



## Quality Report 2009/10





***Sherwood Forest Hospitals NHS  
Foundation Trust***

**Quality Report**



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## Foreword

*Quality is at the heart of everything we do, we believe it is our focus on quality that will make us stand out from other providers of health care, make our services even more efficient and inspire our staff to become more innovative and embrace new ways of working*

*During the last two years we have embedded our vision of Best Care Best People Best Place this vision is guiding us to provide ever improving quality services for our patients and carers. Achievements this year have included significant reduction in healthcare acquired infections, our A&E waiting times and accreditation of key elements of our service including all our laboratory services, stroke and acute cardiac syndrome care and cancer care*

*Staff are key to influencing the quality of care and have helped with patients and carers, Governors and members to produce a set of pledges to assist in achieving our shared vision. I was delighted this year to receive our excellent staff survey results which reflect the enthusiasm and commitment our staff have to helping us to achieve our ambitions*

*During 2010/11 we will again focus on key priority areas within the domains of patient safety, clinical effectiveness and patient experience, ensuring that we have a balanced set of objectives which influence those things which make the most difference to our patients*

*This report looks forward to the coming year which we know will be challenging for us and with this in mind it is even more important that we continue to drive up our quality standards. The report also reflects on our progress last year and high lights our achievements as well as those areas where we know we still have room to improve.*

*I believe this is an honest, transparent and accurate account of our journey towards Best Care Best People Best Place and I would like to thank all the people who have contributed to this report.*

*To the best of my knowledge, the information contained in the Quality Report is accurate.*



*Carolyn White  
Chief Executive*

## The Year at a Glance

Every year provides a new set of challenges and 2009/10 was no different. In our third year as a Foundation Trust we have made considerable progress towards achieving our vision to provide the Best Care, Best People and Best Place. One of the most heartening testimonies to this, and a source of pride, is our results in the nationally run 2009 staff survey. We are rated in the top 20% of Trusts for all the key areas relating to staff satisfaction such as - would you recommend the Trust as a place to work or receive treatment?

The year included some notable landmarks, including the opening in April of the first two of our three 'Towers', the new day case unit in April, the new endoscopy unit in November and the new emergency care centre in August.

The provision of our new accommodation at King's Mill and the hard work of all staff across the Trust enabled us to make a dramatic impact on our MRSA bacteraemia rate, which has been a key priority for the Board of Directors in recent years.

### Delivering our Vision & Meeting our Pledges

Work on our new £367m hospital at King's Mill progressed well during 2009/10. With the first two phases now fully operational, we look forward to the completion of the work in 2011.

Our new inpatient accommodation with 50% of patients in single bedrooms - all with en-suite bathroom facilities – remains the best available locally and will help us achieve the highest standards of cleanliness, dignity and privacy.

Moving into our new facilities has given us a tremendous opportunity to maintain improvements to our clinical services, ensuring that our patients receive the best care available, more quickly than ever before.

During 2009/10, we developed our organisational approach to quality improvement, 'Achieving Best Care' (ABC). This work will continue to drive our strategy, transforming services and further developing our culture in support of the delivery of our pledges to patients.

We remain on schedule to complete the refurbishment of King's Mill Hospital in 2010/11.

### Providing the Best Care – Highlights of 2009/10

1. **Reducing Infections** – We significantly exceeded our reduction targets for both MRSA and Clostridium difficile during the year reflecting the huge amount of work undertaken in recent years to improve our performance. This has consistently been a high priority for the Board of Directors and we are particularly proud of our achievement.
2. **Improving Our Patients Experience** - There has been year on year significant improvement in our national inpatient survey results, increasing the number of domains where we are in the top 20% of Trusts from 7 in 2008 to 23 in 2009. Our patients rated us as 'top 20%' for the cleanliness of wards, toilets and bathrooms, as well as for hand hygiene. With 50% ensuite rooms we are in the top 20% of Trusts for patients not being bothered by the noise of other patients at night, for patients' opinions that there were enough nurses on duty to care appropriately, and for patients feeling that nurse call buttons were answered in a timely way.
3. **Increasing Our Membership, Accountability & Engagement** - At the end of March 2010, we had in excess of 25,000 members in total (including public, staff and affiliate members). Throughout the year we arranged a number of successful member events, information sessions and held constituency meetings in the community to assist our Governors to meet their members first hand to find out their experiences and views of our services. This feedback and engagement assisted us to develop our vision and strategic objectives for 2010/11 and to

develop pledges which truly reflect those things that are most important for our patients and carers.

4. **Listening To Our Patients** – Over 90% of patients from our inpatient wards and outpatient services say we live up to our pledges and over 90% would recommend our services to their family and friends.
5. **Improving our Environment & Investing In New Services** – During the year we progressed towards the completion of our new hospital facilities at King's Mill Hospital and sustained our investment in new hysteroscopy and YAG laser services at Newark Hospital - creating outstanding environments so that our local communities receive health care in the 'Best Place'.
6. **Emergency Preparedness** - The Board of Directors approved additional investment and signed a declaration in September 2009 confirming our preparedness to meet significantly increased demand for our services in response to the anticipated swine flu pandemic.
7. **Attracting & Retaining The Best Staff** – Key to our success is how engaged our staff are in delivering our best care vision and pledges. The 2009 Staff Survey outcomes confirm that we are in the top 20% of Trusts for staff understanding their role and where it fits in; we are better than average in key findings relating to good communication between senior management and staff, and for staff being able to contribute to improvements at work. During the year we recruited many excellent new clinical staff, all of whom see the prospect of helping us develop our new facilities and re-design our services to improve the quality, safety and effectiveness of our services as good reasons for choosing us as their employer. During 2009, we were particularly delighted to be named as one of the Top 100 NHS Employers in the Nursing Times and Health Service Journal Awards.
8. **Technological Innovation** – Once again we were at the leading edge of a number of local and national initiatives in the field of information technology (IMT). The continuing successful implementation of Choose and Book received national recognition from the Department of Health in 2009, and the extended use of our VOCERA communication system and other innovative and imaginative IMT solutions are helping us to improve the work of staff across the Trust were further excellent examples of our continuing success.
9. **External Assurance** - Ensuring that the quality of our services remains the top priority for our Board of Directors. During the year, we were once again rated 'good' for the quality of our services and 'excellent' for our use of resources by the Healthcare Commission. On 16th September 2009, following an unannounced inspection the CQC confirmed that we had fully met all 16 measures relating to the prevention and control of infections. Our pathology department achieved full accreditation with the national accreditation body Clinical Pathology Accreditation (UK) Ltd and during 2009, our maternity services were once again rated as excellent and our caesarean rates were recognised as the best in the country.

## Engaging Our Community

Listening to the views of our local community and engaging with our members remains key to achieving our vision and to ensuring increased transparency and openness in all that we do. By the end of March 2010, we had successfully recruited over 19,000 public members, placing us in the top Foundation Trusts nationally – an achievement that we are particularly proud of.

We are grateful for the hard work and enthusiasm of our Governors during the year in assisting us and in working closely with the Board of Directors to influence and shape our services for the future.

## **Reducing Our Impact on the Environment**

We are committed to reducing our impact on the environment and reducing our carbon footprint. During the year, the investment we made during 2008 in our geothermal heat transfer project assisted us to meet this commitment. We were proud that this project, one of the largest in Europe, was shortlisted for a prestigious national Good Corporate Citizen award.

A separate section providing more details on our commitment to sustainability is included in our Operating and Financial Review.

## Progress Against 2009/10 Priorities

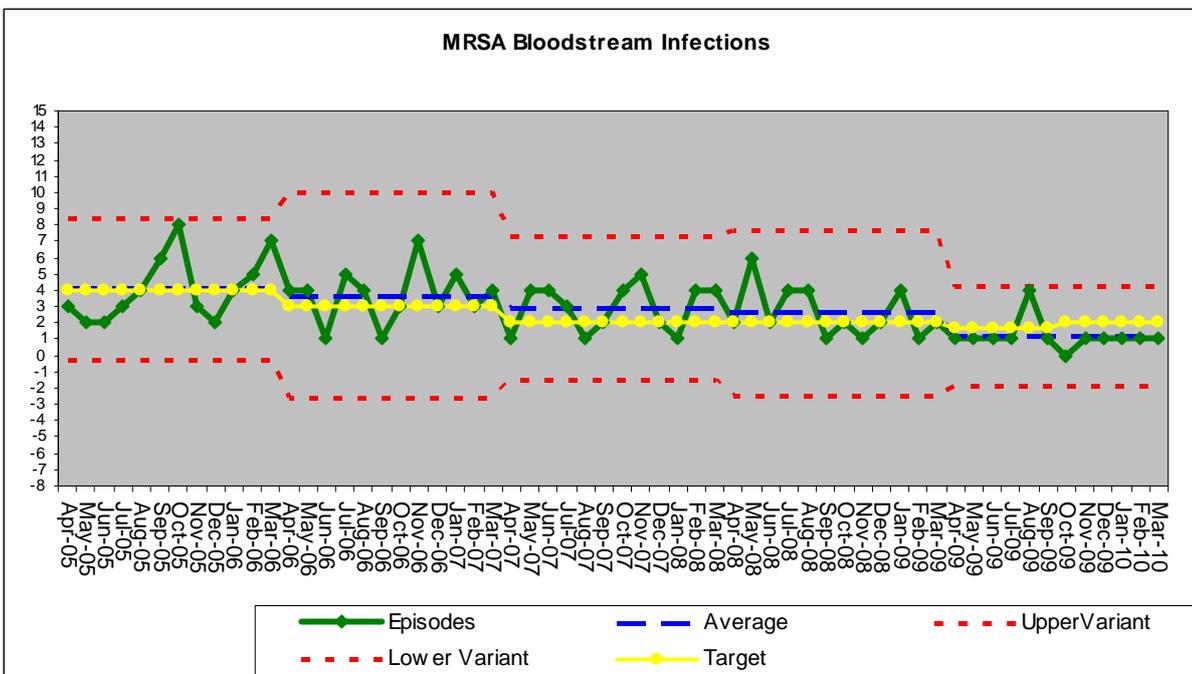
The three main priorities for 2009/10 and progress are discussed below.

**1. Patient Safety.** Reduce incidence of health care acquired infections (HCAI), in particular reducing the number of MRSA bacteraemia by a further 30% during 2009/10.

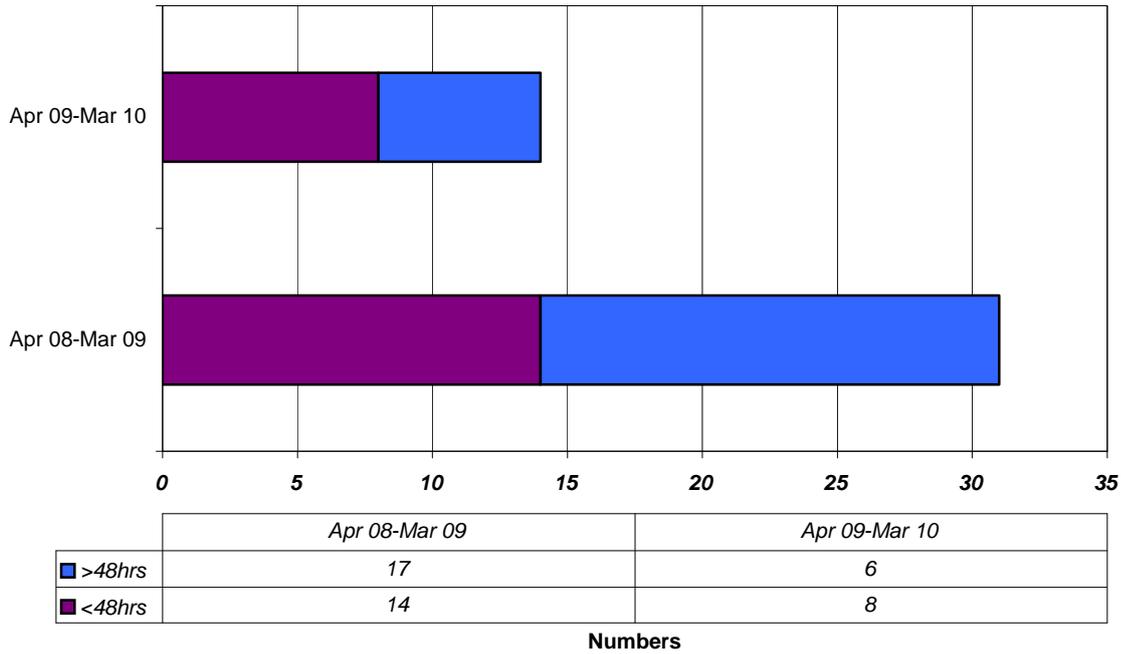
### Progress

We have worked extremely hard to reduce the cases of MRSA bacteraemia and have reduced cases by 55% from 08/09 to 09/10. We have systematically improved the compliance with best practice and have seen a reduction in the cases of MRSA. Each case receives a thorough root cause analysis and lessons are learnt and improvements sustained. Further training has been given to staff throughout the year to assist with reducing the number of cases. We have also seen a month on month reduction in the number of *Clostridium difficile* toxin positive patients. The graphs below are a visual representation of our results.

We ended the year with the third lowest MRSA rate in the region; we are the lowest in the region by a significant margin for our C-Difficile rate.

