These are the Quality Accounts for The Rotherham NHS Foundation Trust for the period 1st April 2009 to 31 March 2010.

Quality Accounts 2009/10

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During 2009/10 we have made significant progress against the four priority areas for improvement we set out in our Quality Accounts last year. These achievements are testament to the time, effort and hard work our staff have put in to improving the quality of care we provide for our patients.

I am particularly pleased about the outcome of our Falls Collaborative programme that has shown a significant and ongoing reduction in patient falls, and which was shortlisted for an HSJ national patient safety award. Through the work of our nursing staff, we have also seen a measurable decrease in the number of patients who develop pressure ulcers whilst in our care. The number of complaints the hospital receives from patients has also decreased and we are committed to a large programme of work (outlined in the report) that will further improve the experience of patients in our care.

The Trust has set out in this year’s Quality Accounts further improvement programmes that focus on improving nutritional care, making sure we have less patients who suffer blood clots and we aim to see further reductions in all hospital acquired infections. We are well on the way with the implementation of our Electronic Patient Record system which will provide enormous benefits to clinical decision making ensuring we have all information about our patients in the right place at the right time.

Our Quality Strategy continues to build the capability and performance of all our staff; improves our reporting and monitoring processes, and increases our capacity to ensure that we drive improvement in the quality of services we deliver.

I would like to take this opportunity to thank and congratulate all our staff in their achievements over the past year. May I also extend my appreciation to our Governors, Members and other stakeholders who continue to take an active and participative role in guiding the organisation and grounding our aspirations to ensure that we stay close to what really matters to our patients.

Brian James
Chief Executive
During 2009/10 the Rotherham Foundation Trust sub-contracted services for the Trauma and Orthopaedics service. The total value of the sub-contracted activity was £265,768 which represents 0.17 per cent of the trusts total contract value (£157m).

The Rotherham Foundation Trust has reviewed all of the data available to them on the quality of care of these NHS services.

The Directors are required under the Health Act 2009 and The National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

In preparing the accounts, directors are required to take steps to satisfy themselves:

- The Quality Accounts present a balanced picture of the NHS foundation hospital’s performance over the period covered.
- The performance information reported in the Quality Accounts is reliable and accurate.
- There are proper internal controls over the collection and reporting measures of performance included in the Quality Accounts, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Accounts have been prepared in accordance with relevant requirements and guidance issued by Monitor.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Accounts.

By order of the Board.

Margaret Oldfield  
Chairman

Brian James  
Chief Executive

2 June 2010
Looking after patients and ensuring they receive the best care possible is Rotherham NHS Foundation Trust’s core business. The Trust aims to provide a safe and healing environment for patients and has put in place measures to monitor the quality of care provided. The Trust is committed to improving the quality of healthcare services and being accountable to the public it serves. These Quality Accounts provide an overview of our achievements against our quality measures so that our patients can see how we are developing care and how they can influence that.

The Annual Report in 2008/9 set out the Trust’s organisational aspirations on quality patient experience and effectiveness and this had been central to our approach to work with patients, Members, Governors and other key stakeholders throughout the year. They have been invited to agree approaches based on what matters most to them. The results from last year have also been shared with them and they have been encouraged to challenge the Trust’s systems and processes and to agree this years quality improvement programme of work. Through engagement with patients, staff, Governors, Members, and other key stakeholders we have worked hard to implement a quality strategy at all levels of the hospital. The Trust set out its aim of developing and embedding structures and processes that would support the delivery of the strategy. It also helped to build the capacity and capability of the organisation in delivering high quality care for all patients. Progress in these areas is set out below.

Our Approach to Improving the Patient Experience

In 2008 the hospital started a three year patient experience strategy. This focussed on three areas of work:

- Improving clinical quality through a programme of Practice Reviews
- Developing leadership and changing the culture through ‘Being with Patients’ - a programme which helped staff to better understand the patient experience and see where improvements could be made
- Feedback for improvement – putting in place ways to find out what patients think of their care whilst they are with us and collecting patient feedback through the Patient Experience Tracker

Practice Reviews

The systematic use of practice reviews (all adult general wards reviewed by March 2010) enables us to provide assurance to the Board of Directors and senior clinical staff of the standard and the quality of patient care that is provided. The practice reviews share and commend good practice - if areas of concern are identified support will be provided to improve the ward.

During the practice reviews a number of ‘tools’ are used to help the Trust understand the standards of care:

- An audit of ten randomly selected notes - five from patients who are no longer in hospital and five from patients currently using the service
- Observations of care over three different days and time of day
- An audit of shift handover on two different days
- A review of all incidents and complaints in the last year
- Review of duty rotas for the last six months to ensure correct staffing numbers and skill mix
- A review of nurses professional development of staff in the last year
- A discussion with designated shift leaders with regards their supervision of patient care
- A discussion with other departments/professionals who regularly interact with the area with regards the strengths and development needs of the ward team
- Analysis of patient feedback collated on a regular basis and through talking to patients and their relatives during the week of the practice review.
Being with Patients

The ‘Being with Patients’ programme uses patients’ experiences of care to positively influence understanding of what it means to be a patient in the hospital. It provides an opportunity for all staff to:

- Reflect on their contribution to patient care and feel valued for the caring behaviours they demonstrate
- Promotes achievement of practical skills to enhance patients’ experiences of care.

We have run ten ‘Being with Patients’ sessions during 2009/10 and there has been real excitement about the programme that has seen attendance from across the organisation including Board of Directors, doctors, nurses, clerical and support service staff.

There is no doubt that staff support the concept of being person or patient centred yet the experiences of patients suggest that this is something that the Trust doesn’t always get right. The concept of ‘being with’ is used to emphasise that ‘how we are’ is as important as ‘what we do’. The ‘Being with Patients’ approach uses actors to both convey how patients have experienced care and is much more about ‘learning in and from practice’ than the usual approach to training. To find out more about the ‘Being with Patients’ programme visit this website: www.beingwithpatients.nhs.uk

The Patient Experience Tracker

Using the electronic Patient Experience Tracker we have developed a small number of patient experience questions (same questions as used in the National Inpatient Survey) against which we collect feedback. The Tracker is regularly used on the wards and departments so that we have a record of patients’ views on the care they receive whilst in Rotherham Hospital.

So far more than 4,470 patients have told us about the care they have received and this is providing real-time data, allowing the Trust to address the issues of care or service more promptly than waiting for the results of the one a year Inpatient survey.

Some of the results the Trust has seen are shown below:

If a friend or family member required hospital services would you recommend The Rotherham NHS Foundation Trust? (total number of patients polled: 1014)

Learning from complaints and incidents

Learning how we can improve what we do and provide better care is central to our approach to managing feedback and complaints. Listening, learning and taking the right action is key and we have designed our procedures to ensure we are approachable and responsive.

The hospital reviewed its complaints procedure in April 2009 in line with new national legislation. Whilst the timescales of responding to complaints have been removed we wanted to ensure that we continued to build on our approach of meeting the individual needs of each complainant in a way that was best for them and this could be through telephone calls, face to face meetings or if they wished purely through letters.

