The Rotherham NHS
NHS Foundation Trust

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

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

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

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

Thank you

QUALITY REPORT 2014/15

DRAFT VERSION 3

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

TABLE OF CONTENTS

Vision, Mission & Values

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Louise Barnett
Chief Executive Officer
May 2015

PART 2

QUALITY NARRATIVE

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

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

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

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

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

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

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

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

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

Quality improvement priorities for 2014/15

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

Table1

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

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

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

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

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

(to be added)

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

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

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

Priority 2: Safe Harm Free Care

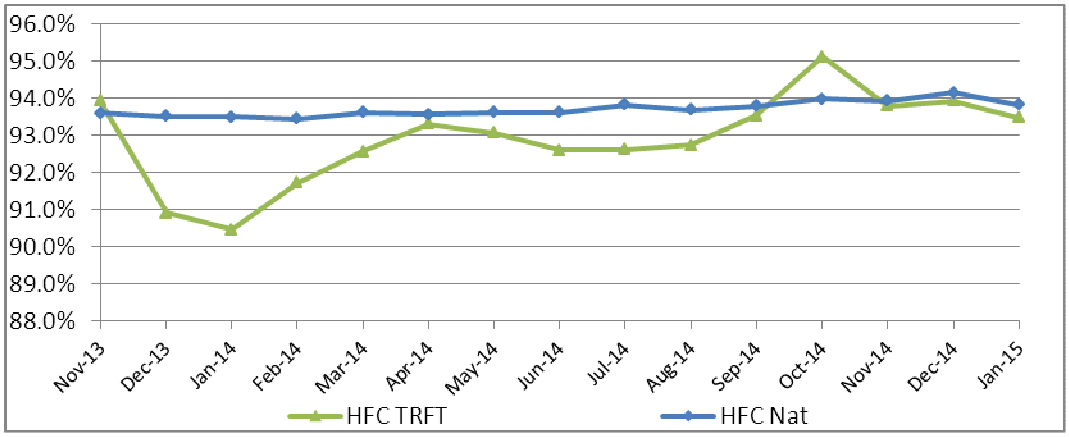
Our aim was to achieve 96% harm free care for our patients. With a particular focus on the prevention of all avoidable falls and all avoidable pressure ulcers graded 2-4 in in-patient areas

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

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

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

Table 3



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

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

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

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

Table 4

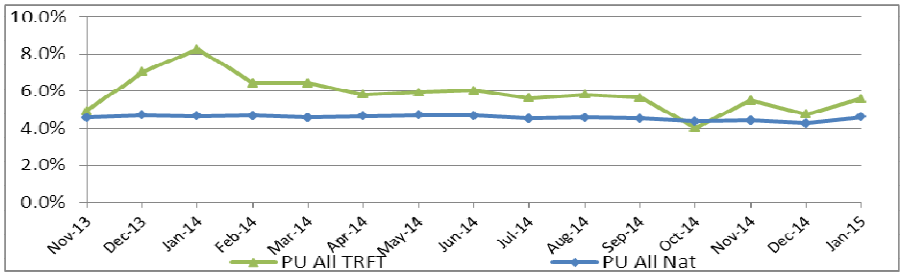
Graph indicating community & acute position separately to be added when data available

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

1. Pressure ulcers

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

Table 5

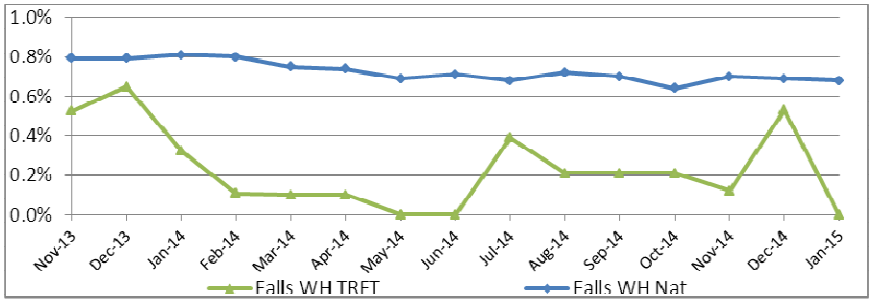


Over 2014/15 there has been a steady decline in the number of avoidable pressure ulcers occurring in both in-patient areas and patients cared for at home by TRFT community staff but while we are pleased with the progress made, the target of zero avoidable pressure ulcers has not yet been reached. The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