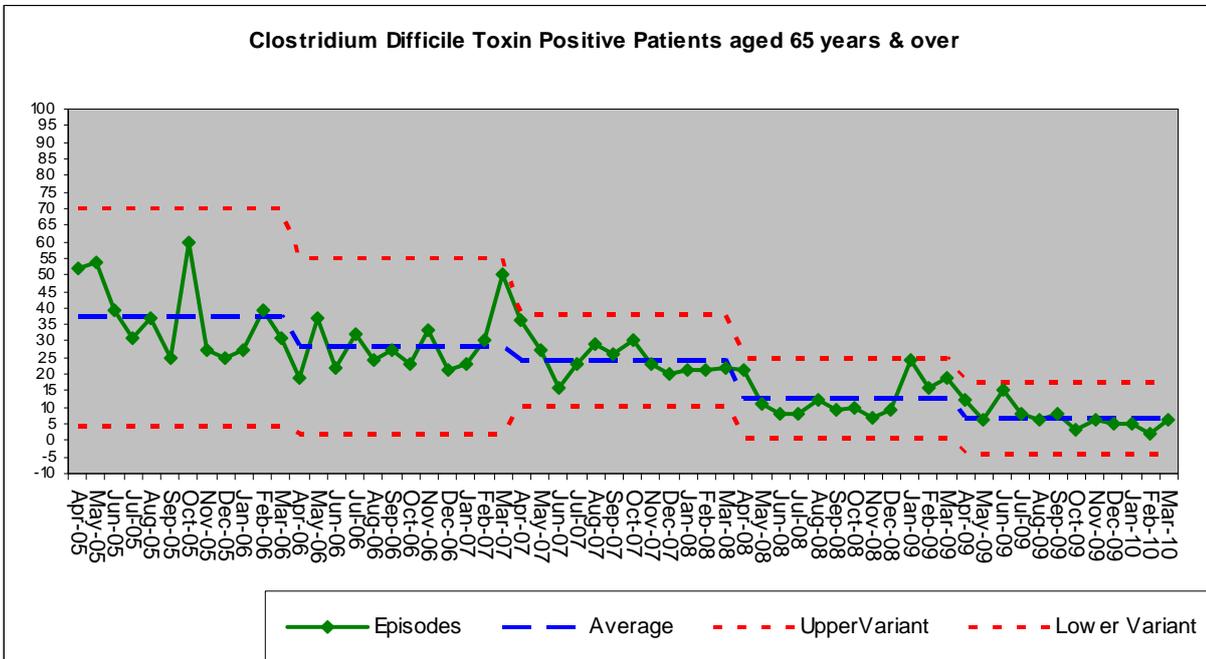


**Comparison of MRSA Bacteraemias by <48hrs & >48hrs from admission  
Apr 08- Mar 09 & Apr 09- Mar 10**



The above graph describes the significant reductions in MRSA bacteraemias achieved in 2009/10 when compared to the previous year. The blue bars in the graph highlight the number of post – 48 hour MRSA bacteraemias recorded – these are the cases that the Trust can control more effectively.

**Clostridium Difficile Toxin Positive Patients aged 65 years & over**



### **Specific initiatives implemented during 2009/10**

- We have introduced a zero tolerance regime rooting out non compliant behaviour.
- We have rolled out a screening programme for all admissions with active surveillance and follow up of positive patients in the community.
- We now have improved isolation facilities with 50% single rooms at the King's Mill site.
- We have improved the contact precautions for any patients known to have an infection or to be colonised.
- There has been cultural change throughout the organisation through positive leadership and engagement at executive and senior management level.
- Numerous local audits have taken place for local action this ensures ownership of issues and improvements.
- There has been a policy written and followed regarding reducing and improved monitoring of antibiotics.

**2. Clinical Effectiveness.** Further improve the way we monitor and care for acutely ill in-patients through the use of an early warning score tool, in line with National Institute for Clinical Excellence (NICE) guidance

### Patient Observations

As part of the Trust wide Commission for Quality and Innovation (CQUIN) project, audits have been carried out to measure Trust-wide compliance with NICE (2007) guidelines for care of the acutely ill adult. Guidelines identified the following standards:

- All six mandatory vital signs (respiratory rate, heart rate, blood pressure, oxygen saturation, temperature and level of consciousness) should be monitored every time the observations are measured.
- With a minimum frequency of 12 hourly observations for all patients.
- Where vital signs exist, frequency of monitoring must be increased.
- All patients must be assessed using a physiological track and trigger score to identify those at risk of further deterioration. At Sherwood Forest Hospitals, the Augmented Care Assessment Tool (ACAT) is the trigger tool in use.

### Audit Methodology

Ten patients were regularly randomly selected from each ward for audit and review. The last set of observations recorded on each patient's chart were reviewed to identify compliance with the standards listed above. The project lead has now carried out four cycles of the audit, and trends in compliance are illustrated in Table 1 below.

Significant achievements have been made Trust-wide with regard to improvement in the recording of patient vital signs. Overall compliance percentage with documentation of the six mandatory vital signs has been maintained above 90%:

**Table 1. Compliance with all elements of the audit.**

	KMH Site (%)	NWK site (%)	Trust wide (%)
<b>June 2009</b>	88	99	91
<b>August 2009</b>	95	100	96
<b>November 2009</b>	91	91	91
<b>February 2010</b>	93	98	94

It is key to note however that audits of vital signs were in progress prior to the outset of the CQUIN project and results presented here do not truly demonstrate the full extent of our achievements. In 2006 the project lead highlighted the significance of vital signs recording in response to the National Confidential Enquiries (NCEPOD 2005) report. This national audit highlighted that respiratory rates were routinely not recorded. Local findings in February 2006 showed similar. In a three-day audit of all patients across the Trust, compliance with respiratory rate monitoring varied significantly in all ward areas, but ranged from only 40-60%. Compliance with respiratory rate monitoring in February 2010 was 100% across the Trust.

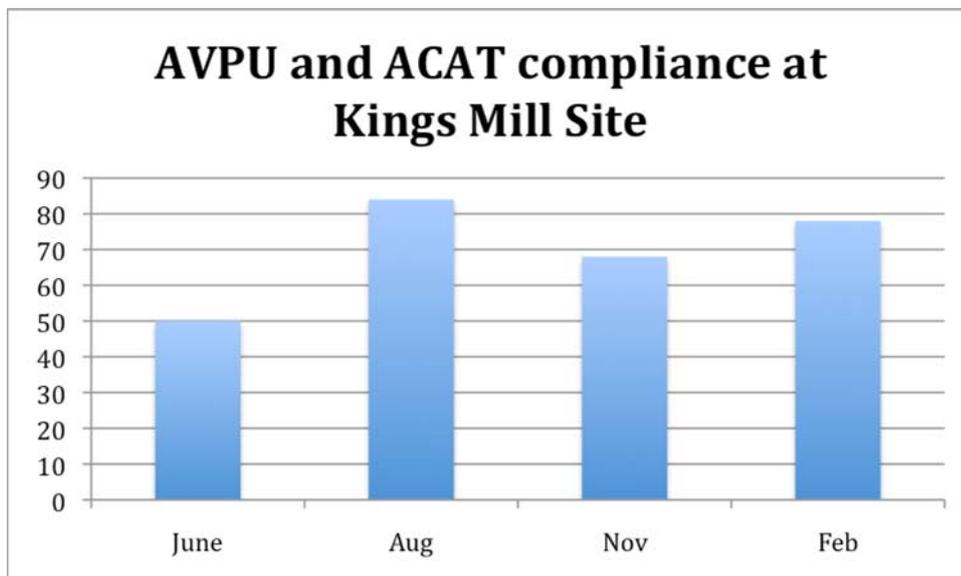
**Table 2. Compliance with AVPU and ACAT monitoring across the Trust.**

	June 2009		August 2009		November 2009		Feb 2010	
	Nwk	KMH	Nwk	KMH	Nwk	KMH	Nwk	KMH
<b>AVPU</b>	100	50	100	84	63	68	100	78
<b>ACAT</b>	93	54	100	84	66	68	100	78

Key areas for future focussed improvement include documentation of the AVPU (a measure of level of consciousness) and the local Track and Trigger score (ACAT). Compliance with these two vital assessments remains variable. The drop in compliance with both these elements and overall compliance in November 2009, shown in Table 2, may be explained by the implementation of a Trust policy that prohibited Healthcare Support Workers from assessing and recording the AVPU or ACAT. This is now the role of the registered nurse alone. With consistent reinforcement of these

issues by the project lead, compliance improved by February this year, with Newark wards all achieving 100% compliance. Small ACAT cards, that can be carried behind identity badges, have now been distributed throughout the Trust to all healthcare professionals and act as a constant reminder of the scoring system in use.

### Compliance with AVPU and ACAT monitoring at the Kings Mill Site



### Education and training

The in-house critical care skills for ward nurses course has been reviewed. Sixteen places have been secured on a local AIMS course for the oncoming year. In addition, the in-house critical care skills course has been re-designed to incorporate an assessment element to bring it in line with the acute illness management (AIMS) course delivery. All nurses new to the Trust attend this training on induction. All doctors new to the Trust will have completed AIMS training during the acute programme in medical school.

Learning from experience will facilitate education in practice. A Consultant Anaesthetist and the Consultant Nurse from Critical Care are leading a project to retrospectively review cases from which multi-professional teams can learn. Currently in its infancy, two cases have already been reviewed by way of a pilot. The review team will progress further over the oncoming year with a goal to review one case per month as a minimum.

### Communication

SBAR is a communication tool that aims to enhance patient handovers. The requirement for its use has been disseminated widely across the Trust.

- S** – situation (explain where you are and what the problem is)
- B** – background (to the patient's situation – past medical history)
- A** – assessment (structured holistically to cover airway, breathing, circulation, disability and exposure)
- R** – recommendations – (what the reporter thinks should happen next)

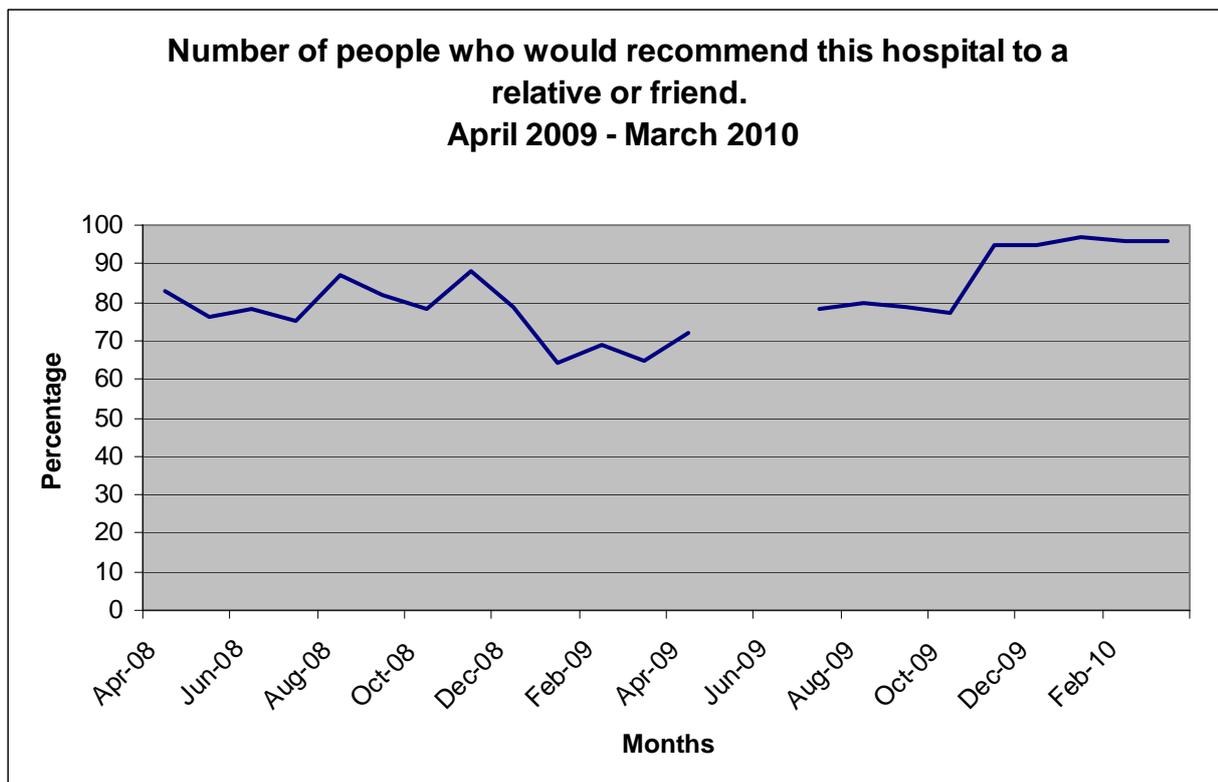
Trust-wide communication has identified that SBAR is the Trust's communication tool of choice. Links to a ten-minute education tool have been disseminated to all staff Trust-wide and anecdotal evidence suggests that some clinical staff are now using the tool. Nursing documentation and staff are currently being consulted about newly-designed SBAR documentation. Subsequent CQUINS audits will include a measure of compliance with this key quality element.

**3. Patient Experience.** Increase the number of people who would recommend our hospital/s to a friend or family member.

The number of people who would recommend the hospitals has increased during the third and fourth quarter of 09/10. The reasons for this could be due to the new environment at the King's Mill site and the introduction and roll out of patient and carer pledges.

The data collection has been taken using Dr Foster intelligence patient experience trackers and is a mixture of in patients and out patients.

(There were no Dr Foster patient experience surveys conducted in June and July 09)



During 2009/10 the Trust has fed back all the results to the relevant departmental managers to inform their service development plans. Specific areas were identified for improvements in particular in relation to the environment. These areas have now improved. It has been decided that the question relating to whether patients would recommend this hospital is not being asked regularly during 2010/11 due to the high positive percentages received during the last year.

The Trust successfully recruited a further 50 volunteers to compliment service provision within our hospitals to further enhance our customer experience. The Trust now has over 650 volunteers supporting our service teams to deliver our patient and carer pledges.

