assessment (Numerator 1)	Trust to achieve 90% monthly data submitted via Unify reported on monthly scorecard	£25,515	£25,515	100%	£25,515	£25,515	100%	£25,515	£25,514.73	100%	£25,515	£25,515	100%	£102,059	£102,059	100%
	Use of Appropriate Prophylaxis (Numerator 2)	Trust to achieve 95% monthly data submitted via Unify reported on monthly scorecard	£25,515	£25,515	100%	£25,515	£25,515	100%	£25,515	£25,514.73	100%	£25,515	£25,515	100%	£102,059	£102,059	100%
2a	Composite indicator on responsiveness to personal needs (National Inpatient Survey)	69.9 Achieved in 2011, Trust to sustain or improve its relative position nationally, using the National Patient Experience Benchmarking Tool.										£204,118	£204,118	100%	£204,118	£204,118	100%
2b	Patient Experience - Community	Community Matrons and Breathing Space improvement on the baseline established at the end of Q2, 2012-13.	£20,004	£20,004	100%	£20,004	£20,004	100%				£28,576	£28,576	100%	£68,584	£68,584	100%
		For District Nursing, Health Visiting, Physiotherapy Clinics, Podiatry, Orthopaedic Triage, where the Q4 (2011-12) baseline is below 90% , payment will be made on improvement on the baseline. Where the Q4 (2011-12) baseline is 90% or above, payment will be made on the position being sustained at 90% or above.										£74,299	£74,299	100%	£74,299	£74,299	100%
3a	Dementia Case Finding (1 - Find)	Numerator 1 - No. of patients aged 75 and above admitted as emergency inpatients, reported as having been asked the dementia case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia. Achievement of 90% in any three consecutive calendar months.										£81,647	£0	0%	£81,647	£0	0%
		Numerator 2 - No. of patients aged 65 and above (local stretch) admitted as emergency inpatients, reported as having been asked the dementia case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia. Achievement of 90% in any three consecutive calendar months.										£20,412	£0	0%	£20,412	£0	0%
3b	Dementia Diagnostic Assessment and Investigation (2 - Assess and Investigate)	Numerator 1 - No.of admissions of patients aged 75 and above admitted as emergency, inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium reported as having had a dementia diagnostic assessment including investigations. Achievement of 90% in any three consecutive calendar months.										£81,647	£0	0%	£81,647	£0	0%
		Numerator 2 - No. of admissions of patients aged 65 and above (local stretch) admitted as emergency, inpatients who have scored positively on the case finding question or who have a clinical diagnosis of delirium reported as having had a dementia diagnostic assessment including investigations. Achievement of 90% in any three consecutive calendar months.										£20,412	£0	0%	£20,412	£0	0%
3c	Referral for Specialist Diagnosis (3 - Refer)	Numerator 1 - No.of all patients aged 75 and above admitted as an emergency inpatient who have had a diagnostic assessment (in whom the outcome is either “positive” or “inconclusive”) who are referred for further diagnostic advice/follow up. Achievement of 90% in any three consecutive calendar months.										£81,647	£81,647	100%	£81,647	£81,647	100%
		Numerator 2 - No. of all patients aged 65 and above (local stretch) admitted as an emergency inpatient who have had a diagnostic assessment (in whom the outcome is either “positive” or “inconclusive”) who are referred for further diagnostic advice/follow up. Achievement of 90% in any three consecutive calendar months.										£20,412	£20,412	100%	£20,412	£20,412	100%