The number of formal complaints, concerns and comments received, which now includes those that would have come via the previously separate Patient Advice & Liaison Service (PALS), for 2009/10 was a reduction by 184 on the previous year from 832 to 648.

The Trust’s web based patient safety incident reporting system is now fully operational and an increase has been seen in the number of incidents reported - this reflects an organisation that wishes to learn from incidents. The Trust has introduced ‘Learning Events’ from serious incidents and monitors all action plans to make sure the risk of the same incident happening again is reduced. Some examples of the work include: introducing additional training for junior doctors in prescribing, developing new falls and pressure ulcer assessments, buying low beds (which lower completely to the floor) to reduce the risk of patients falling, introducing medical checklists and new screening procedures for infection control.

Getting the most from the Patient environment

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to providing every one of our patients with same sex accommodation, because it helps to safeguard their privacy and dignity at a time when they could be most vulnerable.

The Trust’s aim is that all patients who are admitted to our hospital will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex should only happen by exception based on clinical need, for example, in the Intensive Care Unit (ICU).

The hospital was required to declare publicly on its website its position with regards to same sex accommodation and the Trust was able to declare this compliance in all areas apart from Day Surgery and a plan has been put in place to ensure complete compliance by June 2010.
Patient Reported Outcome Measures (PROMs)

PROMs are measures of a patient’s health status or health-related quality of life prior to a surgical procedure. PROMs are typically short, self-completed questionnaires, which measure a patient’s health status or health related quality of life at a single point in time.

From April 2009 all hospitals were required to ask patients to complete questionnaires with regards to their pre-operative health for four common surgical procedures (hip replacement, knee replacement, varicose vein surgery and groin hernia repair).

The hospital has been told that of the 100 per cent of patients asked in each procedure group, the returned surveys showed a response rate as follows:

- Hips: 59 per cent
- Knees: 58 per cent
- Varicose Veins: 25 per cent
- Groin Hernia: 37 per cent

The results of the follow up survey of these respondents will be available to the hospital later in 2010.

‘Ward to Board’ Clinical Quality Indicators

Work has been ongoing in developing ‘Ward to Board’ clinical quality indicator dashboards – these are charts which show how a ward is performing against a set of specific measures. The indicators or measurements include the Patient Experience Tracker data, PROMs, the number of patient safety incidents, whether or not the correct assessments are being done on patients all of the time e.g. checking their nutritional status, whether they are likely to fall. The dashboards tell staff if they are improving in all areas that are important to keep patients safe and give them high quality care.

Going forward the Electronic Patient Record system, currently being implemented, will provide immediate and comprehensive data to support all quality improvement activities. The hospital has also ensured that the data is of a high quality and checked through a quality assurance process prior to reporting.

The Trust is confident that reports are being produced for frontline staff and managers that add value, accurately inform improvement priorities and provide evidence of progress or concerns across the hospital in relation to the quality agenda.

Performance monitoring at Clinical Service Unit level

A key development to support the quality framework is the transfer of responsibility for performance and quality to the clinical service units (directorates). The Quality Accounts and performance information are shared at monthly meetings chaired by the Chief of Rotherham Hospital, with Clinical Directors and clinical service unit staff. The purpose of the meetings is to discuss issues, identify required support and monitor improvements. One of the benefits of this approach is that the operational services identify their work priorities. The success of this approach will be reported in future Quality Accounts.
### The Assurance Unit

The Assurance Unit was set up for a 12 month pilot period which started in July 2009. The role of the Assurance Unit is to look at different areas of work within the hospital and check the way in which we are doing things, highlight areas where we are doing things well, and areas where we need to do things better.

The Assurance Unit is made up of a core ‘validation team’ and a virtual team of people who support the assurance process across the hospital. In the short time since it began the Unit has already made a significant impact upon the assurance provided to the Board of Directors in many areas. In-depth audits have given an objective assessment of areas including the Hygiene Code; Medical Devices (equipment) and Equality and Diversity. These audits have led to the creation and implementation of improvement action plans which are monitored by the Audit and Assurance Committee.

The Trust’s Quality Assurance and Improvement Forum acts as the quality committee that draws in expertise from the validation team and all assurance functions across the hospital, such as, information, performance, risk management, patient safety, clinical effectiveness and audit activities. In addition to ‘people intelligence’ it also collects information from data sources across the hospital to support governance functions, identify areas for improvement and future work programmes for the validation team.

A workshop which was devised and run by members of the Quality Assurance and Improvement Forum (QAIF) explained to key staff members the importance of data quality; the vital nature of robust checking processes. This led to two further actions to improve the quality of data access to managers and their ability to compare their performance against that of other hospitals. The Assurance Unit’s impact upon assurance and improvement processes within the hospital was recently acknowledged when the business case to move the unit from pilot status to a permanent establishment was approved. The Unit is now focussing on the development of its Operational Plan for 2010/11.

#### Building capacity and capability

Quality Improvement Teams, which includes nurses, physiotherapists and clerical staff, have been introduced at ward level – the next step is to involve doctors. The teams have undergone training in patient safety, patient experience, change management and measurement for change. Each ward has an annual programme of work set out. The programme links to the Trust’s improvement activities for this year and includes two areas that the wards feel they need to improve on. The teams are being supported by the Quality and Standards team and the Service Improvement team. Progress is being measured and monitored through the ward to board reporting process.

The Assurance Unit, Ward to Board reporting that links to quality improvement teams at ward level all fit together to provide and support our culture of continuous quality improvement.

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### In 2008/9 the Board of Directors agreed four key priority areas for improvement, based on national priorities, information and data from a number of internal and external sources, including patients and key stakeholders, they were:

**Priority 1** Reducing our mortality rate
**Priority 2** Reducing the number of patients who fall whilst in our hospital
**Priority 3** Increasing the number of Inpatient survey questions in which our hospital is in the top 20 per cent
**Priority 4** To reduce the incidence of pressure ulcers acquired in our hospital

**Priority 1** Reducing our mortality rate

Rationale for Selection of Improvement Initiative: The hospital whilst not an outlier in terms of mortality has set out its ambition to reduce its standardised mortality rate in line with the best hospitals to 85 by 2011.

The national average mortality rate is a 100. If a hospital has a mortality rate of over a 100 then this means that more patients than expected, for a hospital of this size, are dying whilst in the Trust’s care. If the rate is below a 100 then this means that less patients than expected are dying in the hospital. The rate is calculated using different formulas by different information providers. We contract CHKS as our provider.