## Other Priorities Set 2009/10

### Patient Safety

During 2009/10 the Trust has also been working on the following chosen metrics:

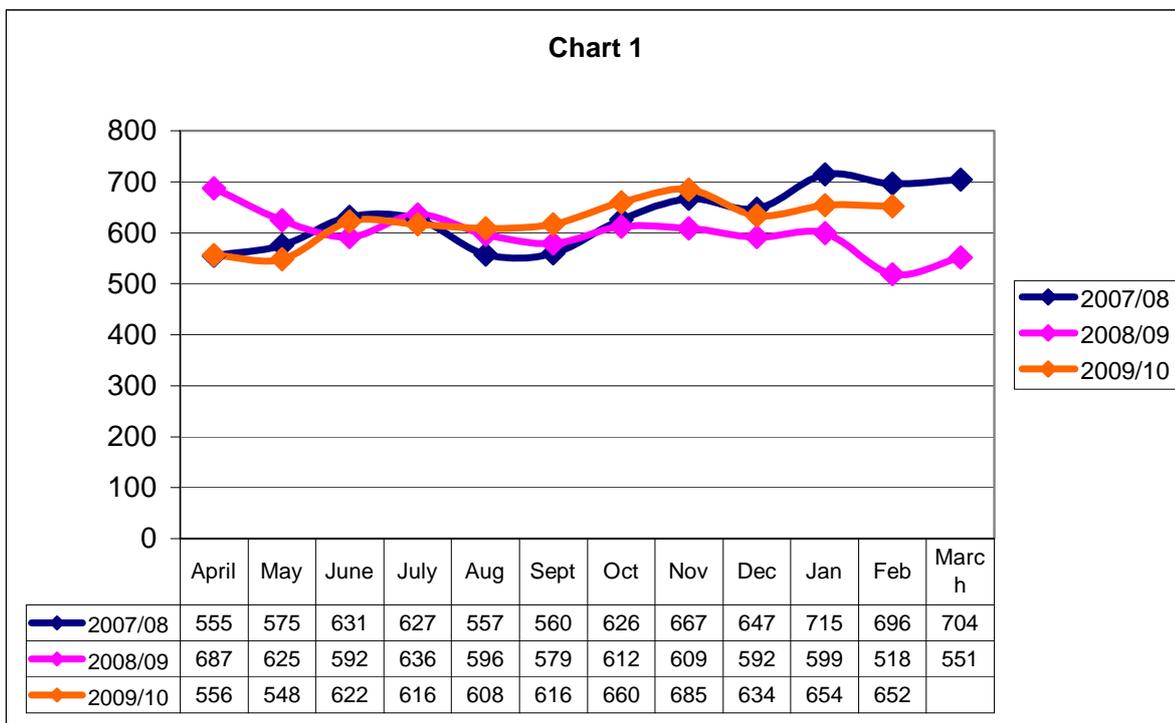
#### Clinical Incident Reporting

Clinical Incident reporting underpins our patient safety strategy as it provides key indicators for review and improvement. National consensus is that a Trust with high reporting levels of clinical incidents has a positive patient safety culture and 'more reporting is better'. The Trust has developed an electronic reporting system and has invested in a system administrator to provide timely reports to clinical teams to inform them of key safety issues. The Trust uploads its clinical incidents to the National Reporting and Learning System (NRLS) co coordinated by the National Patient Safety Agency (NPSA). This Trust is deemed to be an average reporting Trust, when benchmarked against similar sized Trusts. In the last reporting period by the National Patient Safety Agency April 09 to September 09 there were between 250 and 600 incidents uploaded per month, which shows that the Trust is working towards a more systematic process for uploading into the national database.

The median figure for the Trust uploading into the national database over the reporting periods September 2008-March 2009 was 6 incidents per 100 admissions, and over the reporting period April 2009 to September 2009 was 5 incidents per 100 admissions which has increased to the national average.

Below is a table of the data which is reported by month over the previous three years.

The average Incidents reported per month:



The timeliness of Sherwood Forest Hospitals reports being uploaded into the NRLS is now approximately 30 days while the median number of days for the cluster group is 51 days between an incident occurring and the incident being reported demonstrating a high level of compliance by Sherwood Forest Hospitals.

## Never Events

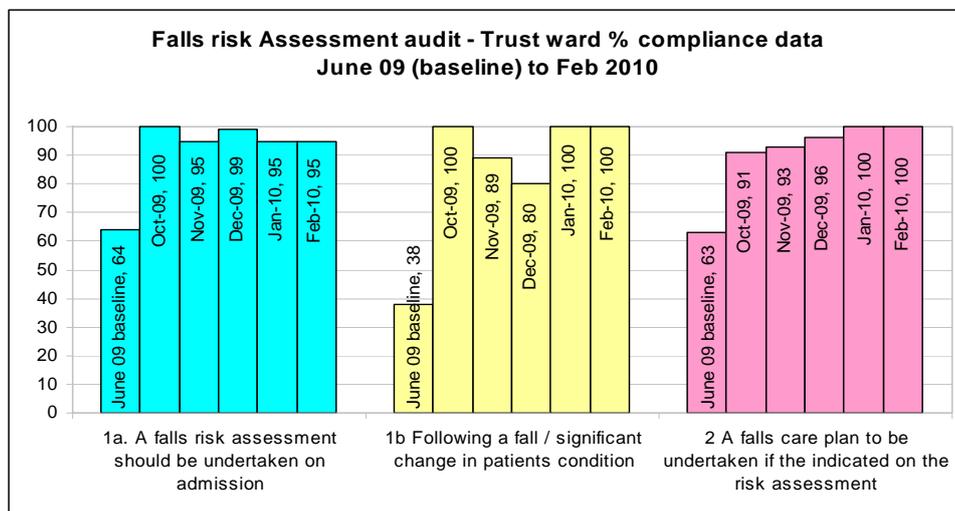
Never Events are very serious clinical incidents which should 'never' occur if appropriate safety checks are built into healthcare practice. Examples of 'never events' might include wrong side amputation or inappropriate injection of a chemotherapy agent.

There have been no reported 'never events' reported for this Trust in the last year. Never events including nil returns are reported in summary form to the Board of Directors on a quarterly basis.

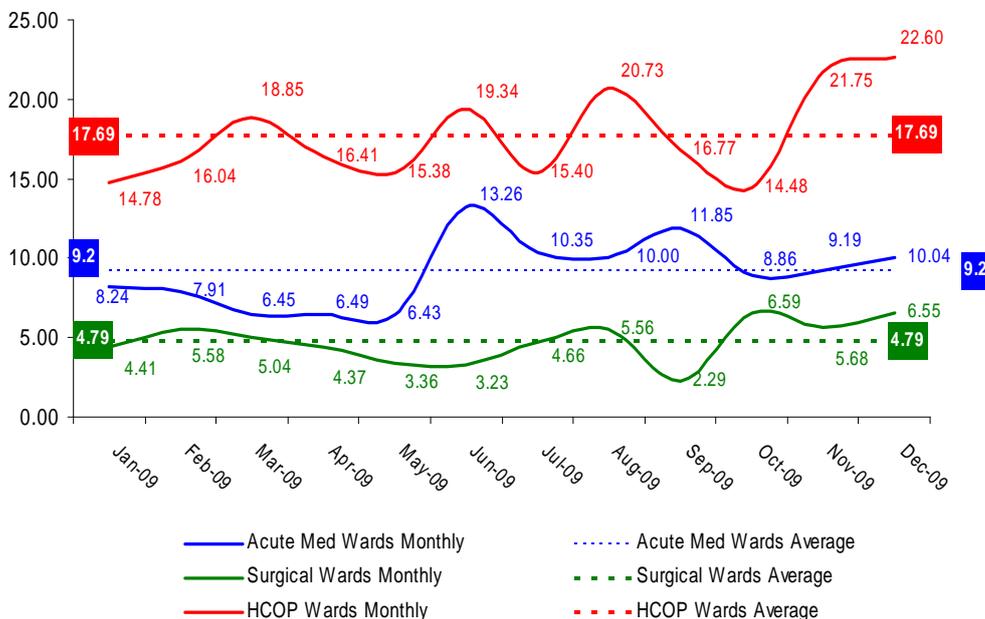
## Slips Trips and Falls

Elderly vulnerable patients are at greater risk of falling and slipping when cared for in unfamiliar surroundings which disorientate them especially if they are suffering from confusion already. The risk assessment and careful management of patients at risk is therefore of utmost importance.

During 2009/10 the Trust has completed an initial cross Trust observational audit on the use of risk assessment tools and care plans. This audit has led to monthly audits of falls risk assessments and care plans across all wards. Compliance with use of the documentation has risen dramatically since this:



There is ongoing analysis of clinical incident data to identify any trends and then responding accordingly. The clinical system for reporting falls is being updated to include more detail in 2010 to make for more detailed analysis for trends in terms of the geography of the wards and multiple events happening to the same individual.



The graph above shows the number of falls per 1000 occupied bed days using the raw number of incidents reported. By way of benchmark, in 2007, the National Patient Safety Authority (NPSA) confirmed that the national average number of falls per 1000 occupied bed days for Acute Trusts was 4.8, with an average of 18 per 1000 occupied bed days for Wards with more vulnerable patients.

- We have implemented an ongoing training programme for both nurses and medical staff to raise awareness and understanding of falls
- We identified the need for key equipment to reduce patients' risk of falling – we now have lowering beds freely available for at risk patients.
- We are promoting falls as a quality indicator for the care we deliver in Sherwood Forest Hospitals and reduce the risks. We aim to improve NHSLA risk assessment from level 1 to level 2 and will be focussing on this in 2010.

### Tissue viability

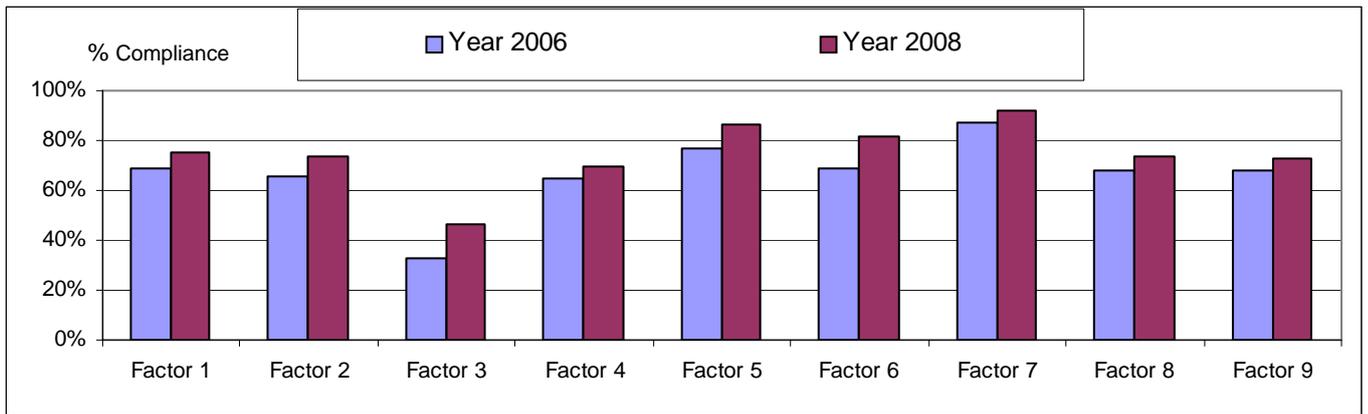
Development of tissue damage is a key indicator of nursing care. The nurses and tissue viability team strive to reduce the incidence of pressure ulcers. The team provide continuing education and audit. Pressure ulcer point prevalence is recorded 4 times a year and all grade 2, 3 and 4 pressure ulcers are reported as a clinical incident via the Trusts clinical incident procedure (Datix). We react to these audits/incidents by examining the issues and create management plans to address them. For example, we provide mandatory training and specific teaching in clinical areas where deficits have been identified and provide individual plans of care for patients at risk of or with existing pressure damage. Audit of pressure relieving equipment occurs on an ongoing basis and findings are actioned accordingly.

The pressure area management policy has been launched this year along with a new pressure ulcer prevention leaflet for patients and carers.

The Trust has a regular audit programme as part of Essence of Care (a national programme). The baseline audit for the pressure ulcer benchmark was undertaken in 2006 with an overall 73% compliance with benchmark; re-audited in 2008 [overall 81%] with the next re-audit planned within the programme for 2010.

Where a factor does not achieve 70% [minimum agreed by Essence of Care Steering Group: Sherwood Forest Hospitals] the factor[s] are highlighted to indicate that a Trust action plan will be implemented to enable improvement or compliance with the factor. The following are the benchmark factors with the findings from 2006 and 2008

Factor 1	Screening and assessment
Factor 2	Who undertakes assessment?
Factor 3	Information patients and or carers [prevention & treatment]
Factor 4	Individualised plan for prevention and treatment of pressure ulcers
Factor 5	Pressure ulcer prevention – re-positioning
Factor 6	Pressure ulcer prevention – redistributing support surfaces
Factor 7	Pressure ulcer prevention – availability of resources and equipment
Factor 8	Implementation of individualised plan
Factor 9	Evaluation of interventions by a registered practitioner



There is an overall improvement from 2006 to 2008; a Trust-wide action plan has been presented to the Steering Group for approval and implementation.