			Quarter 1 Finance			Quarter 2 Finance			Quarter 3 Finance			Quarter 4 Finance			Full Year Financial Outcome		
No.	Indicator Name	Target and Monitoring	Financial Plan Qtr1	Finance Actual Qtr1	% Achieved Qtr1	Financial Plan Qtr2	Finance Actual Qtr2	% Achieved Qtr2	Financial Plan Qtr3	Finance Actual Qtr3	% Achieved Qtr3	Financial Plan Qtr4	Finance Actual Qtr4	% Achieved Qtr4	Full Year Plan	Full Year Actual	% Actual
4	NHS Thermometer	Three consecutive quarterly submissions of monthly survey data for all relevant patients and settings using NHS Safety Thermometer will trigger full payment of the CQUIN. Each set of complete data for a single Quarter will qualify the provider for 33.3% of the total value for this CQUIN (given only 3 quarters of 2012/13 are in scope). Commencing Q2				£68,039	£68,039	100%	£68,039	£68,039	100%	£68,039	£68,039	100%	£204,118	£204,118	100%
5a	Assessment of patients in a non-admitted care setting	Service re-design of the non-elective pathway to accommodate assessment in a non-admitted setting, through TRFT/NHSR clinically led visits and written reports from TRFT. Quarterly milestones to be achieved.	£40,824	£0	0%	£81,647	£81,647	100%	£81,647	£81,647	100%	£122,471	£122,471	100%	£326,589	£285,765	87.50%
5b	Fast Response engagement in assessment of and/or utilisation of alternative levels of care as an alternative to admission or further assessment.	Numerator 1 - Completion of data collection template on a daily basis by Fast Response for all patients seen and submitted monthly to NHSR	£50,213	£50,213	100%	£25,719	£25,719	100%	£25,719	£25,719	100%	£25,719	£25,719	100%	£127,370	£127,370	100%
		Numerator 2 - To increase the number of patients assessed by Fast Response in A&E and Assessment Area. Target is an avg of 50 patients per month in Q3 and Q4				£8,573	£8,573	100%	£8,573	£8,573	100%	£8,573	£8,573	100%	£25,719	£25,719	100%
		Numerator 3 - Analysis by TRFT of capacity requirements for Intermediate Care, Fast Response and other Alternative Levels of Care	£13,880	£13,880	100%	£19,187	£19,187	100%	£13,880	£13,880	100%	£24,494	£24,494	100%	£71,441	£71,441	100%
5c	Community and Secondary Care Clinicians engagement with GP practice multi-disciplinary team meetings	Numerator 2 (Part 1) - Increase the proportion of practices with regular MDTs (not palliative care/GSF),which are attended on a regular basis by community clinicians (e.g. District Nurses, Community Matrons etc). Target is 80% attendance				£32,659	£32,659	100%	£42,865	42864.7485	100%	£61,235	£61,235	100%	£136,759	£136,759	100%
		Numerator 2 (Part 2) - TRFT to submit completed data collection template and register/record of attendance. RFT to provide timetable of Consultant availabilty in a Community setting for access to specialist advice following MDT meetings, as required, to all GP practices (copy to NHSR).	£53,071	£53,071	100%	£28,576	£28,576	100%	£32,659	32658.856	100%	£32,659	£32,659	100%	£146,965	£146,965	100%
		Numerator 4 - Increase the proportion of patients with chronic disease/LTC requiring MDT (updated quarterly) who have a care plan and named case manager. Agreed that patients should be those on the community matron's caseload							£42,865	42864.7485	100%	£61,235	£61,235	100%	£104,100	£104,100	100%
5d	Engagement and improvements to the LTC/Urgent Care pathways - CRMC 5 Pathways plus in 12-13 Childrens & General/Elderly Medicine. Cross -cutting Intermediate care	To reduce the overall number of emergency admissions in 2012-13 to TRFT through engagement and improvements to the Long term conditions/Urgent Care pathways of COPD,Cardiology/CHD, Diabetes, Dementia, Falls, Children and Integrated Medicine. Work of the pathway groups reported quarterly through CRMC.	£48,988	£48,988	100%	£48,988	£48,988	100%	£48,988	£48,988	100%	£48,988	£48,988	100%	£195,953	£195,953	100%
6a	Patient Pathway/Experience in A&E - Improve access to A&E Triage Assessment and maintain time to treatment	To achieve the 15 minute 'Time to triage' for patients arriving by ambulance target (Numerator 1) and to achieve or maintain a 15% reduction on the 'time to see a clinician' (Numerator 2). This is a year-end target with payment for partial achievement. Both numerators to be achieved to receive full payment.										£195,953	£100,018	51%	£195,953	£100,018	51%