#### Mortality trending

<table>
<thead>
<tr>
<th>Month</th>
<th>Mortality Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>February 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>March 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>April 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>May 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>June 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>July 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>August 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>September 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>October 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>November 2009</td>
<td>1.85</td>
</tr>
<tr>
<td>December 2009</td>
<td>1.85</td>
</tr>
</tbody>
</table>

**3 year pooled 08/07, 07/08, 08/09**

**Last complete financial year 08/09**

**Rolling year January to December 2009**

**Latest quarter to December 2009**

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### Risk Adjusted Mortality Index (RAMI 2008)

<table>
<thead>
<tr>
<th>Trust</th>
<th>08/07</th>
<th>07/08</th>
<th>08/09</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>07</td>
<td>80</td>
<td>82</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Peer</th>
<th>08/07</th>
<th>07/08</th>
<th>08/09</th>
<th>08/09</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95</td>
<td>81</td>
<td>72</td>
<td>71</td>
</tr>
</tbody>
</table>
We use this information on a regular basis in the Trust’s mortality review process so that comparisons can be made between Rotherham Hospital and other hospitals of the same size and also all other hospitals in the United Kingdom. The mortality rate used from CHKS is the risk adjusted mortality index (RAMI). Between April 08 and March 09 the RAMI was 107. For the six months April 09 to September 09 (the most recent figures) the RAMI reduced to 94. The Trust has therefore improved its performance compared to previous performance.

Compared to other hospitals nationally, based on Dr Foster mortality data, Rotherham Hospital is moving towards a Hospital Standardised Mortality Rate of 100. This is probably because there has been a continuing increase nationally in the amount of data collected relating to co-morbidities (different diseases) as clinical understanding of clinical coding requirements and involvement of clinicians in the depth of coding process improves. This has been identified as a problem in Rotherham and may affect the published mortality rates. The mortality rate used from CHKS is the risk adjusted mortality index (RAMI). Between April 08 and March 09 the RAMI was 107. For the six months April 09 to September 09 (the most recent figures) the RAMI reduced to 94. The Trust has therefore improved its performance compared to previous performance.

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Priority 3
Increasing the number of Inpatient survey questions in which our hospital is in the top 20 per cent

The National Inpatient Survey data for 2008/9 showed that the hospital had no areas in the worse 20 per cent of performance and in 19 areas was in the top 20 per cent of performance nationally. The Trust hoped to see this performance improve in the 2009/10 annual survey. Unfortunately this did not happen and the hospital was in the top 20 per cent in only 15 areas.

Results of the National Inpatient Survey 2009/10
The results of the National Inpatient Survey were published on the 19th May 2010, from a sample of 436 patients (53 per cent response rate) who were cared for at this hospital in August 2009. This survey provided the Trust with an insight into practice and the care provided and will form the basis of ongoing work in the patient experience committee.

The Care Quality Commission looks at a grouping of 10 themed question areas to give an overall score and the hospital has been shown to be the same as last year.

Year on year comparison of how the Trust performed

<table>
<thead>
<tr>
<th>Theme</th>
<th>2008 Score out of 10</th>
<th>2009 Score out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The emergency / A&amp;E department, answered by emergency patients only</td>
<td>8.00</td>
<td>7.49</td>
</tr>
<tr>
<td>Waiting lists and planned admissions, answered by those referred to hospital</td>
<td>7.10</td>
<td>7.21</td>
</tr>
<tr>
<td>Waiting to get a bed on a ward</td>
<td>8.50</td>
<td>7.72</td>
</tr>
<tr>
<td>The hospital and ward</td>
<td>7.50</td>
<td>7.67</td>
</tr>
<tr>
<td>Doctors</td>
<td>8.50</td>
<td>8.40</td>
</tr>
<tr>
<td>Nurses</td>
<td>8.40</td>
<td>8.23</td>
</tr>
<tr>
<td>Care and treatment</td>
<td>7.70</td>
<td>7.42</td>
</tr>
<tr>
<td>Operations and procedures, answered by patients who had an operation or procedure</td>
<td>8.70</td>
<td>8.60</td>
</tr>
<tr>
<td>Leaving hospital</td>
<td>7.10</td>
<td>6.90</td>
</tr>
<tr>
<td>Overall views and experiences</td>
<td>6.50</td>
<td>6.39</td>
</tr>
</tbody>
</table>

For more information about these scores and this survey, visit the Care Quality Commission website at www.cqc.org.uk.
The 5 National Commissioning for Quality and Innovation (CQUIN) questions and how they compare to 2008/09 and top 20 per cent of NHS Trusts are outlined in the chart below. The hospital has achieved the top 20 per cent in 7 areas and compared to 2008 the Trust has improved or remained the same in 10 questions. The Trust has improved with one of the ‘Vital signs’ questions which relates to same sex sharing toilet facilities.

National NHS Inpatient Survey 2008/2009 comparisons

With the National Inpatient Survey we also receive feedback on what patients want to tell us with regards to what is good and what could be improved. Here are some of our patient comments:

- The Nurses and Doctors were fantastic.
- I don’t think I could have received any better treatment.
- I’ve been in hospital twice now and I can’t fault the treatment I’ve received.
- I felt safe and well looked after.
- I had a problem waiting for my prescription to be delivered. I had to collect it the following day. This could have been improved.
- Yes, customer patient care training for Nurses and Consultants.
- Single sex wards are preferable. Bathing facilities could be improved - not enough.

Priority 4
To reduce the incidence of pressure ulcers acquired in our hospital by 50 per cent from Quarter 3 2008/09 baseline by 31 March 2010

The specialist nurse in pressure ulcer (bed sore) prevention has worked with nursing staff on all of the wards to implement a quality improvement initiative based on the outcome of investigations into the development of pressure ulcers. The programme included the development of a hospital wide pressure ulcer care plan, increased ward level training programmes, study days for ward managers and link nurses, standard systems of work for pressure care both on the wards and in clinical treatment areas. In addition pressure ulcers were audited on a weekly basis and for all pressure ulcers of Grade 3+ a full investigation (root cause analysis) was undertaken. The Intensive Care unit are developing a specific care plan for their patients.

Table 1 identifies the reduction in numbers of pressure ulcers across different grades of pressure ulcer and also the cost of caring for patients (using NHS Institute for Innovation and Improvement 2010 efficiency tool) and the savings to the hospital following these reductions.

<table>
<thead>
<tr>
<th>Grade</th>
<th>08/09 Q3 Costs</th>
<th>09/10 Q3 Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>£14k</td>
<td>£12k</td>
</tr>
<tr>
<td>2</td>
<td>£401k</td>
<td>£197k</td>
</tr>
<tr>
<td>3</td>
<td>£70k</td>
<td>£104k</td>
</tr>
<tr>
<td>4</td>
<td>£43k</td>
<td>£0k</td>
</tr>
</tbody>
</table>

Totals: £528k - £219k

The calculations demonstrate a total decrease of 48 per cent in pressure ulcer incidents and reflect a significant reduction in patient harm and discomfort. Although the target set in 2008/9 was a 50 per cent reduction, this is still a major achievement. It also represents a cost saving for the hospital of £309,000 per year, finances that can be directed towards further improvements in patient experience.
Quality Payments 2009/10: National, Regional and Local Quality Indicators

The Commissioning for Quality and Innovation payment framework (CQUIN) sets out a contractual arrangement, agreed by hospitals, against a set of quality indicators. A proportion of the Trust’s income is conditional on meeting the targets set out in this contract. In 2009/10 the hospital earned payments from the Commissioning for Quality and Innovation at the rate of 0.5 per cent of contract value £772,500 following submission of quarterly data to provide evidence of measurement of the agreed quality indicators. The table below sets out the key national, regional and local indicators that we are being measured against.