### Nutrition

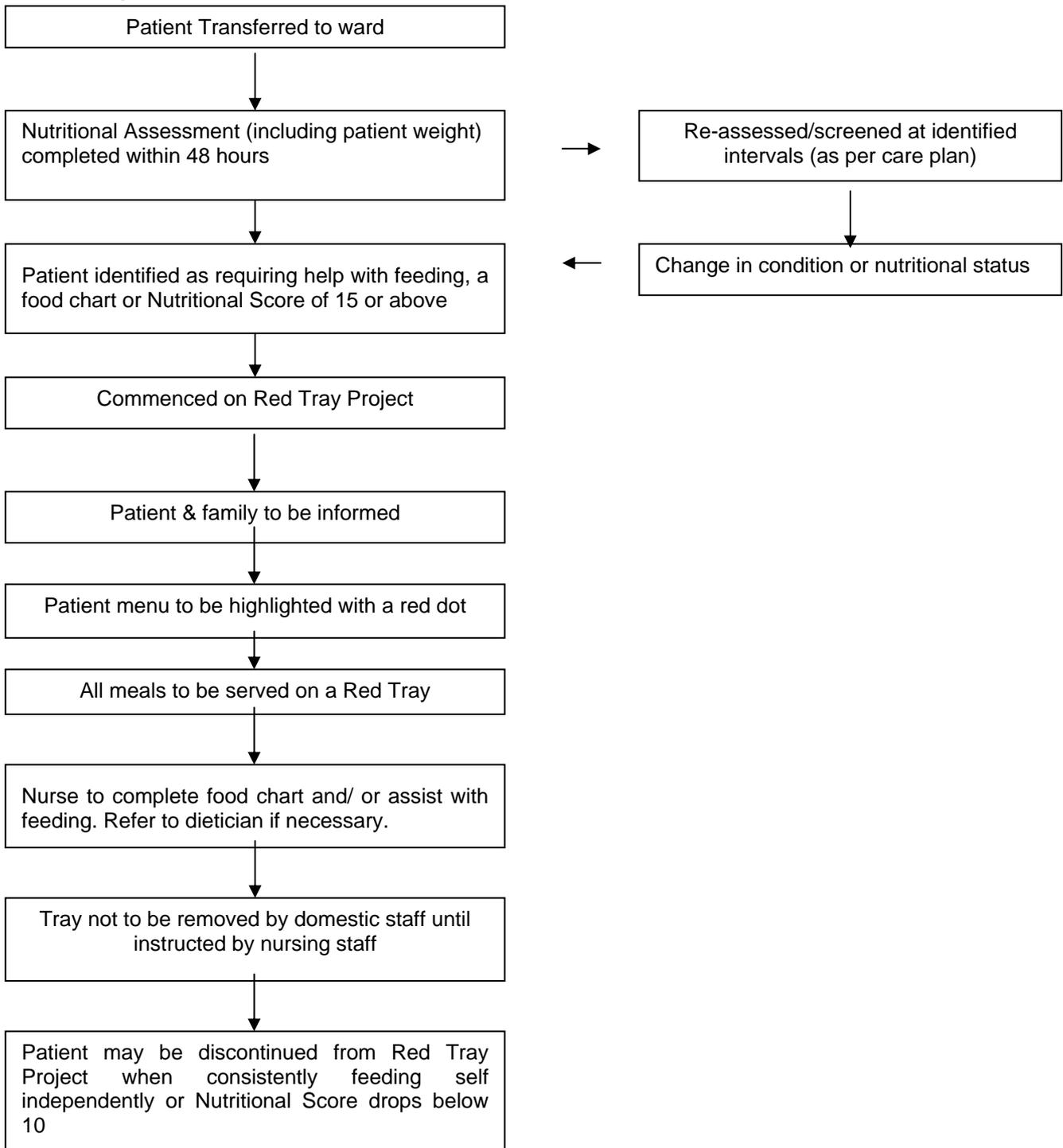
Patient nutrition is key to a healthy recovery. The Trust has well established Nutrition Board Committee and sub group meetings.

Nutrition is now included in new Dr's training and Registered Nurse training and we have developed the role of the volunteer mealtime assistants who are assisting with nutritional needs on the health care of the older persons wards.

A training programme has been developed for ward based staff.

Red tray guidance has been developed to improve patient nutritional status in compliance with Essence of Care. The flow chart highlights patients who need help with feeding or who are on food charts

## Red Tray Flow Chart



For the coming year:

- Essence of care benchmarking to be repeated in June.
- Annual study days for link nurses.
- Protected mealtime policy to be completed and implemented.
- Ward based training on Nutritional screening to continue.

## Maternity

The Trust has an excellent reputation for low rates of interventional deliveries (these are any deliveries which require further medical support) this is supported by an increasing ratio of midwives to birth rate. Currently Midwife to birth ratio is 1:30 but will be 1:28 when latest recruited Midwives are in post. We are experiencing a positive response to recent recruitment campaigns adding experienced and newly qualified midwives to the team. The Trust has delivered against Maternity Matters with the exception of developing the 'one number' (a single access phone number) across Nottinghamshire to access maternity care. A county wide solution is nearly in place with plans to operationalise at local level. Patients who attend this Trust are given the mobile phone number of their midwife.

The Trust has participated in the Nottinghamshire maternity and newborn service review engagement is now completed.

There has been a development of an Internet page which is updated by senior midwife to support information access and choice agenda's. A practice development midwife has been funded by deanery ensuring robust induction for new starters. A lay representative has been identified for Local Supervising Authority (LSA) audit and other activities.

Statistics 2009 :-Total Births 3106

	Sherwood Forest Hospitals	National Picture
Normal Births	74%	70%
Vaginal Births	85%	75%
Caesarians	15%	25%
Home Births	6%	2-3%

# Clinical Effectiveness

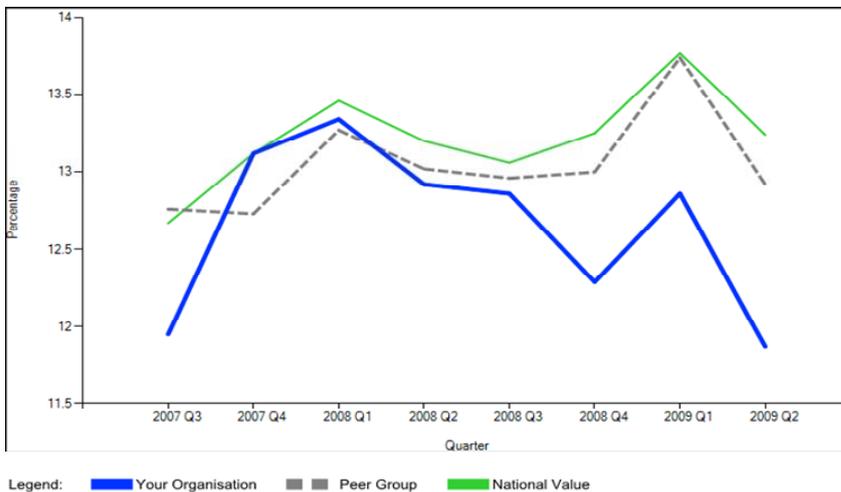
## Emergency Re-Admissions (14 Day)

Trust performance has been consistently better than both the 'medium hospitals' and NHS East Midlands averages since the start point of the NHS Institute for Innovation and Improvement (NHSII) benchmarking trend analysis in Q2 2007. Our current ranking is 60<sup>th</sup> / 167, however over the past 8 quarters we have been ranked in the top 30 Trusts on four occasions. The re-admission trend across Q1-Q3 in 2009/10 has remained at similar levels despite our continued improvement in reducing average length of stay

### NHSII Average Length of Stay Benchmarking Trend Analysis Q3 2007 – Q2 2009: All Specialties

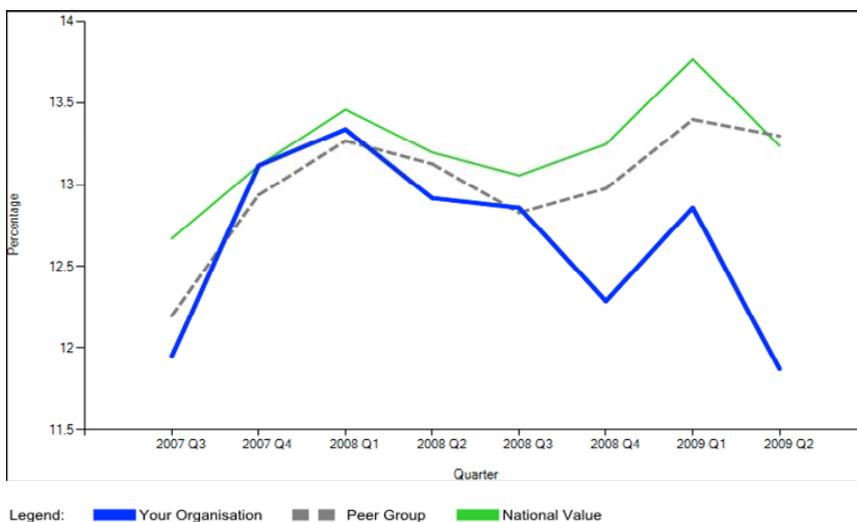
#### Peer Group – Medium Hospitals Average

Acute Trust Length of Stay by Specialty - Quarter Peer Analysis for SFHFT



#### Peer Group – East Midlands SHA

Acute Trust Length of Stay by Specialty - Quarter Peer Analysis for SFHFT



## Cancer

Cancer Waiting Times performance continues to be a priority for the Trust. Due to the lower number of referrals to the Trust and lower number of cancers treated, meeting the new national standards using the 18 week adjustment model continues to be a challenge. In particular performance has been significantly impacted by patient choice to defer diagnostics and/or treatments. This was most noticeable within December and January with the Christmas/New Year holidays and the severe weather experienced over the winter months. Several service improvement initiatives however are underway supported by our Cancer Management Team and local Mid Trent Cancer Network, Service Improvement Team.

## Fractured neck of femur

The National Hip Fracture Database (NHFD) is a joint venture of the British Geriatrics Society (BGS) and the British Orthopaedic Association (BOA), and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. It allows care to be audited against the six evidence-based standards set out in the BOA/BGS 'Blue Book' on the care of patients with fragility fracture and enables local health economies to benchmark their performance in hip fracture care against national data.

The NHFD is intended to focus attention on hip fracture both locally and nationally, benchmark its care across the country, and use continuous comparative data to create a drive for sustained improvements in clinical standards and cost effectiveness and to improve both the acute hip fracture pathway of care and subsequent falls prevention and bone health management: with direct benefits to patient care and outcomes, and eventual reductions in fracture incidence.

The data below (based on data submitted since September 2009) shows that the Trust's average time to theatre and average length of stay are better than regional or national averages. Performance on other indicators is also favourable. The following has been taken from the NHFD website.

### KMH – Latest data up to March 2010 (from September 2009)

Bluebook Times Last 12 months	Sherwood Forest Hospitals	SHA	National
Avg Time to ward (hrs)	8.24	8.33	9.87
Avg Time to Theatre (hrs)	32.75	47.44	43.31
Avg length of stay (days)	14.91	18.43	21.34

Bluebook Indicators Last 12 months	Sherwood Forest Hospitals Count	Sherwood Forest Hospitals %	SHA %	National %
Preoperative Assessment	136	91.28	46.41	58.43
Bone Protection Medication	149	100.00	54.19	57.87
Specialist Falls Assessment	130	87.25	36.84	56.07

## Sentinel Audit

King's Mill Hospital has gained accreditation as a Primary Stroke Centre, with excellent comments on our service, team and facilities from peer review.

Work is ongoing to further improve the service, using a structured stroke service improvement programme, including specific work streams for TIA (mini strokes), pathways and cross county partnership working.

The following table shows the progress made by the Trust with regard to the ongoing measurements against the 9 Sentinel Audit key performance Indicators. The Trust's performance has continued to improve in relation to access to CT scan, physiotherapy assessment within 72 hours of admission, OT assessment within 4 working days of admission and patient mood assessed. The percentage of patients whose care achieves all 9 indicators has improved from 4% in February to 20% in March 2010. (It is important to note that even specialist centres reported 0% of patients achieving all 9 indicators when the baseline was assessed)

		National quartiles			Baseline - Sentinel Audit October 2008	November 2009 24 patients	February 2010 23 pts	March 2010 45 pts
		25% of sites score below	median score	25% of sites score above				
Indicator 1	Patients spend at least 90% of stay on a stroke unit	44%	56%	69%	66%	88%	74%	78%
Indicator 2	Screening for swallowing disorders <24 hours after admission	58%	73%	88%	74%	67%	83%	73%
Indicator 3	Brain scan within 24 hours of stroke	44%	57%	70%	41%	71%	83%	84%
Indicator 4	Aspirin or clopidogrel by 48 hours after stroke	77%	88%	96%	87%	67%	61%	73%
Indicator 5	Physiotherapist assessment within 72 hours of admission	74%	88%	94%	78%	83%	83%	91%
Indicator 6	OT assessment within 4 working days of admission	43%	69%	85%	15%	67%	70%	78%
Indicator 7	Patient weighed during admission	61%	76%	87%	83%	96%	83%	91%
Indicator 8	Patient mood assessed by discharge	43%	68%	87%	72%	67%	65%	71%
Indicator 9	Rehabilitation goals agreed by the multidisciplinary team	80%	92%	97%	78%	100%	91%	98%
% patients who achieve all 9 indicators						4%	4%	20%

## Secondary Prevention

The information below is taken from MINAP (Myocardial Ischaemia National Audit Project) data. Period 01/07/09 to 31/12/09. Data includes patients discharged alive with a discharge diagnosis of myocardial infarction (heart attack).

July –September 2009

	KMH	NEWARK	NATIONAL
ASPIRIN	96.8%	90%	98.1%
B BLOCKER	92.9%	75%	94.3%
ACE	88.3%	80%	92.4%
CLOPIDOGREL	98.4%	70%	
STATIN			
All admissions	94%	80%	96.6%
Number of patients	67	4	

October – December 2009

	KMH	NEWARK	NATIONAL
ASPRIN	96.0%	100%	98.1%
B BLOCKER	95.0%	80%	94.3%
ACE	84.8%	88.9%	92.4%
CLOPIDOGREL	98.7%	88.9%	
STATIN			
All admissions	96.0%	100%	96.6%
Number of patients	142	10	

### Hospital Standardised Mortality Ratios (HSMR)

HSMR is an analysis of data drawn from Secondary Users Service (SUS, hospital figures), by the Dr Foster unit at Imperial College. The data uses the diagnostic code for cause of death and standardises by adjusting for a number of factors including age, sex, co morbidity, deprivation and method of admission. Monthly analysis of the data is made by the Dr Foster unit and any outliers are notified to respective Trusts for investigation.

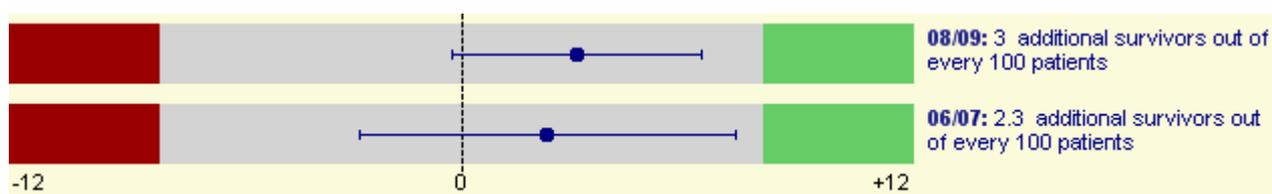
All alerts related to Dr Foster data were investigated by the Trust and there were no causes for concern last year.