2. Falls

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

Table 6



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

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

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

Priority 3: <u>Achieve national waiting time targets</u>
Our aim was to:

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

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

3.2 Achieve A&E 4 hour waiting targets

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

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

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

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

3.3 Achieve 18 week wait target

Did we achieve this goal ? Yes

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

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

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

3.4 Achieve 52 week referral to treatment target

Did we achieve this goal? No

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

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

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

Priority 4: Achieve improvement in all Friends and Family Test scores

(to be updated with year end data when available)

Our aim was to achieve:

4.1 A&E - net promoter score of 75 (national average: 54)

The position at the time of reporting is **51** (year to end of February 2015 figures)
The position at the same time last year was **53**

4.2 In patient areas - net promoter score of 83 (national average: 72)

The position at the time of reporting is **72** (year to end of February 2015 figures)
The position at the same time last year was **72**

4.3 Maternity - net promoter score of 83 (national average: 82)

The position at the time of reporting is **81** (year to end of February 2015 figures)
The position at the same time last year was **77**

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

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

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

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

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

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

2.2 LOOKING FORWARD: QUALITY IMPROVEMENT PRIORITIES FOR 2015/16

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

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

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

Table 7: Quality Improvement Priorities for 2015/16

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

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

CLINICAL EFECTIVENESS

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

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

Implementation Lead: Associate Medical Director, Standards of Medical Care

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

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

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

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

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

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

Table 8

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

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

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

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

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

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

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

Implementation Lead: Director of Operations

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

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

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

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

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

PATIENT SAFETY

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

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

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

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Associate Director, Patient Safety and Risk

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

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

What will we do to achieve this?

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

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

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

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

Reduction in Trust attributed VTE

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

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

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

How will progress be monitored?

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

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

Priority 2:

Sign up to Safety

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

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

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

   Goal for 2015/16: 15% reduction from baseline

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

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

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

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

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

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

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

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

PATIENT EXPERIENCE

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

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

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

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

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

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

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

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

Priority 2

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

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

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Deputy Chief Nurse

Current position and why this is important:

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

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

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

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

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

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

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

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

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Assistant Chief Nurse: Vulnerabilities

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

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

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

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

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

Priority 4:

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

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

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Deputy Chief Nurse

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

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

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

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

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

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

2.4 STATEMENTS OF ASSURANCE FROM THE BOARD

REVIEW OF SERVICES AND INCOME GENERATED

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

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

CLINICAL AUDIT ACTIVITY

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

Table 9

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

Total number of audits 2014-15

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

Table 10

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

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

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

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

Detailed audit participation 2014-15

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

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

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

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

Review of Local Clinical Audits

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

Table 11

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTICIPATION IN CLINICAL RESEARCH

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

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

Table 12: Active Studies

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

Table 13 : Recruitment

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

Table 14 Studies currently undergoing approval

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

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

GOALS AGREED WITH COMMISSIONERS: CQUIN FRAMEWORK

To be updated for 2014/15 when available

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

(web link to be added when available)

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

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

CQC REGISTRATION AND PERIODIC REVIEWS / SPECIALIST REVIEWS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

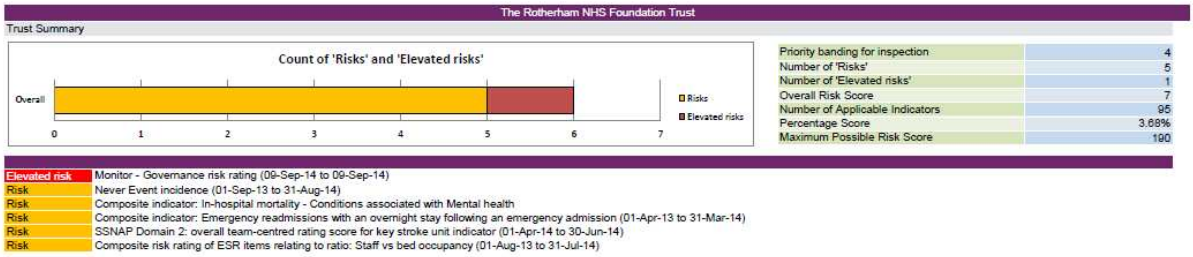
Each incident has been investigated and in March 2014 the Quality Assurance Committee reviewed progress against the action plans agreed with the clinical lead for radiology in order to be assured that internal process failures are not likely to be repeated. That assurance was obtained and the committee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