**Indicator 1**  
Reduce avoidable death, disability and chronic ill health from preventable causes

**Indicator 2**  
Improve responsiveness to the personal needs of patients

**Indicator 3**  
Movement towards improvement in delivery of maternity services including a reduction of stillbirth rates, unexpected admissions and C-section rates

**Indicator 4**  
Patients and carers can be expect the highest possible standards of end of life care

**Indicator 5**  
Reduce the length of stay in hospital, reduce readmission rates and improve patient outcomes

**Indicator 6**  
Reduce mortality rates, increasing rates of percutaneous coronary intervention as first line treatment, quicker arrival to procedure times, reduction in rates of re-infarction, Regional lower rates of Venus Thrombosis

**Indicator 7**  
Improve the focus on the care of the patients, in line with Essence of Care

**Indicator 8**  
Improved inpatient pressure ulcer prevention and management in line with Essence of Care

More details about the national, regional and local indicators and the Trust’s baseline measures are set out in Appendix 1.

All of the CQUIN national, regional, local indicators and hospital improvement indicators (including those selected by our patients and staff) are included in our ‘Ward to Board’ Quality Accounts reporting and monitoring framework.

**Our performance against our selected Quality Indicators 2008/09**

The Annual Report in 2008/09 set out a number of quality indicators that the Trust wanted to measure and improve on in 2009/10. The indicators were divided into patient safety, patient experience and clinical quality of care. The Trust also wanted to measure ‘culture’ and the quality of our data and information. The indicators for ‘culture’ provide the organisation with a measure of staff satisfaction, whether or not it is providing them with the required training and how confident they feel in reporting patient safety incidents. In addition without accurate data and information then the Trust may not be focusing its resources and improvement effort in the areas that need them the most.

<table>
<thead>
<tr>
<th>Quality Indicators 2008/09</th>
<th>Targets</th>
<th>Change in year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee sickness rates</td>
<td>2008/09 target 6.5%</td>
<td>2009/10 achieved 1% reduction</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>2008/09 Top 20% for 2040 ques</td>
<td>2009/10 Top 20% for 2540 ques</td>
</tr>
<tr>
<td>Staff Satisfaction Survey</td>
<td>Top 20% for 2040 ques</td>
<td></td>
</tr>
<tr>
<td>Increased INV reporting to mid percentile by 2009/10</td>
<td>2008/09 2 per 100 admissions</td>
<td>2009/10 5.7 per 100 admissions</td>
</tr>
<tr>
<td>All applicable staff have in year PDR</td>
<td>2008/09 target 100%</td>
<td>2009/10 66% of all staff received PDR</td>
</tr>
<tr>
<td>All staff receive mandatory and statutory training</td>
<td>Not available due to data quality issues</td>
<td></td>
</tr>
<tr>
<td>Reduction in patient falls 1000 admissions by 40%</td>
<td>2008/09 falls from height 6.3/1000</td>
<td>2009/10 falls from height 4.2/1000 Falls same level no change</td>
</tr>
<tr>
<td>Reduction in medication errors 100,000 prescriptions</td>
<td>2008/09/10 42/100,000 dispensing episodes</td>
<td>2009/10 : 9 /100,000 dispensing episodes (new robotic dispensing system introduced)</td>
</tr>
<tr>
<td>Reduction in hospital acquired MRSA</td>
<td>2008/09 : 4 MRSA cases</td>
<td>2009/10 : 9 MRSA cases</td>
</tr>
<tr>
<td>Reduction in patients with Cdiff / 10,000 bed days</td>
<td>2008/09 : 54 cases (2.75 per 10,000)</td>
<td>2009/10 : 42 cases (2.17 per 10,000)</td>
</tr>
<tr>
<td>Never Events that occur within the Trust</td>
<td>Target 2008/09 : 0 Never Events</td>
<td>2009/10 : 0 Never events</td>
</tr>
<tr>
<td>Reduction in hospital acquired pressure ulcers</td>
<td>Target 50% reduction from q3 2008/09</td>
<td>Reduction 48% Q3 2009/10</td>
</tr>
<tr>
<td>Reduction in hospital mortality rate</td>
<td>RADD = 107 2008/09</td>
<td>RADD = 94 2009/10</td>
</tr>
<tr>
<td>HSMR 99</td>
<td>2008/09 = 7.3%</td>
<td>2009/10 = 7%</td>
</tr>
<tr>
<td>Reduction in unplanned admission rates within 28 days</td>
<td>2008/09 = 5.2%</td>
<td>2009/10 = 5%</td>
</tr>
<tr>
<td>Division for hip replacements increase in management line with evidence based practice</td>
<td>Target 2008/09 : not collected</td>
<td>2009/10 = ALL elements Current:88.6%,98.8%,95.8%</td>
</tr>
<tr>
<td>Statistical records coded to ICD 10 and OPCS 4 Level</td>
<td>2008/09 = 2.3 (negative end of national scale)</td>
<td>2009/10 = 2.4 (negative end of national scale)</td>
</tr>
</tbody>
</table>

**Table 1: The Rotherham Foundation Trust**
Our Performance against national priorities

Care Quality Commission (CQC) Annual Health Check
The CQC ratings include assessment of the quality of services delivered in Rotherham Hospital and how the Trust manages finances and gives value for money. For the second year running the hospital was awarded a ‘double excellent’ rating from the Care Quality Commission in the annual health check ratings.

Core standards declaration for 2009/10
The hospital core standards declaration for the first six month of 2009/10 was submitted in time to meet the 7 December 2009 deadline and full compliance with the Standards for Better Health was recorded. Subsequently, the Board of Directors submitted a full year declaration of insufficient assurance for the Care Quality Commission core standard that related to Information Governance, specifically to data mapping and the encryption of CD Roms used to send individual patient’s x-rays to other hospitals or solicitors. This matter was resolved in line with the agreed action plan with the Care Quality Commission by 31 March 2010.

Care Quality Commissions (CQC) Registration procedure
The Board of Directors continued to monitor our compliance position as the Core standards were replaced by the Essential Standards of Quality & Safety which supported the move to the new registration process.

The new registration procedure requires the hospital by law, to register with the CQC, to show that we are meeting the new essential standards set. These essential standards include quality and safety domains across all of the services that we provide across the whole hospital. The essential standards cover:

- Involvement and information
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

The hospital applied for registration with the CQC during January 2010 and was registered successfully ‘without conditions’ in March 2010. This means the CQC agree the Trust is an organisation that has shown it has met all of the essential standards and that systems are in place to make sure continued compliance. The Assurance Unit will support the Trust by carrying out an increased range of audits as well as a programme of unannounced visits across the Hospital. These activities will be designed to provide increased confidence to the processes for ensuring the essential standards across the hospital are met and improved upon.