Case note reviews did not identify any individual or systematic issues with quality of care with regard pneumothorax, cardiac failure or visceral atherosclerosis. Other variables such as definitions, data quality, patient case-mix, and chance may play a role.

Overall mortality reported by Dr Foster for 1 year is 96.16 compared to the national average of 100. Therefore the Trust is displaying lower than the national average for mortality.

### Trauma audit

The Trust collects and summarises data to the UK Trauma Audit and Research Network (TARN) The chart below shows the results for the audit showing the Trust as a Trauma Unit is performing better than average in the survival rates for patients admitted with severe injuries, with upper quartile outcomes for most areas of trauma care including head injuries and fractures.



### Rate of Survival at this Hospital: Yearly Figures

### Patient Reported Outcome Measures (PROMs)

PROMs were introduced in April 2009 and require assessment of patient's quality of life pre and post operatively. Data is analysed independently by nationally commissioned agencies.

The Trust has received the first set of results on participation rates for pre-op questionnaires, but to date no patient outcome reports.

Our participation rate for Hip replacements is 45%, Knee replacements 41%; Varicose veins 26.3% and hernias 33.5%

Within the East Midlands we are 4<sup>th</sup> out of 8 Trusts for veins and hernias, and 5<sup>th</sup> for orthopaedic procedures for response rates. The best responses are around 80%, and the worst are at 1%

An action plan has been implemented to improve participation rates, as the expected rate of return was expected to be 80% nationally, although this was before the process had been tried on this scale.

### **Discharge information**

We are one of a few local Trust's perform electronic same day discharge summaries for Emergency Care and in-patients. This is in response to GP's suggestions to improve care. The Trust is working with NHS Nottinghamshire County, NHIS (Notts Health Informatics service) and a panel of local GPs to improve the quality of the Trust's discharge summaries. A questionnaire was sent to all of the local GP practices in November 2009 and the results showed that the majority of respondents felt that they received timely discharge summaries and that the content is good and well laid out. The survey did highlight that the consistency of information did vary across the Trust and also highlighted specific areas for improvement. The results were discussed with the GP panel and a suggestion to incorporate a 'GP to action' box is currently being implemented by NHIS. The GP panel also highlighted some technical problems surrounding the electronic discharges, and five GP surgery visits have been conducted to understand how the Trust's system interacts with the different systems being used in our local primary care communities.

An audit focusing on the quality of the information within the discharge summary is currently being planned. The audit will be conducted in the first quarter of 2010-11 and the findings will be used as a training tool to continually improve the quality of the summaries further.

### **18 weeks from referral to treatment**

18 Weeks is about delivering the right care, at the right time and of the right quality without unnecessary delays.

18 Weeks measures the whole patient pathway from referral to the start of treatment, including all tests and out-patient consultations up to the start of treatment.

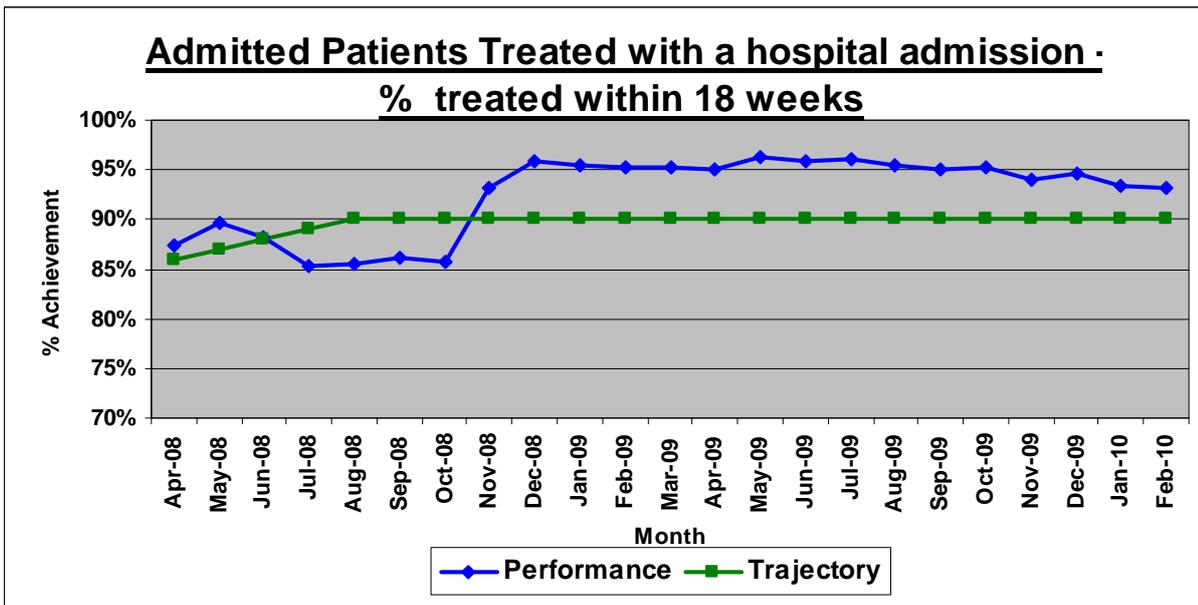
National Target from December 2008

90% of patients treated on an 'admitted' (where treatment is often an operation or procedure) pathway; and

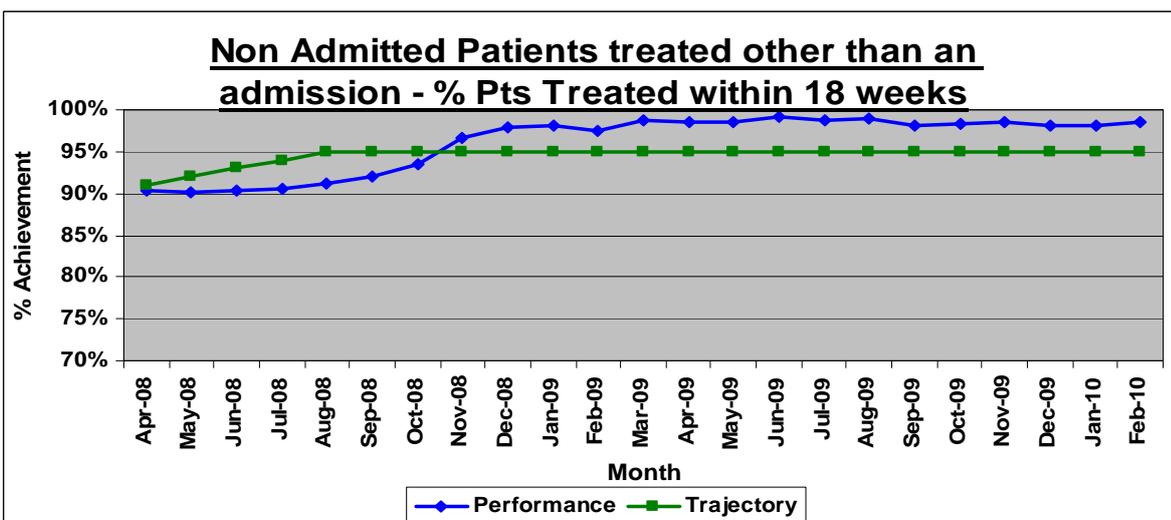
95% of patients treated on a 'non-admitted' pathway are treated within 18 weeks.

At the end of March 2010 the average (median) wait for admitted patients waiting for surgery was 10 weeks and non admitted patients was 4-5 weeks.

**Performance  
Monthly Summary – Admitted**



**Monthly Summary - Non Admitted**



The Trust is consistently achieving in all specialties with the exception of trauma and orthopedics, where there is an action plan to address this.

The data for the last quarter is still to be validated.

**End of Life Care**

The Trust has implemented an End of Life Action Plan & Pathway. The national End of Life Care Strategy quality markers for Acute Hospitals consist of 14 identified measures. The Trust's General Palliative and End of Life Care Group have base-lined against these measures and can demonstrate full compliance with 3 measures. The work plan for the coming year is to work towards full compliance in all standards.

Compliance with 3 measures:

1. Hospital based Specialist Palliative Care MDT
2. Full implementation of LCP (Liverpool Care Pathway) across all Wards within the Trust
3. Quiet spaces in wards for relatives and carers.

Work being progressed throughout the year:

1. End of Life Care action plan.
2. Accessing the needs of carers and relatives.
3. Effective communication with GP's and health care professionals within Primary Care.
4. Auditing of End of Life Care data
5. Effective mechanism for identifying those who are approaching end of life.
6. Accessing and recording needs and preferences.
7. Identifying patients preferred place of care.
8. Development of a locally wide register.

## Patient experience

### Pledges

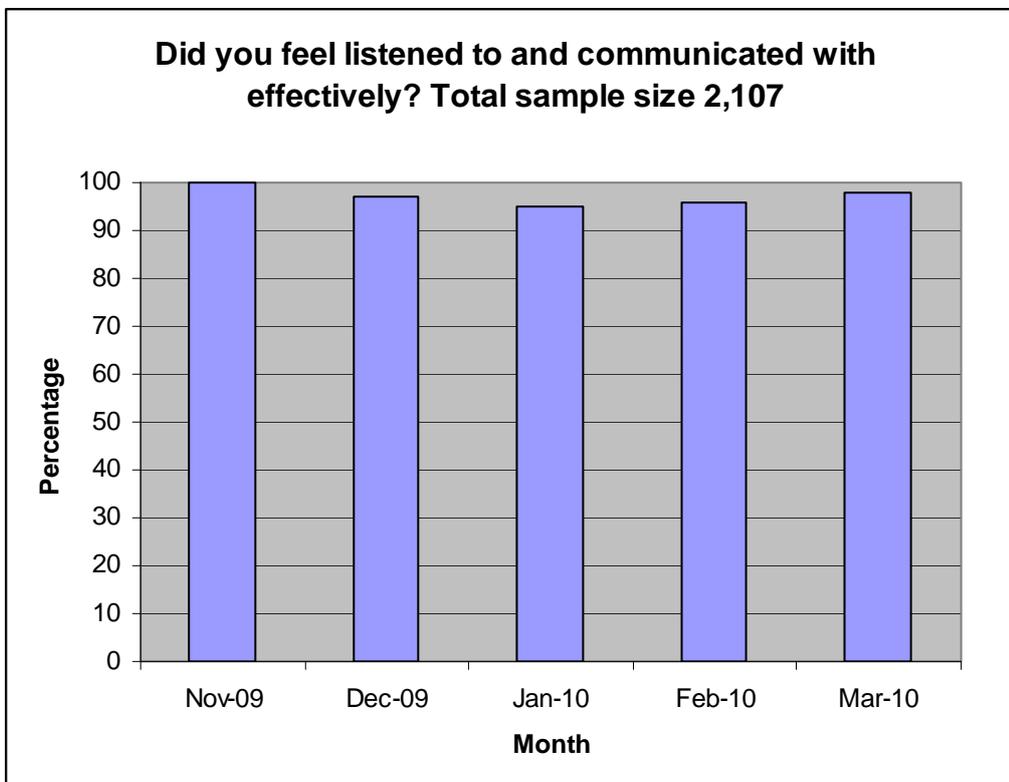
Throughout the year real time data collection has been captured. In-patients and outpatients have been surveyed on a daily basis and the information gained used to make service improvements.

The graphs below show a visual representation of the results from the real time data collection of adult in-patients During November 2009-March 2010. The questions are based on the patient and carer pledges, which have been developed with patients, carers, staff, members and Governors and are:-

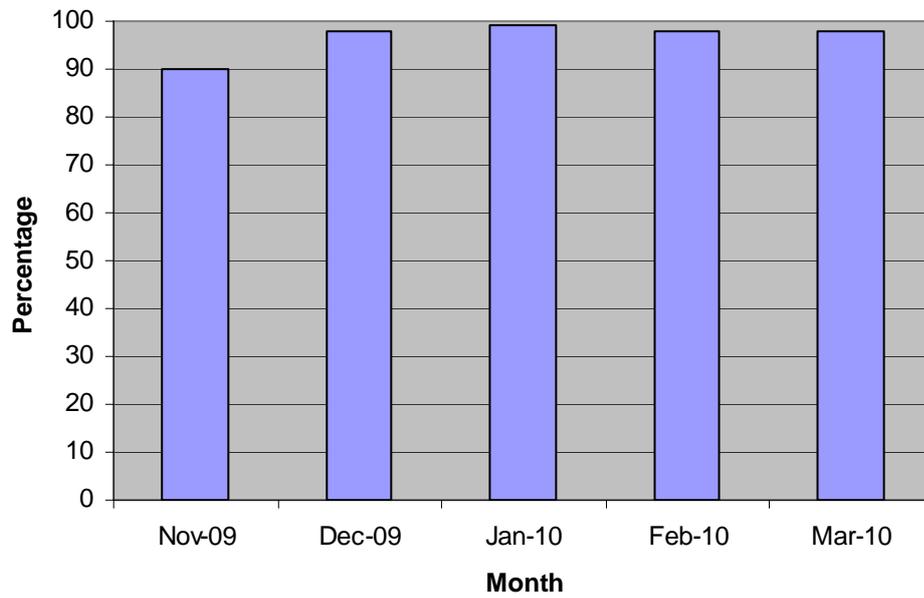
#### *Patient and carer pledges*

- We will listen to you  
(Your individual needs and concerns, and respond to them)
- We will work together as a team  
(and with you, to give you the best care)
- We will show kindness and compassion  
(treating each of you with dignity and respect)
- We will communicate effectively  
(at the right time and in a way that is easy to understand)
- We will care for you in a safe and clean environment

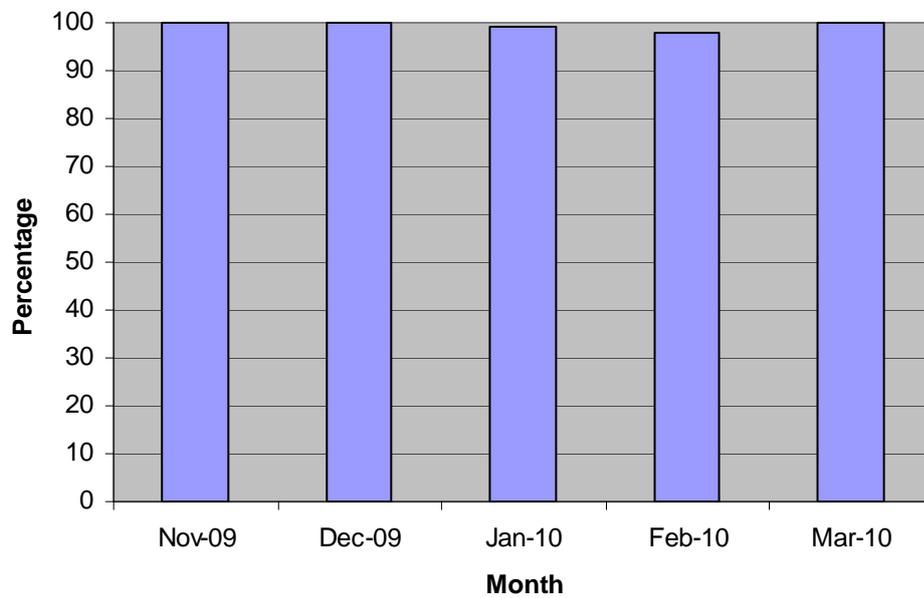
The graphs below show the percentage of people who answered yes.