			Quarter 1 Finance			Quarter 2 Finance			Quarter 3 Finance			Quarter 4 Finance			Full Year Financial Outcome		
No.	Indicator Name	Target and Monitoring	Financial Plan Qtr1	Finance Actual Qtr1	% Achieved Qtr1	Financial Plan Qtr2	Finance Actual Qtr2	% Achieved Qtr2	Financial Plan Qtr3	Finance Actual Qtr3	% Achieved Qtr3	Financial Plan Qtr4	Finance Actual Qtr4	% Achieved Qtr4	Full Year Plan	Full Year Actual	% Actual
6b	To reduce the average length of time patients have to wait to be admitted into a specialty bed after a decision to admit has been made by the A& E department.	To incentivise individual speciality areas to improve the patient pathway and communication links between A&E and the individual speciality areas. There are two key elements to this indicator. 1) The timeliness of A&E staff to access at speciality level, Senior Doctors or Consultant's to gain advice on individual patients, seven days a week. 2) Once a decision to admit is made we would like to see improvements in the time to admission onto the speciality ward. Q1 develop action plan with quarterly milestones and hold clinician to clinican meetings on a quarterly basis to assess and agree progress.	£40,824	£40,824	100%	£106,141	£106,141	100%	£183,706	£183,706	100%	£183,706	£183,706	100%	£514,377	£514,377	100%
7a	Improving quality & timeliness of clinic letters from secondary to primary care	To increase the proportion of clinic letters for the specialties of Trauma & Orthopaedics, Obstetrics & Gynaecology, Ophthalmology, ENT, Dermatology, General Medicine and General Surgery, issued from secondary care to primary care, which are received by GPs in a timely manner and have a quality standard. Trust to achieve a total increase of an additional 30% on the baseline value up to a maximum target value of 90% by March 2013 (Q4). If the 90% target is achieved in year it is expected that this would then be sustained to the end March 2013 (Q4).	£64,909	£64,909	100%	£0	£0	N/A	£102,875	£102,875	100%	£77,157	£77,157	100%	£244,941	£244,941	100%
7b	Improving quality & timeliness of discharge letters from secondary to primary care	To increase the proportion of discharge letters for the specialties of Integrated Medicine (including Diabetes, Cardiology, Respiratory and Gastroenterology), and A&E (non-admitted), issued from secondary care to primary care, which are received by GPs in a timely manner and have a quality standard. The Trust to achieve a total increase of an additional 30% on the baseline value for Integrated Medicine and 20% for A&E up to a maximum target value of 90% by March 2013 (Q4). If the 90% target is achieved in year it is expected that this would then be sustained to the end March 2013 (Q4).	£57,153	£57,153	100%	£40,824	£40,824	100%	£40,824	£40,824	100%	£57,153	£57,153	100%	£195,953	£195,953	100%
7c	Improving quality & timeliness of handover/case management plans to primary care	To increase the number and the quality and timeliness of handover/case management plans received by the patients GP for their patients discharged/transferred to and from Breathing Space and the Virtual Ward and discharged to Intermediate Care for T&O and Integrated Medicine. Year- end target is an improvement on the baseline of the quality and number of handover plans received by GPs	£44,906	£44,906	100%	£40,824	£40,824	100%				£61,235	£61,235	100%	£146,965	£146,965	100%

No.	Indicator Name	Target and Monitoring	Quarter 1 Finance			Quarter 2 Finance			Quarter 3 Finance			Quarter 4 Finance			Full Year Financial Outcome		
			Financial Plan Qtr1	Finance Actual Qtr1	% Achieved Qtr1	Financial Plan Qtr2	Finance Actual Qtr2	% Achieved Qtr2	Financial Plan Qtr3	Finance Actual Qtr3	% Achieved Qtr3	Financial Plan Qtr4	Finance Actual Qtr4	% Achieved Qtr4	Full Year Plan	Full Year Actual	% Actual
8a	Audits of First and Follow-Up Outpatient Appointments and Engagement in the CRMC agenda	To undertake a number of audits on First and Follow-Up Outpatient Appointments, to assess where improvements can be made to the planned care pathway across a number of specialties (see Matrix 8a), determined by the Clinical Referrals Management Committee (CRMC). Engagement of secondary care clinicans in the CRMC agenda	£57,153	£57,153	100%	£40,824	£40,824	100%	£0	£0	N/A	£97,977	£97,977	100%	£195,953	£195,953	100%
8b	Diagnostics provision of Datsets	To reduce pathology requesting rate by Rotherham GP practices, through the provision of benchmarking data to practices. The benchmarking data will provide information on total, specific and repeat request activity, which will enable GP practices to reflect on activity levels and the appropriateness of requests for repeat activity. Year-end target with payment for partial achievement of completion of requirements set out in Numerators 1 to 3.										£48,988	£48,988	100%	£48,988	£48,988	100%
9	Reduction of inappropriate Fast Track discharges to Continuing Healthcare (CHC) and increasing the number of patients on to LCP who are at End of Life	The aim is to ensure that CHC patients are discharged on appropriate packages of care and to improve quality and care provision of those patients who are deemed truly at End of Life. Numerator 1 - LCP 100% Numerator 2 - No patients assessed using Karnofsky scale with a score above 20 are moved to Fast Track.	£48,988	£48,988	100%							£48,988	£48,988	100%	£97,977	£97,977	100%
10	Implementation of the Safeguarding Standards	To agree plans and to work towards ensuring full compliance against both Adult and Children's Safeguarding Standards, which are detailed in Section C 7.2 of the 2012-13 NHS Standard Contract. Target is to achieve agreed quarterly milestones.	£24,494	£24,494	100%	£40,824	£40,824	100%	£40,824	£40,824	100%	£138,800	£138,800	100%	£244,941	£244,941	100%
			£616,436	**£575,612**	**93%**	**£653,858**	**£653,858**	**100%**	**£784,493**	**£784,493**	**100%**	**£2,027,571**	**£1,727,517**	**85%**	**£4,082,357**	**£3,741,480**	**91.65%**

Appendix 2b: CQUINs agreed goals for 2013-14 (also to be found at www.rotherhamhospital.nhs.uk/CQUINqualityindicatorframework)