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

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

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

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



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

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

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

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

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

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

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

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

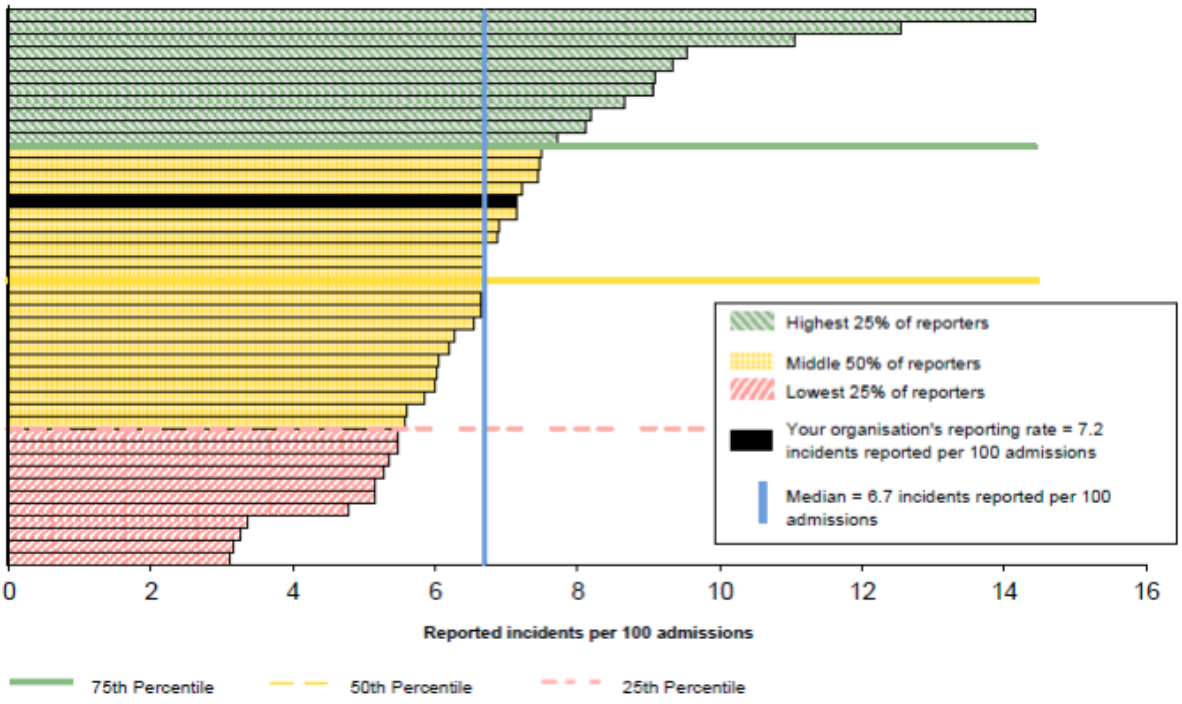
The Trust is reporting an increase in the number of serious incidents this year. The total number reported in 2013/14 was 23 and in 2014/15 was 41. This increase is due to the Trust aspirations to prevent harm. This requires zero tolerance and expectation of openness, candour and honesty in line with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

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

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

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

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



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

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

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

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

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

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

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

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

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

Table 15

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

Data Quality Index (HRG4 based)

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

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

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

Average diagnoses per coded episode

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

Information Governance

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

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

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

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

Table 16

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

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

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

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

Clinical Coding

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

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

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

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

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

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

Department of Health Mandatory Core Indicators for Acute Trusts

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

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

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

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

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

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

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

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

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

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

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

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

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

PART 3

OTHER INFORMATION – QUALITY COMMENTARY

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

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

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

PATIENT EXPERIENCE AND ENGAGEMENT STRATEGY

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

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

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

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

Elimination of mixed-sex accommodation

Executive Lead: The Board sponsor is the Chief Nurse

Implementation Lead: Deputy Chief Nurse

Current Position and why this is important:
TBC

How will progress be monitored?