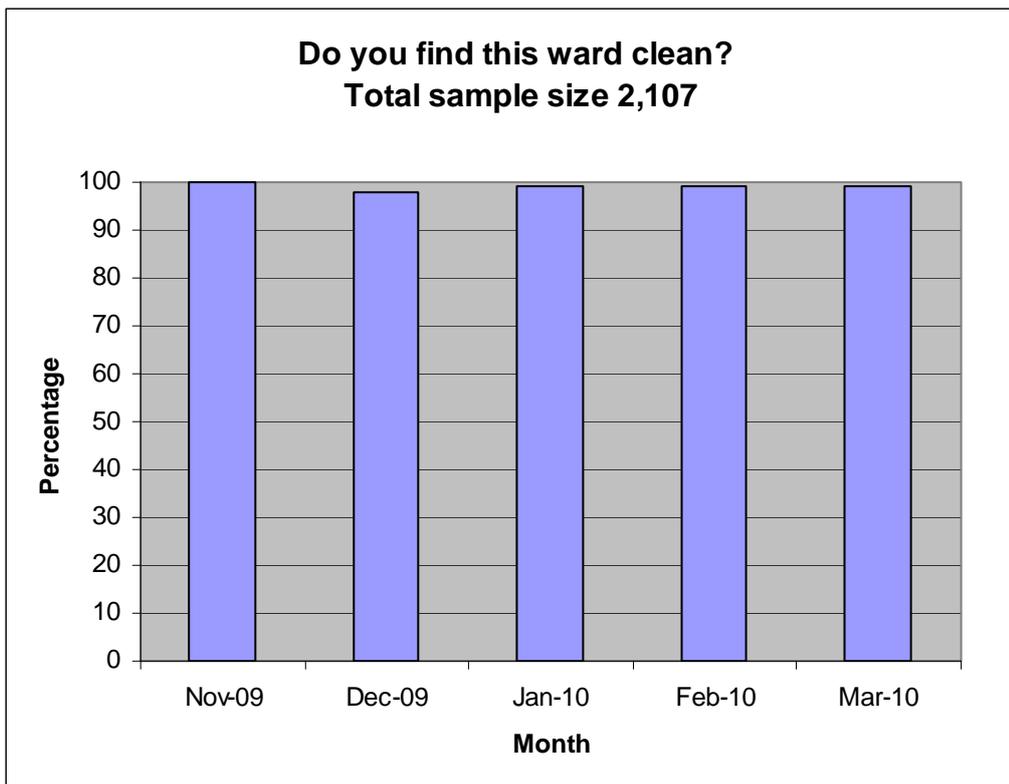


**Did you feel people caring for you worked as a team? Total sample size 2,107**



**Did you feel you are shown kindness and courtesy? Total sample size 2,107**





### Complaints

Following the introduction of revised National Complaints Regulations on 1 April 2009, more emphasis has been placed on involving complainants in how their complaint is handled. The Complaints team is committed to strengthening communication links with patients, carers and relatives.

The Trust received 485 complaints in 2009/10, compared with 499 in 2008/09.

The national target for acknowledging complaints is three working days and this was achieved in 96% of cases. There is no national target for responding to complaints and the emphasis is placed on agreeing an appropriate timescale for investigation with each individual complainant. To assist in monitoring purposes, the Trust uses a red, amber green rating system. Complaints graded red are the most complex and can take up to a maximum of six months; amber complaints 30 working days, and green complaints 20 working days. 81% of complaints were answered within the initially agreed response period and 19% of complaints were answered within an extended period.

The Trust continues to use complaints positively in order to make improvements to services and examples of actions implemented are provided in our quarterly board reports.

### Patient Advice and Liaison Service (PALS)

The PALS team continue to support our patients, carers and visitors through their NHS journey. During 2009/10 the team handled 6,903 contacts and the common themes were communication, waiting times, appointment cancellations and environmental issues. Monthly reports containing all patient experience data including PALS referrals are shared with service management teams identifying possible service improvements, training needs and sharing patient compliments.

### Cleanliness / PEAT Assessment results 2009.

The Patient Environment Action team (PEAT) was established in 2000 to assess NHS hospitals.

Under the programme every hospital providing inpatient and outpatient care has to undertake an assessment of its patient environments, cleanliness and food. Assessments can be either using internal / external teams. Results are validated for internal audits with the inclusion of a patient

representative and / or a Patient Governor. Performance may also be assessed by an external representative participating either on the day or post validation visit – both would be unannounced.

In 2009 Sherwood Forest Hospitals undertook an internal audit involving two patient representatives.

Improvement was noted in the environment and privacy and dignity categories with a move from acceptable to good. Food services retained its good rating.

At Newark Hospital the improvement was noted in the environment and food with a move from acceptable to good. Privacy and dignity retained its rating.

### Comparison of 2008 performance to 2009 performance

Year 2008	Site Name	Environment Score	Food Score	Privacy and Dignity Score
	King's Mill Hospital	Acceptable	Good	Acceptable
	Newark Hospital	Acceptable	Acceptable	Good
Year 2009	King's Mill Hospital	Good	Good	Good
	Newark Hospital	Good	Good	Good

During the last year we have continued to work closely with our service providers to continually improve. The audit for 2010 was undertaken during February and was supported by an external validator. Although official scores will not be available until June, initial findings were excellent. The team found that standards across both sites were consistent in both new and old estate with only a few minor issues being identified.

### Steamplicity

The Trust has worked closely with our service providers to introduce a new meal service system, Steamplicity to all the wards in the new hospital. This was rolled out during September 2009. Steamplicity is a meal cooking system that steams food in four to six minutes. Each meal is individually plated and steamed in packaging that contains a steam-release valve – like a mini pressure cooker – which regulates the temperature throughout the cooking process, keeping the food in the best possible condition. The valuable nutrients are retained and food keeps its colour and texture.

There are 24 choices of main meals on the current menu all offered at lunch and suppertime, from roast chicken to cod Provencal, macaroni cheese to beef casserole. There are choices of salads and sandwiches as well as 15 desserts to choose from. Special diets are also catered for including diabetic, high energy, vegetarian, gluten free, low salt. The menu can be provided in any language, including braille.

Steamplicity meals are free from artificial additives and preservatives, created using quality ingredients and analysed by nutritionists to meet the latest Government and NHS guidelines.

Introducing the new system was a huge challenge to both the Trust and Medirest; the new Ward Hostesses role was introduced at the same time, to separate the cleaning and catering functions at ward level.

Whilst the Trust and Medirest were pleased with the introduction of the new service, the real test of course is how the patients responded. These are a few of the many positive comments we have received:

“Much to my surprise I really look forward to ordering meals, I never thought I would see the day whereby hospital food tasted so nice” (retired GP)

“I am due to go home go home after three weeks in hospital and am upset to be leaving as the new food is marvellous”

“I love the food, the best I had ever had at any hospital and I have been to a lot of hospitals.”

“As a diabetic I liked the wide range of choice and symbols showing the healthy options.”

Steamplicity was introduced onto the children’s surgical ward during December 2009 and this has significantly improved the children’s experience too.

The contract management team have continued to monitor the food service delivery at ward level and the standard of service being delivered continues to be very high.

PEAT 2010 demonstrated positive feed back on all elements of food service, whether delivered via the Steamplicity or conventional cook chill method. There was plenty of choice and variety on the day of the audit, and the quality and presentation of the food achieved an “excellent” rating on both sites.

Steamplicity will be introduced onto the remaining wards as they move into the third tower of the new hospital in 2010.

The Trust are also considering the roll out at Newark Hospital in the future.

### **Privacy and Dignity-Same Sex Accommodation**

National Standard;

Deliver substantial and meaningful improvements which will virtually eliminate mixed sex accommodation (MSA), including shared sleeping accommodation and sanitary facilities.

The Trust is committed to:

- Ensuring that all patients receiving care within its hospitals feel that they are treated with respect and that their right to privacy and dignity is upheld and actively promoted.
- There are no exemptions from the need to provide high standards of privacy and dignity. This applies to all areas, including when the patient’s admission is unplanned.
- High standards involve a presumption that men and women do not have to sleep in the same room nor use mixed bathing and toilet facilities, unless there is a compelling clinical need.
- To protect patients from unwanted exposure, including casual overlooking and overhearing the Trust will aim to ensure that all patients admitted to or transferred to another area within its hospitals have access to the right bed, in the right place at the right time.

A full review of the Trust’s estate at both Newark and King’s Mill Hospitals was undertaken in late Spring 2009, and over £692,000 was spent to enhance accommodation.

A proposal to improve elements of the estate was developed and approved by the Executive Management Board and schemes of work agreed.

A very positive peer review was undertaken by representatives from the Department of Health, NHS East Midlands and NHS Nottinghamshire County

Specific initiatives during 2009/10 included:

- Transfer of adult medical and surgical wards at King's Mill Hospital to new wards with 50% single occupancy rooms and en-suites and multi occupancy bays with en-suites.
- Provision of en suite WCs to the majority of bays and some single occupancy rooms at Newark Hospital.
- Provision of additional shower and bathrooms at Newark Hospital
- Provision of additional assisted WCs including within the minor ops suite at Newark Hospital.
- Refurbishment of Wards 8 & 9 in preparation of opening the Emergency Assessment Unit, including the provision of additional bathrooms and the creation of solid partitions to all multi occupancy bays
- Creation of a second trolley recovery area on the Day Surgery Unit enabling patients of the opposite sex to recover in separate areas.
- Provision of a second assisted WC in the new Endoscopy dept to enable patients of the opposite sex to be cared for in separate recovery areas.
- Erection of full height solid partitions to some bed spaces in the Intensive Care Unit to reduce overlooking and overhearing.
- Revision and launch of the Trusts Privacy & Dignity Policy with an individual copy to every member of Trust staff.
- Participation in two public awareness campaigns, including a manned stand during Dignity and Same Sex Accommodation Awareness Week

### **Ongoing Improvement Work**

The Trust will have undertaken a self assessment and published a public declaration of compliance with virtually eliminating mixed sex accommodation by 31<sup>st</sup> March 2010.

A monitoring and reporting procedure for any mixed sex occurrences will be implemented from 1<sup>st</sup> April 2010.

The written information provided to patients regarding same sex accommodation will be reviewed

Staff training requirements in relation to privacy and dignity will be reviewed with a view to ensuring that all staff groups within the Trust receive training on their roles and responsibilities and the behaviours expected by the Trust.

We are continuing to ask patients real time questions relating to same sex accommodation and report these findings back to the Board of Directors on a quarterly basis as well as the lead nurse on a monthly basis.

## **Our Staff**

### *Staff Engagement*

In partnership with staff, during 2009 we developed and published pledges for both our staff and patients. These 'pledges' set the standards which form the basis of our relationships with staff and patients and upon which we will measure and communicate our progress:

**Our Pledges to Staff**

**We will appreciate you**

(showing respect and recognition for what you do)

**We will listen to you**

(ask your views, working and communicating with you effectively)

**We will support you to do the best in your job**

**We will provide a safe environment**

We have a number of formal and informal mechanisms in place to support the pledge to our staff of - "*We will listen to you*". The Joint Staff Partnership Forum is the forum for consultation and negotiation, which meets on a monthly basis to discuss and explore the key strategic issues. A new Workforce Change Group has recently been established to support and oversee consistency of approach to changes affecting our staff. This group has been established as a direct result of feedback from staff side colleagues regarding their need to fully understand and support workforce changes.

During the latter part of the year, the Board of Directors and Executive Team commenced the development of our corporate turnaround strategy focused on clearly communicating the actions required during 2010/11 to ensure that we have a sustainable financial future - protecting our cash, reducing our costs and increasing our profitability, whilst continuing to further improve our efficiency.

The successful delivery of our 'Meeting the Challenge Strategy' will depend upon our ability to call our staff to action, to communicate and engage with them and to ensure that all our staff are clear about the role they play in assisting us to deliver our plans and maintain a relentless focus on quality. During the early part of 2010, we have held a number of forums to brief staff on the challenges and priorities contained within "Meeting the Challenge" which sets out our vision and strategy for the coming years. This mechanism has already assisted us to improve our engagement with staff and to identify potential service improvement solutions for the future. Some 400+ suggestions were received from staff regarding opportunities for improvement. A group has been established to review the suggestions made and provide responses either on themes (such as sickness absence) or an individual basis.