<table>
<thead>
<tr>
<th>National Priorities 2009/10</th>
<th>Year end position</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Genito Urinary Medicine Clinic</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Clostridium difficile infection</td>
<td>42 cases</td>
<td>133 cases</td>
</tr>
<tr>
<td>MRSA</td>
<td>9 cases</td>
<td>12 cases</td>
</tr>
<tr>
<td>Delayed transfers of care</td>
<td>3.16%</td>
<td>3.50%</td>
</tr>
<tr>
<td>Infant health &amp; inequalities: breastfeeding initiation</td>
<td>59.24%</td>
<td>58%</td>
</tr>
<tr>
<td>Nobody waits more than 18 weeks from GP referral to treatment</td>
<td>96% Admitted Patients</td>
<td>90% Non-Admitted Patients</td>
</tr>
<tr>
<td>Percentage of patients waiting less than 4 hours in A&amp;E</td>
<td>98.66%</td>
<td>98%</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>1.03%</td>
<td>0.69%</td>
</tr>
<tr>
<td>Percentage of patients seen within two weeks of urgent GP referral or suspected cancer for outpatient appointment with a specialist</td>
<td>97.50%</td>
<td>93%</td>
</tr>
<tr>
<td>Percentage of patients beginning treatment within 1 month of a cancer diagnosis</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Percentage of patients treated within 2 months of referral</td>
<td>90.20%</td>
<td>85%</td>
</tr>
<tr>
<td>Proportion of patients with breast symptoms, not suspected of cancer, referred to a specialist who are seen within two weeks of referral</td>
<td>95.10%</td>
<td>93%</td>
</tr>
<tr>
<td>Percentage of patients treated within 2 months of Consultant Upgrade</td>
<td>97.40%</td>
<td>Not yet set</td>
</tr>
<tr>
<td>Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery)</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (Chemotherapy)</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less than 62 days from referral to treatment</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Outpatients seen within 13 weeks of a GP written referral</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients waiting less than 6 months for an inpatient procedure</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of patients with new onset chest pain thought to be angina seen in a RACPC within 2 weeks of referral</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of women who have been a midwife or a maternity healthcare professional by 12 completed weeks of pregnancy</td>
<td>90.17%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of patients who spend at least 80% of their time on a stroke unit</td>
<td>71.31%</td>
<td>70%</td>
</tr>
<tr>
<td>Percentage of higher risk TIA cases who are scanned and treated within 24 hours</td>
<td>42.59%</td>
<td>45%</td>
</tr>
</tbody>
</table>
Monitor compliance framework/risk ratings 2009/10

The Trust submits quarterly declarations to Monitor for Finance, Governance and Mandatory Services. Monitor reviews the declaration and issues a quarterly risk rating for each element.

The Finance rating is based on the Trust’s financial performance in the quarter against the Annual Plan. The risk rating is on a scale of 1 to 5 with 5 being the lowest risk.

The Governance rating (Red, Amber or Green) is based on the Trust’s self declaration against the following areas:

- Compliance with their constitution
- Growing a representative membership
- Maintaining appropriate Board structures
- Co-operating with other NHS bodies
- Risk Management
- Service performance and continuing improvement in clinical quality

The Mandatory Services rating (Red, Amber or Green) is based on the Trust providing the services listed in its Terms of Authorisation. In 2010/2011, Monitor’s governance ratings system will change to Red, Amber/Red, Amber/Green, Green. The Trust is confident that its Monitor risk ratings at the end of the 2009/10 year will be:

Finance  4
Governance  Green
Mandatory Services  Green

The tables below show detailed analyses of the quarterly reporting to Monitor, as referred to in the text. They are featured for comparison purposes as required by Monitor.

Table 1 features ratings for the four quarters of 2008/09, compared with the Trust’s expectation at the beginning of the year in the Annual Plan. Similarly, Table 2 provides quarterly ratings for 2009/10, plus the expectation in the Annual Plan.

Table 1

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial risk rating</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Governance risk rating</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Mandatory services</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan 2009/10</th>
<th>Quarter 1 2009/10</th>
<th>Quarter 2 2009/10</th>
<th>Quarter 3 2009/10</th>
<th>Quarter 4 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial risk rating</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Governance risk rating</td>
<td>G</td>
<td>G</td>
<td>A</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Mandatory services</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>
Periodic reviews
The hospital was not subject to any periodic reviews by the Care Quality Commission during the year 2009/10.

Care Quality Commission Investigations
In December 2009 the Trust was asked by the CQC to investigate its mortality data in two areas (peripheral and visceral atherosclerosis and pleurisy, pneumothorax, pulmonary collapse) to identify why it had a small increase in patients dying from pleural effusion and vascular disorders.

The Director of Clinical Effectiveness and a senior group of doctors and nurses reviewed the health records of all the patients identified and provided a full report to the CQC. At the time of writing the Trust has had notice that in one area there was not an issue and this has been closed (pleurisy, pneumothorax, pulmonary collapse) – the outcome of the second review is still awaited.

Following the investigation the Trust initiated a number of actions, two of which are:
- An improvement programme for coding and documentation
- A further look at our mortality review process

These actions are now in progress and changes to the mortality review reporting forms to capture more accurately the primary diagnosis is complete.

Quality of Data
The hospital submitted records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data that included the patient’s valid NHS number was 96 per cent for admitted patient care; 97 per cent for outpatient care; and 86 per cent for accident and emergency care.

The hospital has invited PriceWaterhouseCoopers (PWC) as internal auditors to check data quality in three areas: those of 18 week wait, MRSA Bacteraemias and cancer waiting times. PWC have advised that having regard of both internal and external data that is manually validated through a number of systems that they believe the data to be a ‘true and fair’ representation.

Episodes Statistics which are included in the latest published data. The percentage of records in the dataset where the primary diagnosis code was correctly entered was 85 per cent. The percentage of records in the dataset where the primary procedures coded correctly was 91 per cent. The percentage of records in the dataset where the secondary procedures coded correctly was 94 per cent. The percentage of records in the dataset where the primary diagnosis code was incorrectly entered was 12.7 per cent. The percentage of records in the dataset where the secondary procedures coded incorrectly was 9.5 per cent. The percentage of records in the dataset where the primary procedures coded incorrectly was 12.7 per cent. The percentage of records in the dataset where the secondary diagnosis coded incorrectly was 22.4 per cent.

Payment by Results
The Payment by Results (PbR) 2009-10 clinical coding audit carried out by the Audit Commission, that includes error rates for diagnoses and treatment coding (clinical coding) were:
- Primary procedures coded incorrectly 9.7 per cent
- Secondary procedures coded incorrectly 9.5 per cent
- Primary diagnosis code incorrectly 12.7 per cent
- Secondary diagnosis coded incorrectly 22.4 per cent

Safeguarding declarations
All NHS hospitals are required to publish a declaration to ensure that they are compliant with the arrangements relating to Safeguarding Children. This hospital has declared compliance.