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

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

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

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

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

Table 19 – final report will show figures for full year

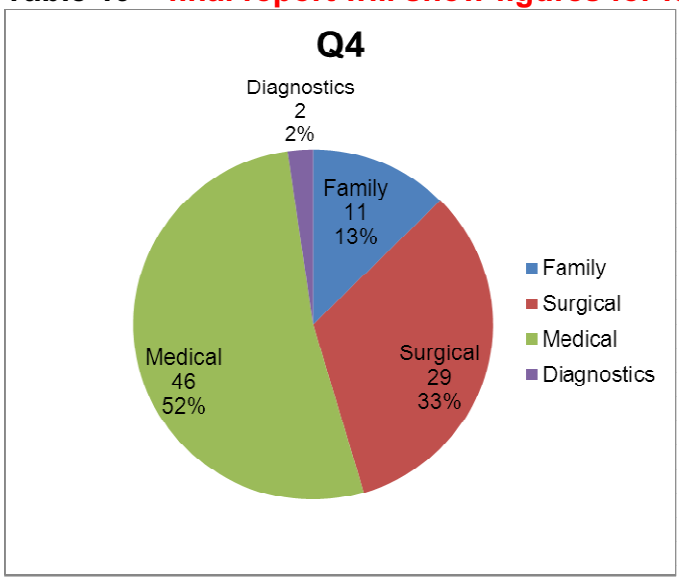
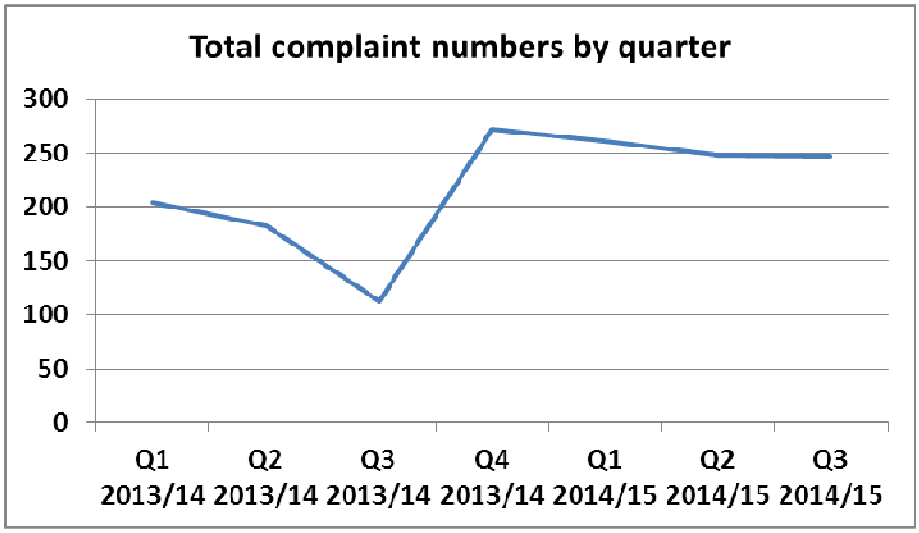


Table 20



FRIENDS AND FAMILY TEST

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

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

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

Response can be:

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

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

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

***The Net Promoter Score**

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

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

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

Table 21 (figures to January 2015)

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

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

DEMENTIA CARE

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

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

Dementia and Delirium Screening Process.

[5] Commissioning for Quality and Innovation

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

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

Effective screening processes enable the following:

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

2. Carer engagement

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

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

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

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

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

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

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

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

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

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

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

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

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

TRFT responses have included:

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

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

3. Training

A range of approaches are being utilised including:

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

Other developments:

Mental Capacity Act 2005.