Goal No.	Goal Name	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Sub-Indicator Expected Financial Value of Indicator
1	Friends and Family Test	1.1	Friends and Family Test - phased expansion	2.33%	£83,647
		1.2	Friends and Family Test - increased response rate	2.33%	£83,647
		1.3	Friends and Family Test - improved performance on staff test	2.33%	£83,647
2	NHS Safety Thermometer	2.1	NHS Safety Thermometer - improvement on baseline	4.20%	£150,564
3	Dementia	3.1	Dementia - Find, Assess, Investigate and Refer (F.A.I.R)	1.75%	£62,735
		3.2	Dementia - clinical leadership	1.75%	£62,735
		3.3	Dementia - supporting carers of people with dementia	1.75%	£62,735
		3.4	Adherence to the locally agreed dementia pathway	1.75%	£62,735
4	VTE	4.1	VTE risk assessment	2.10%	£75,282
		4.2	VTE root cause analyses	2.10%	£75,282
5	Communications and Improving Waiting Times	5.1	Improving Waiting Times for Admitted and Non-Admitted Care and Diagnostic Waits.	16.70%	£598,672
		5.2	Improving Quality and Timeliness of Clinic Letters from Secondary Care to Primary Care	8.40%	£301,128
		5.3	Improving Quality and Timeliness of Discharge Letters from Secondary Care to Primary Care including Handover Plans	8.40%	£301,128
6	Implementing the Recommendations of Francis	6.1	Safeguarding (Francis and Winterbourne)	7.00%	£250,940
		6.2	Community Patient Experience	5.60%	£200,752
		6.3	Engagement in CRMC including audits	5.60%	£200,752
		6.4	Engagement in UCMC including audits	5.60%	£200,752
		6.5	Review of complaints process and implementation of related Francis report recommendations	4.20%	£150,564
		6.6	Review of death certifications	4.20%	£150,564
		6.7	Nurse leadership/key nurses	11.90%	£426,599
			Total	**100.00%**	**£3,584,863**

GLOSSARY OF TERMS

A&E	Accident & Emergency Department
CEPOD	Confidential Enquiry into Perioperative Deaths
CMACE	Centre for Maternal and Child Enquiries
CHKS	Comparative Health Knowledge System, a web based performance benchmarking system, utilised by many hospitals
COPD	Chronic Obstructive Pulmonary Disorder
Composite indicator	An indicator formed from a number of other indicators, providing a high level summary of performance
CQC	Care Quality Commission
CQUIN	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
CSEC	Corporate Safety & Experience Committee
DAD	Data Assurance Document
Datix	National risk management and reporting system
DGH	District General Hospital
DQI	Data Quality Index, a composite indicator reflecting data quality, provided by CHKS
DoH	Department of Health
EPAU	Early Pregnancy Advisory Unit
EPR	Electronic Patient Record system
GP	General Practitioner
HES	Hospital Episode Statistics – National benchmarking of hospital activity, fed by Shared Uses Service (SUS) data
HoT	Healthcare of Tomorrow
HRG	Healthcare Resource Group – the means of classifying diagnoses and interventions for Payment by Results (PbR)
HSCIC	Health and Social Care Information Centre
IOFM	Intra Operative Fluid Management
IR1	Incident Reporting form
LCP	Liverpool Care Pathway
LINks	Local Improvement Networks

MAST	Mandatory and Statutory Training
MCPCIL	Marie Curie Palliative Care Institute Liverpool
MDT	Multi-Disciplinary Team
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide by people with mental illness
Never event	Defined by the DoH as a very serious, largely preventable, patient safety incident that should not occur if the relevant preventative measures have been put in place
NG	Naso Gastric
NHSLA	National Health Service Litigation Authority
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
PAS	Patient Administration System
PEC	Patient Experience Committee
PET	Patient Experience Tracker – a composite survey indicator of patient opinion, used in a variety of locations and departments in hospital, including Community Services
PGMC	Post Graduate Medicine Centre
NHS QUEST	Quality improvement collaborative across 12 Trusts in the UK – this has now been extended and rebranded as NHS Safety Thermometer, and applies to all Acute Trusts as a 'Harm Free Care' initiative
RAG	Red, Amber, Green – classification system for indicator performance review
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RIE	Rapid Improvement Event
RPS	Royal Pharmaceutical Society
Safety Thermometer	The expanded National patient safety improvement initiative, promoting 'Harm Free Care', linked to National CQUIN funding – previously known as NHS QUEST
SBAR	Situation, Background, Assessment, Recommendation tool
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident

SOP	Standard Operating Procedure
SPA	Single Point of Access
SUS	Secondary Uses Service – data submitted by trusts for national analysis and benchmarking purposes
TRFT	The Rotherham NHS Foundation Trust
WNAS	Ward Nursing Accreditation System