NHS Litigation Authority Assessment
The hospital successfully achieved Level 1 of the NHS Litigation authority (NHSLA) Risk Management Standards for Acute Hospitals in December 2009.

The risk management standards cover five key risk management areas, with each standard containing 10 criteria.
- The 5 standards are:
  1. Governance
  2. Competent and Capable Workforce
  3. Safe Environment
  4. Clinical Care
  5. Learning from experience

Planning for the assessment was steered by the Quality and Standards team and an NHSLA Implementation Group was formed to assist the process. The main policy which shaped this preparation was the Policy for the Development Monitoring and Review of Hospital Documents. This document guided the authors through the approval and notification of their policies and ensured all policies were produced in a uniform manner through the use of a policy template. All policies produced contained a monitoring table, the assessor was very impressed with the tables and could see how they would assist the hospital in providing evidence of implementation of the policies for a subsequent Level 2 assessment. The practice of ensuring that the hospital contained a list of policies for a subsequent Level 2 assessment and evidence of monitoring for a future Level 3 assessment.

During the assessment the hospitals risk management framework and the policies were reviewed by the assessor. The hospital received complimentary feedback from the NHSLA assessor about the well organised visit, appreciation of the time that hospital staff had set aside to meet with the assessor and the excellent overall outcome. The visit although scheduled over two days was in fact completed on the first day.

To gain compliance in the assessment the hospital was required to get an overall success rate of 40 out of 50 criteria with no fewer than seven criteria passed in any one standard. The hospital actually achieved a phenomenal score of 49 out of 50.

The NHSLA also provide a risk assessment scheme for maternity services and the hospital is at Level 2.

Health and Safety Executive Visits
The Health and Safety Executive visited the hospital once during 2009/2010. The visit took place in May 2009 in connection to an over exposure of radiation incident. No actions were required from this visit and no recommendations were made.

Information Governance Toolkit
The hospital submitted records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the dataset where the primary diagnosis code was correctly entered was 85 per cent. The percentage of records in the dataset where the primary procedures coded correctly was 91 per cent. The percentage of records in the dataset where the secondary procedures coded correctly was 94 per cent. The percentage of records in the dataset where the primary diagnosis code was incorrectly entered was 12.7 per cent. The percentage of records in the dataset where the secondary procedures coded incorrectly was 9.5 per cent. The percentage of records in the dataset where the primary procedures coded incorrectly was 12.7 per cent. The percentage of records in the dataset where the secondary diagnosis coded incorrectly was 22.4 per cent.

The Information Governance Toolkit was:
- Secondary Use Assurance 75% (GREEN)
- Information Security Assurance 66% (AMBER)
- Information Governance Management 80% (GREEN)
- Corporate Information Assurance 58% (AMBER)
- Confidentiality and Data Protection Assurance 83% (GREEN)
- Clinical Information Assurance 66% (AMBER)
National Clinical Audits
During 2009/10, the hospital was eligible to and participated in 100 per cent (n = 22) of national clinical audits which are listed opposite. The cases submitted as a percentage of the number required are also given.

National Confidential Enquiries into Perioperative Deaths (NCEPOD)
NCEPOD’s purpose is to assist in maintaining and improving standards of medical and surgical care, for the benefit of the public, by reviewing the management of patients who die in hospital. This is done by carrying out confidential surveys and research. To date NCEPOD have published 28 reports, all of which contain recommendations for consideration by hospitals across the country. In Rotherham Hospital compliance is achieved in 299/332 recommendations and work is ongoing to achieve compliance on the remaining 33 recommendations. The national confidential enquiries that the hospital was eligible to participate in during 2009/10 are set out below.

NCEPOD : 2009/10

<table>
<thead>
<tr>
<th>Enquiries</th>
<th>Cases submitted as % of number required</th>
<th>NCEPOD sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery in Children</td>
<td>81 (100%)</td>
<td>0 included</td>
</tr>
<tr>
<td>Deaths in Acute Hospital</td>
<td>264 (100%)</td>
<td>15 included</td>
</tr>
<tr>
<td>Preventive Haemostasis</td>
<td>15 (100%)</td>
<td>12 included</td>
</tr>
<tr>
<td>Emergency Elective Surgery in the Elderly</td>
<td>18 (100%)</td>
<td>6 included</td>
</tr>
</tbody>
</table>

Research Activity
The number of patients receiving NHS services provided or sub-contracted by The Rotherham NHS Foundation Trust, that were recruited during the 2009/10 to participate in clinical research approved by a research ethics committee, was 315.

Deteriorating Patients Research Programme
During 2009/2010 the Trust worked with Sheffield Hallam University to develop the assessment process for Patients at Risk (PAR scoring) of becoming unwell. The PAR score alerts clinical staff to those patients who need monitoring more closely by medical staff. The programme successfully trained staff on all wards in the hospital in carrying out the clinical assessment and showed a significant improvement in the confidence of staff in carrying out these assessments and also increasing their confidence in knowing when to call for medical assistance.

Inpatient Falls Collaborative
The hospital's Inpatient Falls Collaborative programme included a 'realistic evaluation' component conducted by Sheffield Hallam University researchers. The work involved asking patients about their understanding of patient safety, how safe they felt in the hospital ward and how well they felt the staff explained their care to them. In addition, staff were also interviewed to ask what type of things prevent them from providing safe care and what they thought was needed to help them as well as how satisfied they were about their job. Patients confirmed a significant improvement in how safe they felt and how satisfied they were with the care they received. Staff also felt more satisfied and confident about patient safety.

Preventing blood clots (veno-thromboembolism VTE)
The hospital has secured support from the Collaboration for Leadership in Applied Health Research and Care (CLARHC) Research programme that includes a researcher and a whole time equivalent Band 6 secondment opportunity for a member of staff to carry out work that will reduce the risk of patients getting a blood clot. The aim of the project will include increasing VTE assessments to 100 per cent, medication management relating to anti-coagulation and the patient experience to ensure information and patient education on VTE is provided in an easy to understand format and can be adopted across the health community.
Quality Account Improvement programmes for 2010/2011 (reporting 2011/12):

- **Venous Thromboembolism reduction and management:**
  Rationale: This is a Department of Health and hospital target and is high priority in terms of the impact on the number of patients potentially at risk. The hospital has secured support from the CLARHC research programme that includes a researcher and a whole time equivalent Band 6 secondment opportunity for a member of staff to carry out the work. The aim of the project will include increasing VTE assessments to 100 per cent, medication management relating to anti-coagulation and the patient experience to ensure information and patient education on VTE is provided in an easy to understand format and can be adopted across the health community.

- **Stop inappropriate weight loss (nutrition) and dehydration (fluid balance management):**
  Rationale: The Chief Nursing Officer for England has identified a number of High Impact Intervention and this is also an important area identified by: the health overview and scrutiny committee, Trust Members, Governors, our mortality reviews, Inpatient survey results and also evidence from incidents and complaints that suggest this is an area where the hospital can make improvements. At present the MUST nutritional tool is being rolled out across the organisation and fluid balance has been included in the Quality Improvement Teams (QIT) programme of work. This means a baseline and methodology for improvement has already been put in place.