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

Dementia Friendly Environments

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

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

SAFEGUARDING VULNERABLE SERVICE USERS

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

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

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

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

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

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

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

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

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

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

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

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

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

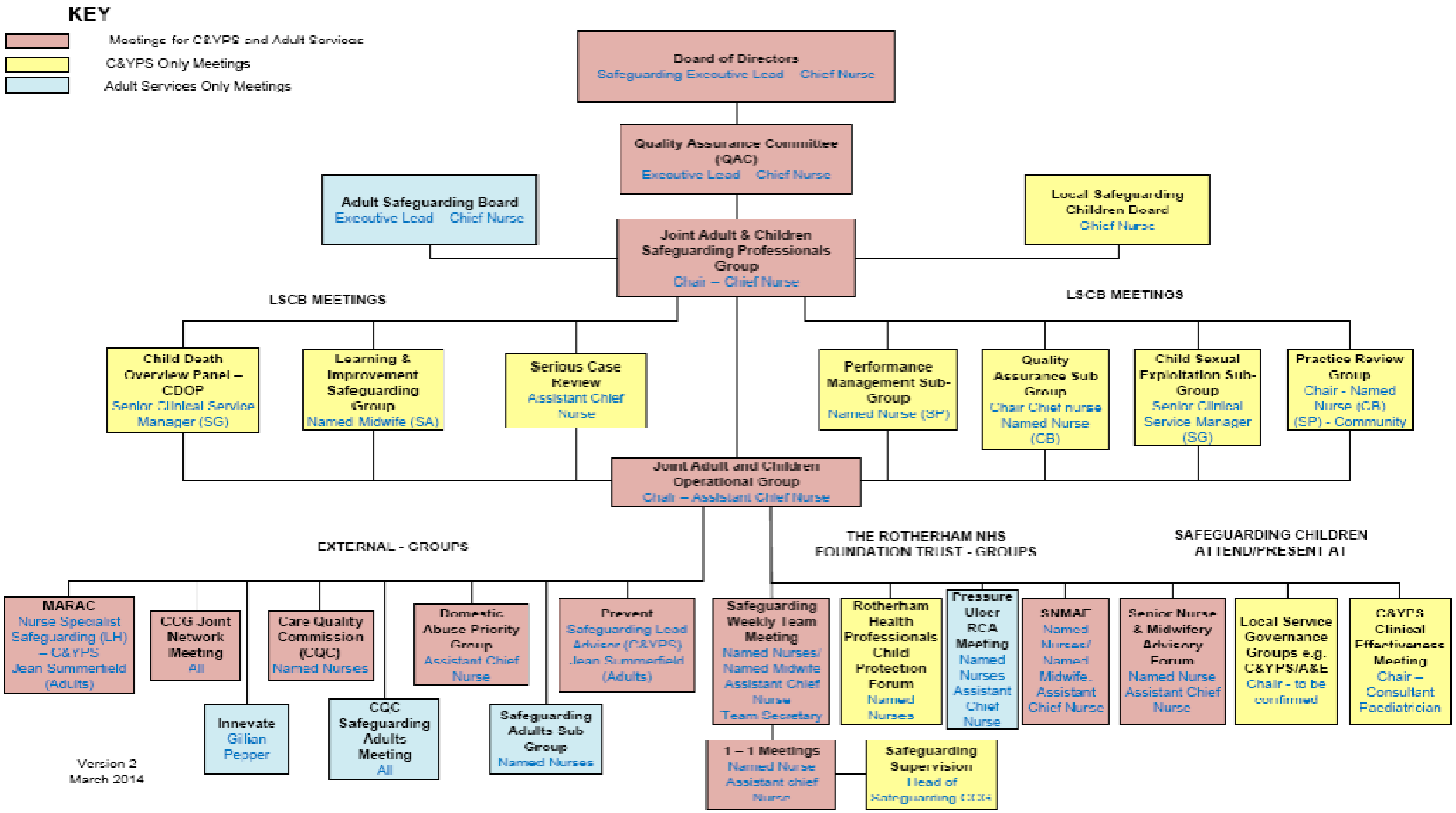
From these reviews ongoing and further improvements have been made in relation to TRFT processes regarding prevention of CSE. This includes awareness raising and training of Trust colleagues, supporting them in their understanding and awareness of how to raise concerns.

CSE is a standing agenda item on TRFT Safeguarding Groups.

The organisational structure for safeguarding is shown below.