We are committed to delivering our pledges and to working in partnership with staff and their representatives. During the year we have listened to the views of staff in relation to our internal communications. As a result of feedback, we have recently introduced our Chief Executive's "blog", reviewed our 'team' brief and used internal surveys to improve our communications with staff.

We also recognised the achievements of our staff at our annual staff excellence awards presentation ceremony in September 2009 and introduced a Star of The Month scheme to recognise the contributions of individuals

Throughout the year, we worked closely with our staff Governors: obtaining their views on our forward plans, discussing our operational and financial performance, engaging them as Governors in improving the quality and safety of our services and assisting them to engage with our staff members. We are grateful to them for their significant contribution.

Our priority for 2010/11 will be the continued implementation of our new staff engagement strategy: improving staff communications, continuing our initiatives to enhance team working and the development of a new training, education and development strategy. These improvements are

critical to our Achieving Best Care (our ABC) approach that will help ensure we deliver our pledges to staff and support cultural change within the organisation.

### 2009 Staff Survey

The Trust participates in the National Staff Survey on an annual basis in which 850 randomly sampled staff are surveyed.

An analysis of the response rate and top and bottom four ranking scores from the 2009 survey is shown below:

#### Response Rate:

Response Rate 2008		Response Rate 2009		Improvement / Deterioration
Trust	National Average	Trust	National Average	
52%	52%	50%	50%	Our response rate decreased by 2% but remained in line with the national average

#### Top 4 Ranking Scores:

	2008		2009		Improvement/Deterioration
	Trust	National Average	Trust	National Average	
<b>Percentage of staff experiencing harassment, bullying or abuse from patients/relatives in last 12 months</b>					
	21%	22%	16%	21%	2009 Trust lowest (best) 20% Decreased by 5% points (positive)
<b>Percentage of staff suffering work-related injury in last 12 months</b>					
	13%	17%	13%	17%	2009 Trust lowest (best) 20% No change in % points
<b>Percentage of staff experiencing discrimination at work in last 12 months</b>					
	4%	---	4%	7%	2009 Trust lowest (best) 20% No change in % points
<b>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</b>					
	18%	19%	14%	18%	2009 Trust lowest (best) 20% Decreased by 4% points (positive)

#### Bottom 4 Ranking Scores:

	2008		2009		Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
<b>Percentage of staff having equality and diversity training in last 12 months</b>					
	26%	27%	26%	35%	No change in % points. 2009 Trust below average
<b>Percentage of staff receiving health and safety training in last 12 months</b>					
	76%	76%	75%	78%	Decrease by 1 % points (negative). 2009 Trust below average
<b>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</b>					
	90%	95%	94%	95%	Increase by 4 % points (positive). 2009 Trust below average
<b>Percentage of staff experiencing physical violence from patients/relatives in last 12 months</b>					
	14%	12%	11%	11%	Decrease by 3 % points (positive). 2009 Trust at national average

**Note:** National Average figures given represent those for Acute Trusts

The 2008 staff survey outcomes suggested the need to improve our approach to staff appraisal, violence and aggression, flexible working and incident reporting. During the year significant work

was completed to ensure all staff received an appraisal together with an associated personal development plan (PDP). We are pleased to note improvements in responses for 2009 regarding staff appraisal, staff having a well structured appraisal and staff appraised with a PDP, all of which ranked highly when compared to other Trusts.

We have also completed a review of our violence and aggression policy and introduced personal security devices for vulnerable staff, again we are pleased to note improved responses in relation to the perceptions of us as an employer towards violence and harassment. We will continue to focus our attention on the reporting of errors and near misses which remains an area for improvement.

The 2009 staff survey outcomes identify many positive responses - we performed average or above in 37 out of the 40 key finding areas – see below.

The survey responses show an improvement in 10 key finding areas, no change in 25, 1 area which has worsened and 4 new key finding areas which were previously unreported and therefore have no comparable data.

#### **40 key findings**

	<b>2008</b>	<b>2009</b>
<b>Best 20%</b>	11 Areas	18 Areas
<b>Better than Average</b>	10 Areas	12 Areas
<b>Average</b>	9 Areas	7 Areas
<b>Worse than Average</b>	1 Area	3 Areas
<b>Worse 20%</b>	5 Areas	0 Areas

Whilst we are pleased with the survey outcomes there remain a number of areas which require improvement. Our action plan for 2010/11 will focus on:-

- Reviewing incident reporting processes regarding errors, near misses or incidents
- Developing and implementing a programme of Equality and Diversity training
- Developing and implementing new approaches to increase the uptake of health and safety training
- Developing and implementing new approaches to deliver job related training

Detailed action plans have been developed for these priority areas and will be led by identified Managers. Delivery of the action plans will be overseen by the Workforce Committee.

## **Accreditation**

### **Pathology**

All of the departments within Pathology at Sherwood Forest Hospitals have been awarded full accreditation by Clinical Pathology Accreditation (UK) Ltd, the recognised accreditation body for medical laboratory services in the United Kingdom.

The process of accreditation involves the external assessment of a medical laboratory to assess conformance with 'Standards for the Medical Laboratory' incorporating ISO 15189:2003 to ensure that the laboratory provides a service that meets the agreed needs and requirements of its users. Cellular Pathology were the first department within Pathology to be awarded full accreditation status in March 2008 followed by Haematology and Clinical Chemistry in June 2009. Microbiology were the last department to be fully accredited in November 2009. The staff in Pathology are committed to maintaining the standards required to remain fully accredited after future inspections in order to support the Trust in continually improving the quality of care that is delivered to its patients.

## **Cancer**

The Trust has 8 Cancer multidisciplinary teams (teams made up of various health care workers) who all take part in the new annual self-assessment Peer Review Programme. In addition cross-cutting services will join the programme as and when the national standards are released. The Trust plans to participate in the national cancer patient survey programme and will use the results to feed into local service provision and cancer MDT teams. The Trust was one of the first in the East Midlands to do a rigorous self assessment for peer review. In addition the Trust's skin and upper gastrointestinal teams were externally reviewed in Jan 2010 with Gynaecology and Lung scheduled for an external review in Jan 2011.

We have (noted by the Mid Trent Cancer Network Peer Review Group) a robust internal validation process and plan to review all teams annually after their self-assessments. Any issues are raised with the relevant divisions and monitored by the local Cancer Unit Board via a risk register.

## **Stroke**

A set of criteria have been developed for organisations accepting stroke patients.

Comprehensive Level 1 provides 24 hour a day direct admission to an acute stroke unit with access to neurological and neuro-radiological service in addition to a foundation of stroke care  
Primary Level 2 provides direct admission to an acute stroke unit for a restricted number of hours per day (up to 24 hour) in addition to a foundation of high quality stroke care  
Local Level 3 A centre providing a foundation of high quality stroke care

Under the new proposals, people will be taken by ambulance directly to the nearest hospital with a specialist stroke centre rather than the closest hospital.

The NHS East Midlands Acute Stroke Services Project set out minimum criteria each level must achieve within 3 years in order to be accredited. This includes having appropriately trained staff who can offer urgent care including brain scans. There will be 24-hour cover to ensure patients can access specialist care at any time of the day or night.

King's Mill Hospital was successfully accredited as a Primary (level 2) stroke centre and Nottingham University Hospitals has been accredited as a comprehensive (level 1) stroke centre, following a rigorous assessment process.

## **Primary Percutaneous Coronary Intervention (PPCI) (heart attack treatment)**

In order to deliver a comprehensive reperfusion therapy (treatment for heart attacks) service it is proposed that three levels of service provision provided within the East Midlands for heart attack patient who need reperfusion therapy.

- Level 1: 24/7 Primary Percutaneous Coronary Intervention (PPCI);
- Level 2: PPCI (Restricted hours) with an out-of-hours regional PPCI service;
- Level 3: Gold standard Acute Coronary Syndrome Management.

To ascertain the level of service provision:

- It is mandatory that each centre meets the minimum standard of a Level 3 provider. This will mean clear, robust, sustainable protocols for management of these services, working with partner organisations, e.g., ambulance services other level providers.
- All centres comply with current and future British Cardiovascular Intervention Society (BCIS) requirements.
- Interventional cardiologists will be required to form part of the rota for 24/7 PPCI care, to ensure a sustainable reperfusion therapy service for the region.
- Thrombolytic therapy (clot busting drugs) will be available within protocols for the region.

King's Mill Hospital was successfully accredited at level 3

## Our Priorities for 2010/11

The three main priorities for the 2010/11 quality report will be linked to the domains of patient safety, clinical effectiveness and patient experience. Other priorities will also be identified for 2010/11. The priorities will stretch the organisation further in its vision of providing *Best Care Best People Best Place*.

### Why have they been chosen?

These priorities have been chosen after consultation with staff and the Board of Governors who represent the views of the public. A development day was held in January 2010 and various board of Governors sub committees have taken place throughout the year namely, performance and strategy, membership and engagement and patient quality and experience.

### How will progress be monitored and measured?

Progress will be monitored via monthly and quarterly quality report's which are presented to the Board of Directors, the PCT at the monthly Quality Scrutiny Panel, through the Clinical Governance Committee, to the Patient Quality and Experience sub committee of the Board of Governors and monthly and quarterly reports to the Board of Directors.

### Priorities for 2010/11

The three top priorities for 2010/11 are listed below.

#### 1. Patient safety

Further reduce incidents of slips trips and falls

#### 2. Clinical effectiveness

Reduce avoidable death, disability and chronic ill health from VTE (venous thromboembolism)

#### 3. Patient experience

Improve privacy and dignity of patients including Same Sex Accommodation

### Other Quality Priorities for 2010/11

#### Patient safety

- Reduce cases of healthcare acquired infections (specifically urinary tract infections and MSSA bacteraemia).
- Maintain a zero tolerance on hospital acquired pressure ulcers
- Implement national best practice standards within the patient safety first campaign, to include specific focus on reducing slips, trips and falls
- Implementation of the world health organisation (WHO) theatre check list
- Maintain improvement in caesarean section rates to be within the top quartile of peer comparator Trusts

#### Clinical effectiveness

- Continue to improve monitoring of acutely ill patients
- Further participation in national clinical audits
- Monthly review of hospital standard mortality rates
- Improve patient's dignity in theatre with more effective theatre gowns
- Reduce the number of infections associated with indwelling urinary catheters
- Improvement in the number of procedures listed in the BADS handbook (day case procedures)
- To reduce the number of under 17 year old accident and emergency attendees who are admitted
- Reduction in the mean medical emergency length of stay

- Reduction in emergency readmissions for people with long term conditions
- Improvement in post stroke death and dependency rate
- Improvements in national sentinel process of care audit scores

### **Patient Experience**

- Improve patient meals service, specifically meals for patients with compromised nutrition
- Improvement on ambulance turn around times
- Improvement against the five national indicator measures
  1. Were you involved as much as you wanted to be in decisions about your care and treatment?
  2. Did you find someone on the hospital staff to talk to about your worries and fears?
  3. Were you given enough privacy when discussing your condition or treatment?
  4. Did a member of staff tell you about medication side effects to watch out for when you went home?
  5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- Participation and development of action plans in relation to the East Midlands patient experience project
- Continue to use real time data to improve the customer experience and identify themes and trends for service improvement
- Continue to develop the role of volunteers in enhancing the customer experience

## Our Assurance

### Review of services

During 2009/10, the Trust provided 50 clinical services.

The Board of Directors has reviewed data made available to it in relation to the quality of care of these services.

The income from clinical services represented 79% of the total income generated from the provision of services by the Trust for 2009/10.

### Audit and research

During 2009/10 17 national clinical audits and 6 national confidential enquiries covered NHS services that Sherwood Forest Hospitals provides

During 2009/10 Sherwood Forest Hospitals participated in 88% of national clinical audits, and 100 % (6/6) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals was eligible to participate in during 2009/10 are as follows:-

#### National Confidential Enquiries (NCEPOD)

Title of national audit / patient outcome project	Participated
Parental Nutrition (Jan 09-Dec 09)	Yes
Elective & Emergency Surgery in the Elderly (Oct 08-Dec 09)	Yes
Surgery in Children (Apr 08 –Mar 10)	Yes
Peri-operative Care (Mar 2010)	Yes

#### Confidential Enquiries into Maternal and Child Health (CEMACH)

Title of national audit / patient outcome project	Participated
Obesity in pregnancy (March 09 –April 09)	Yes
Head injuries in Children (Sept 09 – Feb 10)	Yes

#### National Clinical Audits (as defined by the HQIP 2009/2010 schedule but with N/A projects removed e.g. paediatric cardiac surgery / not done at Sherwood Forest Hospitals)

Title of national audit / patient outcome project	Participated
Bowel cancer (NBOCAP)	Yes
National lung cancer audit (NLCA)	Yes
Oesophago-gastric (stomach) cancer	Yes
Mastectomy and breast reconstruction	Yes
British Association of Urological Surgeons. (BAUS)	No. Audit will commence 2010/11
National Neonatal Audit (NNAP)	Yes
National Audit of Cardiac Rehab.	Yes
Heart Failure	Yes
Heart rhythm management	Yes
Myocardial ischaemia (MINAP)	Yes

National Diabetes Audit	No
National Joint Registry (NJR)	Yes
RCP Continence audit 3rd round 2009	Yes
Carotid Interventions / NVD	Yes
Hip Fracture Database	Yes (from Sept 09)
TARN	Yes
Intensive Care National Audit and Research Centre (ICNARC)	Yes

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals participated in, and for which data collection was complete during 2009/10, are listed below alongside the number of cases submitted to each audit enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

Clinical audits and national confidential enquiries	Number of cases	Percent submitted
Parental Nutrition	19	58%
Elective and Emergency Surgery in the Elderly	16	63%
Surgery in Children	Still in 'cases ascertainment' stage – NCEPOD will inform the Trust by mid July of the total number of cases expected – case submission will commence after that.	TBC by June/ July 2010  NCEPOD to confirm sample size following national case ascertainment stage
Peri-operative Care	101 cases submitted from theatres against 216 actual in-patient procedures	41%
Obesity in pregnancy	54	100%
Head injuries in Children	31	100%
Bowel cancer (NBOCAP)	On-going	100%
National lung cancer audit (NLCA)	On-going	100%
Oesophago-gastric (stomach) cancer	114	100%
Mastectomy and breast reconstruction	183	100%
National Neonatal Audit (NNAP)	337	100%
National Audit of Cardiac Rehab.	831	100%
Heart failure	242	100%
Heart rhythm management (pacing/implantable defibrillators)	223	100%
Myocardial ischaemia (MINAP)	661	100%
National Joint Registry (NJR)	884	100%
RCP Continence audit 3rd round 2009	80	100%
Carotid Interventions / National Vascular Database	58	28%

Hip Fracture Database	191	100%
TARN	144	64%
ICNARC	684	100%

The reports of 1 National Clinical Audit were reviewed by the provider in 2009/10 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided

1. National Falls and Bone Health Audit – Organisational audit only – undertaken in 2008 but reported and reviewed in 2009

Conclusions:

The Trust was not fully compliant with all areas of the national falls guidance although significant improvements have been made to the service. The action plan below has contributed to further improvements in service.