- **Protection against Infection:**
  Rationale: This is another of the Chief Nursing Officers High Impact Interventions, a hospital priority, and a national, regional and local target. The programme will focus on a group of infections not just solely MRSA Bacteraemia and Clostridium difficile and will include a specific aim of reducing the rate of Urinary Tract Infections (UTIs). A by-product of this work will also be in further reducing the number of falls as UTIs are a high risk factor for falls as well as a potential reservoir for MRSA infections. The aim in the first year will be to develop an accurate baseline of all infections, including UTIs, that patients have acquired whilst in the hospital.

- **Increase in meeting RCGP documentation guidelines and depth of coding from baseline April 2010.**
  Rationale: Data from the mortality review process, clinical documentation and coding audits highlights the need for a further hospital wide approach to improving our current situation. In terms of patient safety and experience it is crucial to record and document, the interventions being undertaken and the care received, when and by whom. Our mortality data may also be adversely affected by our limited coding of co-morbidities.

Jackie Bird
Chief of Quality & Standards
Annual Plan

This document sets out the Trust’s annual financial forecasts, strategic plans, key risks and priorities.

CQC

Care Quality Commission

CQUIN

Commissioning for Quality and Innovation

DSSA

Delivering Same Sex Accommodation

Essence of Care

The government’s strategy to improve the quality of the fundamental aspects of nursing care

FT

Foundation Trust

HCAI

Healthcare Associated Infections

Monitor

Independent regulator for Foundation Trusts

NPSA

National Patient Safety Agency

NHSLA

National Health Service Litigation Authority

NICE

National Institute for Health and Clinical Effectiveness

OSC

Overview and Scrutiny Committee – a local authority body which scrutinises and makes recommendations regarding public services provided by the Trust.

PEAT

Patient Environment Action Team

PbR

Payment by Results

PCT

Primary Care Trust

QIPP

Quality, Innovation, productivity and prevention

Quarter 1

April, May, June

Quarter 2

July, August, September

Quarter 3

October, November, December

Quarter 4

January, February, March

ShA

Strategic Health Authority

SUI

Serious untoward incident – an unexpected occurrence requiring investigation

Tool / Toolkit

A package of information and written guidance

Standards for Better Health

A set of core and developmental standards covering NHS healthcare provided for NHS patients in England

Validate

Prove, valid, declare, provide evidence for

Engaging patients, Members, Governors and other key stakeholders

A letter explaining the Quality Accounts process with an attached questionnaire was sent to all members, requesting them to respond by completing the questionnaire or telephoning our helpline to provide us with their views.

In addition we presented our progress and our views on improvement programmes to the Overview and Scrutiny committee on 29th April 2010 and received comments from the committee which can be seen below.

NHS Rotherham, our commissioners, were also asked to comment on our previous report and the final draft of this report.

We received 35/122 (35 per cent) response from our members and the main comments/themes from the questionnaires and from LINks and NHS Rotherham are highlighted below

Statements from NHS Rotherham, Local Involvement Networks and Overview and Scrutiny Committees

Statement from NHS Rotherham

NHS Rotherham welcomes the publication of The Rotherham NHS Foundation Trust’s 2010 Quality Report. As commissioners of health services for all Rotherham patients we work closely with the Trust to ensure that patients receive high quality services, that quality continues to improve and that information about quality is increasingly available to the public.

NHS Rotherham has been closely involved with many of the initiatives described in this report and has a detailed understanding of the quality of services patients receive through our representation on The Rotherham Foundation Trust’s Corporate Safety and Experience Committee, through the joint work we undertake to learn from feedback and incident reporting and numerous informal and formal visits to the Trust services.

This report means that the public in Rotherham now has more information than ever before about the quality of care in their local acute hospital. We welcome the important initiatives that have been carried out this year including addressing the four priority improvements areas of reducing mortality, reducing falls, improving patient satisfaction and reducing pressure ulcers. We know that the Trust has also given high priority to improving single sex accommodation and meeting data quality standards.

Next year we look forward to seeing further improvements in the priority areas highlighted in both the 2009 and 2010 reports and seeing improvements as a result of the jointly agreed local clinical quality indicators that are detailed in this report.

Joint Statement from LINkRotherham and Adult Services and Health Scrutiny Panel

The Rotherham NHS Foundation Trust has demonstrated throughout the year that they are committed to patient care. They have actively engaged inpatient involvement and joint working with stakeholders.

Dementia Event

Representatives from The Rotherham NHS Foundation Trust attended a joint Adult Services and Health Scrutiny panel and LINkRotherham event to talk about the support in place for people with dementia. They demonstrated their commitment to a holistic approach to patients with dementia.

Quality Accounts Event

The Trust also attended a joint event to share the content of their draft Quality Accounts.

We look forward to working closely with the Rotherham Foundation Trust in 2010 / 2011.
# National, Regional and Local CQUIN Indicators: Baseline 2010/11