The Rotherham NHS
NHS Foundation Trust

Joint Safeguarding Children and Adult Services – Organisational Governance Structure



Version 2
March 2014

HEALTHCARE ASSOCIATED INFECTIONS

Will be update to include year-end data when available

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

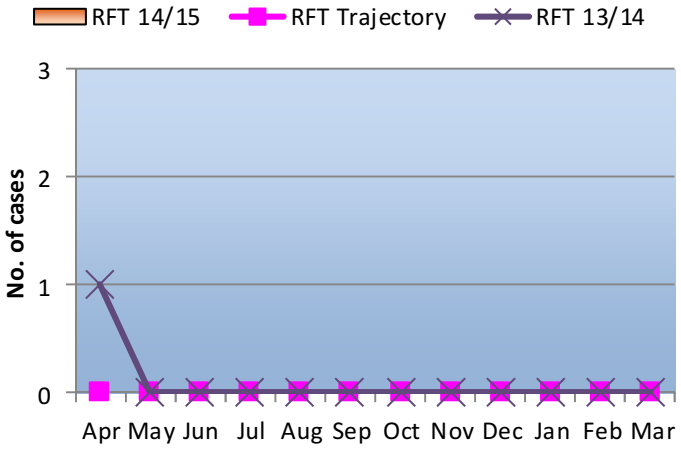
To date there have been zero cases of hospital acquired MRSA bacteraemia against a zero preventable cases trajectory. The Trust has been MRSA bacteraemia free for 21 months and indeed the case reported 22 months ago was from a blood culture contaminated sample and not a clinical infection.

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

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

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

Table 22



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

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

Table 23

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

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

Table 24

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

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

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

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

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

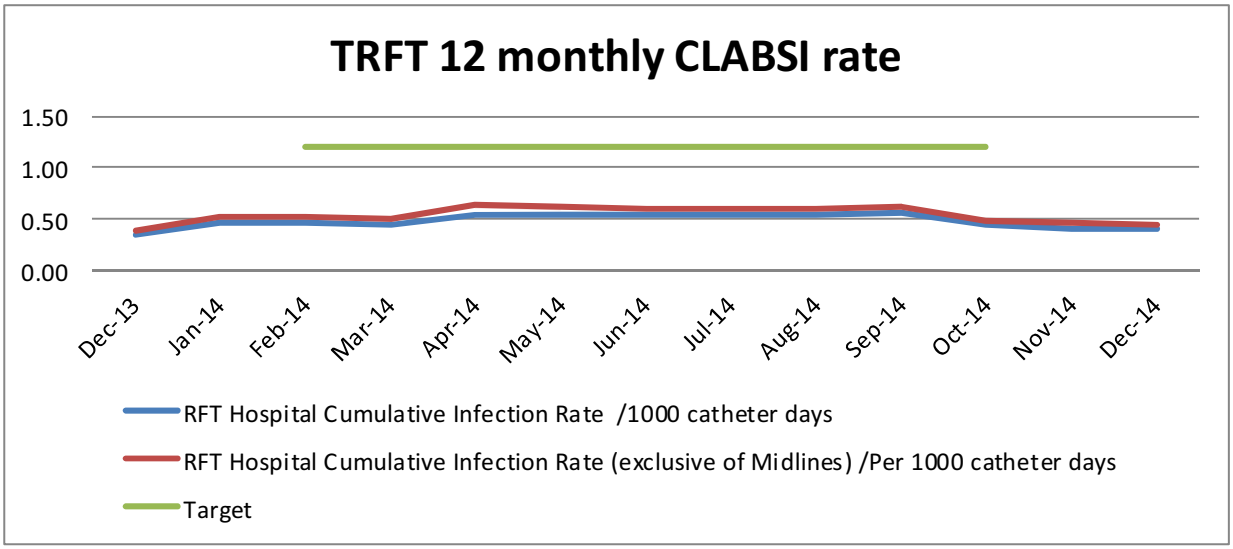
The IPC team undertook a deep dive review of cases 1-30 at the request of the Quality Assurance Committee (QAC), the review which entailed detailed analysis all risk factors associated with C diff infection, was presented by the DIPC.The conclusion was that only one of the 30 of cases was avoidable as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

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

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

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

Table 25



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

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

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

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

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

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

MORTALITY

Section will be updated when final data available and validated

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

Hospital Standard Mortality Ratio (HSMR)