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description of Goal</th>
<th>Quality Domain(s)</th>
<th>Process/Outcome Measure</th>
<th>Target 2011/12</th>
<th>National or Regional Indicator</th>
<th>Goal</th>
<th>Description of Goal</th>
<th>Quality Domain(s)</th>
<th>Process/Outcome Measure</th>
<th>Target 2011/12</th>
<th>National or Regional Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)</td>
<td>Safety</td>
<td>Completed VTE assessments</td>
<td>90% completed VTE assessments in all areas by Q4 2010/11 Baseline: 2010/11</td>
<td>National 0.15</td>
<td>8</td>
<td>Improvement in pressure ulcer prevention and management in line with Essence of Care</td>
<td>Patient Safety</td>
<td>Care and Compassion – Improvement of Pressure Ulcers</td>
<td>Point prevalence Q2 Trust target: Reduction of 50% from April 09/10 in Grade 2 and above pressure by April 2010/11: 100% RCA for all Grade 2+</td>
<td>Regional</td>
</tr>
<tr>
<td>2</td>
<td>Improve responsiveness to the personal needs of patients</td>
<td>Patient Experience</td>
<td>Composite indicator on responsiveness to personal needs from the Adult Inpatient Survey</td>
<td></td>
<td>National 0.15</td>
<td>9</td>
<td>Smoking in pregnancy</td>
<td>Patient Experience</td>
<td>Effectiveness</td>
<td>Expectant mothers ID</td>
<td>Baseline: End quarter 1 Local</td>
</tr>
<tr>
<td>3</td>
<td>Movement towards improvement in delivery of maternity services, including a reduction of stillbirth rates, unanticipated admissions and C-section rates</td>
<td>Effectiveness</td>
<td>3a Reduce the rates of intra-partum stillbirths 3b Reduction of the number of babies being admitted to the neonatal unit 3c Reduction in Caesarean sections</td>
<td>Baseline value Q1 2010/11 Regional Agreement locally</td>
<td></td>
<td>10</td>
<td>Breastfeeding</td>
<td>Patient Experience</td>
<td>Effectiveness</td>
<td>Be referred</td>
<td>Baseline: 58% Q3 2009/10</td>
</tr>
<tr>
<td>4</td>
<td>Patients and carers will be able to expect the highest possible standards of end of life care</td>
<td>Effectiveness</td>
<td>Patients on EOL pathway</td>
<td>Point prevalence audit June 10/11 Q1 baseline Regional Agreement locally Q2 Re-audit Q4</td>
<td></td>
<td>11</td>
<td>Children with diabetes</td>
<td>Patient Safety</td>
<td>Effectiveness</td>
<td>Increase 5% on diabetic register HbA1c &gt;7.5-8.5% by Q4</td>
<td>Baseline: Q1</td>
</tr>
<tr>
<td>5</td>
<td>Reduction in post operative infection rates, reduce use of reduse use of amniotic antibiotics, lower rates of Venous Thrombosis</td>
<td>Patient Experience</td>
<td>Hip and knee replacement best practice bundle</td>
<td>Baseline: established Q1 95% compliance ALL elements Q3 Current: 98.6% - 98.6%, 95.8% Regional Agreement locally Q2</td>
<td></td>
<td>12</td>
<td>Readmissions within 14 days</td>
<td>Patient Safety</td>
<td>Effectiveness</td>
<td>4% for Q4</td>
<td>Q3-Q2 Current value 6.1%</td>
</tr>
<tr>
<td>6</td>
<td>Reduce mortality rates, increasing rates of percutaneous coronary intervention as first line treatment, quicker access to procedure times, reduction in rates of re-infraction, increased rates of long-term smoking cessation.</td>
<td>Patient Experience</td>
<td>Acute Myocardial infarction best practice bundle</td>
<td>Baseline: 2010/11 Q1 values Current value: Smoking = 100% Receiving aspirin 74.1% Prescribing medication 80.8% Regional Agreement locally Q2</td>
<td></td>
<td>13</td>
<td>Neonatal care</td>
<td>Patient Safety</td>
<td>Effectiveness</td>
<td>Babies to neonatal units, babies with temperature recorded within 1 hour, bed days on neonatal and HCAI on unit</td>
<td>Baseline: Q1</td>
</tr>
<tr>
<td>7</td>
<td>Improve the focus on the care of the patients, in line with the Essence of Care. Use of validated nutritional indicator screening tool will be encouraged to reduce rates of malnutrition and associated adverse outcomes.</td>
<td>Patient Experience</td>
<td>Care and Compassion – Nutritional Screening</td>
<td>Baseline: point prevalence June 2010/11 Q2 Action Plan Regional Agreement locally Q1</td>
<td></td>
<td>14</td>
<td>Outpatient letters</td>
<td>Patient Safety</td>
<td>Effectiveness</td>
<td>Letter received within 5 working days to include specific minimum data set</td>
<td>Baseline: Q4 09/10 value of 10% Q4 2010/11: target 90%</td>
</tr>
<tr>
<td>8</td>
<td>Improve responsiveness to the personal needs of patients</td>
<td>Patient Experience</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td>Health promotion activity</td>
<td>Patient Experience</td>
<td>Effectiveness</td>
<td>Patients identified as eligible for referral to smoking cessation, weight management and alcohol services are referred</td>
<td>Baseline Q1 2010/11 Final Q4 2010/11 100%</td>
</tr>
</tbody>
</table>
### Quality Accounts 2010/11: Hospital selected quality indicators and improvement programmes

#### Patient Safety Indicators 2010/11

<table>
<thead>
<tr>
<th>Indicator</th>
<th>CQUINs/Regional/Local</th>
<th>Improvement programme</th>
<th>Quality Accounts Priority programme</th>
<th>Start date of Improvement programme (if new)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reduction in the number of hospital acquired UTIs (50% from baseline)</td>
<td>N,R,L,T High Impact Target</td>
<td>✓</td>
<td>✓</td>
<td>May 2010</td>
</tr>
<tr>
<td>2 Reduction of stillbirth rates, unexpected admissions and C section rates</td>
<td>R,N,L</td>
<td>Continued programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Increase in meeting RCGP documentation guidelines and depth of coding from baseline April 2010</td>
<td>T</td>
<td>✓</td>
<td>✓</td>
<td>May 2010</td>
</tr>
</tbody>
</table>

#### Patient Safety 2009/10 Indicators: Sustainable Improvement

<table>
<thead>
<tr>
<th>Indicator</th>
<th>CQUINs/Regional/Local</th>
<th>Improvement programme</th>
<th>Quality Accounts Priority programme</th>
<th>Start date of Improvement programme (if new)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Number of patients with hospital acquired MRSA (3 DH target)</td>
<td>N,R,L,T</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2 Patients with C Diff/10000 bed days</td>
<td>N,R,L,T</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3 Inpatient falls/1000 Inpatient admissions</td>
<td>High Impact, T</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Medication errors/errors per 1000 administrations</td>
<td>T, QIPP</td>
<td></td>
<td>New: part of VTE programme</td>
<td></td>
</tr>
<tr>
<td>5 Never events that occur within the hospital</td>
<td>N,L</td>
<td>Incident management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Experience Indicators 2010/11

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1 Reduction in the number of complaints from baseline April 2010</td>
<td>T</td>
<td>Ongoing programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Increase in the number of patients on end of life care pathway</td>
<td>R,L,T</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Increase in the % of categories that the hospital is in top 20% for all indicators on the National Patient Survey by April 2011</td>
<td>N,T</td>
<td>Ongoing programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Increase in the number of patients assessed using the MUST nutritional tool and completed fluid balance charts</td>
<td>R,L,T, High Impact</td>
<td>New programme</td>
<td>✓</td>
<td>April 2010</td>
</tr>
</tbody>
</table>

#### Patient Experience 2009/10: Sustainable improvement

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>1 Reduction in hospital acquired pressure ulcers grade 2 and above from Q1 2010/11 baseline</td>
<td>R,L,T,High Impact QIPP</td>
<td>Continued programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Clinical Effectiveness Indicators 2010/11

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Start date of Improvement programme (if new)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a 50% Increase in the number of patients undergoing VTE assessments from baseline April 2010 by April 2011</td>
<td>N,R,L,T</td>
<td>New programme</td>
<td>✓</td>
<td>July 2010</td>
</tr>
<tr>
<td>1b Reduction in re-admission for PE (CHKS baseline April 2010)</td>
<td>R,T</td>
<td>Ongoing programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Increase in patients on Hip and Knee replacement bundle</td>
<td>T</td>
<td></td>
<td>New programme</td>
<td></td>
</tr>
<tr>
<td>3 Appropriate reduction in LOS for patients following orthopaedic and abdominal surgical interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Clinical Effectiveness Indicators 2009/10 Sustainable improvement

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</tr>
</thead>
<tbody>
<tr>
<td>1 Reduction in HSMR from April 2010 data</td>
<td>T</td>
<td>Continued programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Reduction in Unplanned readmission rates within 28 days</td>
<td>T</td>
<td>Continued programmes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>