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

Summary Hospital Level Mortality Indicator (SHMI)

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

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

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

Table 26

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

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

Table 27

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

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

NHS STAFF SURVEY

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

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

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

Summary of performance – NHS staff survey

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

- Response rate

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

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

- areas of improvement from the prior year and deterioration;

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

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

- top 5 ranking scores;

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

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

- bottom 5 ranking scores;

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

Table 28: Staff survey

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

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

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

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

Future priorities and targets

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

Culture

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

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

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

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

2. Compliance against Mandatory and Statutory Training (MAST)

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

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

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

Table 29

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

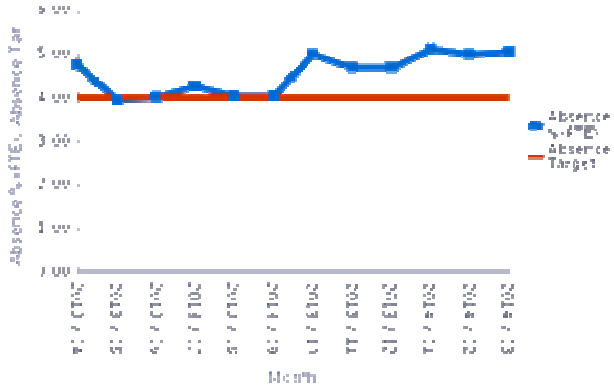
The corporate induction is changing form the 1st of April 2015 and will become days for non-clinical and 3 days for clinical staff. The induction will take place every two weeks so that the new starters are inducted in a timely manner, and will include the 11 Core MAST topics to help increase compliance.

1. Employee sickness rates

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

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

Table 30



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

NHS IN-PATIENT SURVEY

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

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

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

Position in 2014/15 - to be updated on publication

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

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

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

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

Table 31: TRFT PERFORMANCE against Patient Experience Domains

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

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

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

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

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

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

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

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

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

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

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

Table 32

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

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

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

DOH= Department of Health

MON= Monitor

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

Domain	ID	Indicator name	Rationale for monitoring	Continued focus 2015/16?
Patient Safety	PS_1	Have zero 'Never Events'	Zero target not achieved over 2014/15	yes
	PS_2	Rate of patient safety incidents/1000 admissions	Linked to 'no blame' reporting culture	yes
	PS_3	Percentage of patient safety incidents resulting in severe harm or death	Linked to 'no blame' reporting culture and Harm Free Care (NHS Safety Thermometer)	yes
	PS_4 a	Number of patients with C. Diff	On-going infection control surveillance	yes
	PS_4 b	Number of patients with MRSA	On-going infection control surveillance	yes
Patient Experience	PE_1	Increasing our responsiveness to our patients' needs using a composite indicator of care, from April 2011 baseline	Links to 'caring' objectives/on-going Trust requirement	yes
	PE_2	Increase in the number of patients assessed using the MUST nutritional tool	Important safety metric	Routine Monitoring to continue
	PE_3	Increase in the number of patients with completed (and calculated) fluid balance charts	Monitoring to continue as part of Ward2Board indicators, linked to IOFM improvement programme	Routine monitoring to continue
	PE_4	Increase in number of complaints	Focus will continue on monitoring complaints KPIs including volume but with a greater focus on quality measures, patient satisfaction and learning from complaints continue to aim for increase but to focus on the Trust's responsiveness to complaints	This specific priority in relation to complaints will not be monitored. Priorities for Quality Accounts asdetailed part 2.2

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

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

Annexe 1:

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

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

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

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

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

By order of the Board:

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

Annexe 2

Annexe: Statement on behalf of Council of Governors.
Date

Insert statement

Annexe 3: Statement from Rotherham Clinical Commissioning Group

Insert statement

Annexe 4: Statement from Healthwatch Rotherham
DATE:

Insert statement

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

Insert statement

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

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

Appendix 2: CQUIN agreed goals for 2015/16

Appendix 3: GLOSSARY

Acronyms

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

Glossary of Terms

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

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

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

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

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

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

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

Monitor
Sector regulator for foundation trusts in England.

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

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

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

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

The Secondary Uses Service (SUS)

the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services