	<b>Actions planned</b>	<b>Date to implement by</b>	<b>Date implemented</b>
1	Instigate multidisciplinary, consultant led, fully integrated Falls Clinic.	May 2009	May 2009
2	Follow up of >65yrs, fallers who attend A&E with Multi-factorial falls risk assessment form	April 2009	April 2009
3	Data – The Falls group will review in patient falls data against inpatient activity (occupied bed days)	June 2009	Process commenced April 09
4	Audit – the Falls group will discuss audit requirements for 09/10 including potential audit of the use of the falls risk assessment form.	Sept / Oct 2009	Oct 2009
5	Undertake a Patient Satisfaction Survey of falls clinic	Dec 2009 / Jan 2010	Underway Jan 2010
6	Community osteoporosis protocol to be made available on the Trust intranet.	Oct 2009	Oct 2009
7	Nursing core plan to include Day case patients as well as inpatients	Feb 2009	Feb 2009
8	Pre-operative medical assessment and treatment on the orthopaedic ward by a senior physician with relevant training	Jan 2011	Process commenced Jan 2010

The reports of 31 Local Clinical Audits were reviewed by the provider in 2009/10 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided.

<b>Audit</b>	<b>Question</b>	<b>Outcome</b>
1	Are we compliant with procedures for requesting, consenting obtaining and sending bone donations following Total Hip Replacements at King's Mill Hospital? Audit reported 19 <sup>th</sup> April 2009	Findings sent to relevant group's pre-op nurses, theatre nurse, and Orthopaedic surgeons. Refresher/ Update Courses under taken. Posters and information leaflet for patients explaining process devised. Blood collection on admission completed.
2	Eye casualty review appointments Audit standard: All review appointments for eye casualty patients should be arranged in the time-frame stated by the casualty officer	A repeat prospective audit to address the issue of appropriateness of referrals. All non-A & E referrals to be referred directly to OP clinic. Reserve a specific number of OP clinic slots for such patients. Triage of patients seen in A & E over weekend, to allocate an appropriate review date.

	100% Local target Results: Only compliant in 59% of cases audited. Audit reported 23rd April 2009	This is being re audited in 2010 to complete the audit loop.
3	Diabetic Ketoacidosis protocol (DKA) - is it being followed for the immediate management of patients? Audit reported 5 <sup>th</sup> May 2009	Presentation of audit results at the Medicine Grand Round March 2010 Availability of printed protocol on the wards
4	Treatment and documentation around treatment variance for causes of gonorrhoea in GU Med Audit reported 6th May 2009	Highlight guidelines to all staff Present findings Plan re-audit in April 2010
5	Clinical care of under 16 year olds in GU medicine Audit reported 28th May 2009	New proforma for notes of under 16's developed and staff trained in its use
6	Secondary prevention and osteoporosis at King's Mill Hospital- are non-hip fractures managed according to current nice guidelines? Audit reported 12 <sup>th</sup> June 2009	Flow diagrams used in fracture clinic to guide fragility fracture management Osteoporosis link nurse identified to facilitate referrals and treatment.
7	MINAP verification audit 2008: Medications on discharge - are we compliant with the NSF for CHD Audit reported 18 <sup>th</sup> June 2009	Form designed to aid data collection. We are compliant see further information in this quality report.
8	Liverpool Care Pathway (LCP) for the care of people in the last days of life Audit reported 30/06/2009	Formal audits of care for dying patients will begin again in 2010/11. Quality reports are submitted on a quarterly basis to the Trust board regarding the end of life pathway.
9	Aetiological investigations done for congenital deafness Audit reported 13/07/2009	Findings shared with relevant groups Diagnostic and investigatory form designed Plan joint paediatric deafness clinics between ENT and Paediatrics Consent discussed with Clinical Geneticist.
10	GP referrals to skin cancer target wait clinics Audit reported 14/07/2009	Information shared with GPs regarding target wait.
11	Paediatric Forearm fractures / pain management in A&E Audit reported 22/07/2009	On-going education regarding documenting pain score implemented.
12	Paediatric efficiency and effectiveness of sedation in children undergoing radiological imaging - are we adhering to Trust guidelines? Audit reported 27/07/2009	Agreed actions Revise patient info sheet to show that IV sedation not given. Update care pathway to show patient info given. Completed
13	2 week wait Urgent referrals to King's Mill Hospital Maxillofacial department for investigation of oral white patches Audit reported 31/07/2009	Any inappropriate referrals to be highlighted to the referring clinicians regarding future referrals. Completed

14	Falls risk assessment documentation on admission to hospital Audit reported 13/8/09	Old care plans destroyed Ward level audit reports and action plans to submitted to falls group on a monthly basis Findings presented to clinical governance Mandatory training completed
15	Secondary prevention of osteoporotic fragility fractures at King's Mill Hospital Audit reported 04/09/2009	Findings shared with relevant group's Group discussion between senior surgeons and formulation of an action plan
16	Patient Identification (Wristband) Audit July 2009 Combined report for planned care and surgery and emergency care and medicine Audit reported 29/09/2009	Staff have been reminded that when a patient's wristband has been removed for an invasive procedure, it must be replaced immediately. Audit results to be reported to the Division Clinical Governance Meeting. This annual audit will be on the Trust's forward clinical audit plan for 2010/11 which takes place during the summer.
17	Central Venous Catheter (CVC)securing Audit reported 30/09/2009	CVC checklist introduced June 2009
18	Prevention of inadvertent hypothermia related to operations Audit reported 03/11/2009	Staff education completed Guidelines reviewed Request review of stocks and availability of warming machines. Patient outcomes improved? Yes, reducing the risk of peri-operative hypothermia reduces the risk of surgical site infection and improves healing.
19	Observations and subsequent interventions carried out on the wards during the 24 hours preceding sudden death, unexpected ICU admission or cardiac arrest, as recommended in current guidelines? Audit reported 3/11/09	Key areas where problems may occur were highlighted by this audit. It is anticipated that dissemination of the findings of this audit might generate network-wide discussions around the formulation of a care bundle to enhance the care of the acutely ill adult. Documentation of mandatory vital signs and TTS is essential to any future improvement.
20	CNST: Standards for Maternity care 2008 Audit reported 18/11/2009	Training: Greater emphasis on attending training for senior house officers and provision of adequate number of training sessions to account for people on nights etc. Possibility of incorporating more training into induction session. Encourage specialist registrars and staff grade doctors to frequently refresh training, for example by including emergency training as part of the RITA assessment. Documentation: To accentuate emphasis on proper documentation, so as to provide an accurate environment with which to assess performance.
21	Thromboprophylaxis risk assessment compliance in Planned Care & Surgery Division 2009 Audit reported 26 <sup>th</sup> Nov 2009	Improve the rate of completion of the initial thromboprophylaxis risk assessment in accordance with DoH guidance. Improve the prescribing practices according to the level of calculated risk. Consolidate improvement in relation to completion of

		<p>thromboprophylaxis risk assessments and prescribing practices Undertake weekly rapid cycle clinical audit Weekly audits on completion of forms are in place</p> <p>There have been 10 weekly audits to date (stated 12<sup>th</sup> Feb 10) Compliance for all adult in-patients having a VTE risk assessment undertaken on admission has improved from 21% (12<sup>th</sup> Feb 2010) to 42% (16<sup>th</sup> April 2010)</p>
22	Haematology admissions with suspected neutropenic sepsis Audit reported 1 <sup>st</sup> Dec 2009	The neutropenic sepsis policy has been re-written and was launched in May 2010. Re-audit in late 2011.
23	Nephrectomy operations - laparoscopic and open - audit of length of stay and operative times Audit reported 22 <sup>nd</sup> Dec 2009	<p>At present, practice at Kings Mill is fulfilling the audit criteria / good practice demonstrated. No changes to practice are necessary.</p> <p>Recommendations for further audit: It is recommended these criteria should be re-audited in 3 years (allowing a larger sample size) to ensure standards are being maintained and to measure any improvement as further experience is gained by surgeons new to the procedure.</p>
24	NHSLA Consent: Chemotherapy, Clinical haematology Audit reported 4 <sup>th</sup> Jan 2010	<p>Ensure Trust consent form completed for all planned (oral and IV) chemotherapy - Nov 2009. completed and implemented</p> <p>Write a local information leaflet for CTD and MPT chemo - implemented Nov 2009</p> <p>Re-audit annually Nov 2010</p>
25	Are nutritional core care plans A&B being implemented and followed correctly? Audit reported 5 <sup>th</sup> Jan 2010	<p>The findings of the audit will be disseminated to: The Nutrition Board, Heads of Nursing, Ward Leaders, Nutrition Link Nurses by 31st March 2010 Audit findings and summary to be included in new ward information pack and ward briefings. To be included in Nutrition Link Nurse training. By 31st March 2010</p> <p>Anticipated outcomes: It is anticipated that a higher percentage of patients will be screened within 24 hours of admission to hospital, and that they will be placed on the correct care plan and monitored and reassessed appropriately in accordance with the care plans.</p>
26	Cytology smear and results 2008 GUM Audit reported 20 <sup>th</sup> Jan 2010	<p>Good compliance with standards demonstrated</p> <p>Highlight to staff need for letter contact</p> <p>Highlight to staff need to complete register for each cytology sample</p> <p>ongoing quality audit feedback to individual consultants</p> <p>Diary system implemented</p>
27	Paediatric DKA guidelines Audit reported 20 <sup>th</sup> Jan 2010	Develop standardised protocol for the young adult age group (15 – 20yrs), balancing fluid requirements of individual versus risks of cerebral oedema

		Detailed review of current literature regarding development of cerebral oedema in this age group
28	Paediatric Surfactant 2008 (AUDIT Cycle 3) Audit reported 16 <sup>th</sup> Jan 2010	As a result of the audit we plan to change our current guidelines for use of rescue surfactant (increased dose). The next step is to look at cost of using higher dose vs. two smaller doses.
29	Carotid Doppler for stroke patients at Newark Audit reported 25 <sup>th</sup> Feb. 2010	Audit has demonstrated / confirmed that we are not yet achieving national standards. The 2 week target is difficult to achieve. Better coordination between stroke team, cardio respiratory team and vascular department is required to reduce and minimise delay. Following presentation of audit findings and discussions with network various steps have been taken and a noticeable improvement noted- re-audit recommended in 1 year.
30	Haematology Clinic Letters 2009 Audit reported 17 <sup>th</sup> March 2010	Dictated clinic letters within 2 days of clinic - by 1st April 2010 - all consultants Type clinic letters within 2 days of completion of tape by 1st April - all secretaries Sign / post completed letters within 1 day by 1st April all staff.  Improvements / Impact as a result of audit: These actions should ensure that we improve communication with primary care colleagues and ensure that secondary care colleagues have access to up to date information in the case notes.
31	Care of the acutely ill patient a baseline audit of the NICE guidelines (2007) Audit reported 27/07/2009	Quarterly audits have demonstrated incremental improvements across all clinical areas

### Clinical research

The number of patients receiving NHS services provided by Sherwood Forest Hospitals that were recruited during 2009/10 to participate in research approved by a research ethics committee was 830 in NHS portfolio studies. This is lower than average due to vacancies in posts during 2009/10.

### Commission for Quality and Innovation (CQUIN)

A proportion of Sherwood Forest Hospitals income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between Sherwood Forest Hospitals and NHS Nottingham County through the Commissioning for Quality and Innovation payment framework. All of these quality payments were achieved. In addition the Trust received an incentive payment for a stretch target for C Difficile rates, which it has also achieved. Further details of the agreed goals for 2009/10 and for the following twelve month period are available on request from the Chief Executives office.

The monetary total for the amount of income conditional upon achieving the quality improvement and innovation goals for 2009/10 was £837,500 and £150,000 for achieving C Difficile targets; the total amount achieved was £987,500

### Care Quality Commission (CQC)

Sherwood Forest Hospitals is required to register with the Care Quality Commission. The Trust's registration was subject to two conditions based upon the CQC assessment of breaches to regulation 10 'Assessing and monitoring the quality of service provision'

The conditions are as follows:

#### *Condition 1*

The Trust must ensure that effective systems to assess and monitor the quality and safety of service provision are in place across all services by 31 July 2010. Evidence must be available to demonstrate this from 31 July 2010.

#### *Condition 2*

The Trust must ensure that the Integrated Critical Care Unit has in place a system of clinical governance that supports continual improvement and clinical excellence by 31 May 2010. Evidence must be available to demonstrate this from 31 May 2010.

Sherwood Forest Hospitals has agreed actions plans to ensure that concerns identified by the CQC are resolved by the end of July 2010.

- Specifically to improve clinical governance systems in ICCU to support continual improvement and clinical excellence by the end of May 2010.
- To ensure effective and improved systems to assess and monitor the quality and safety of service provision are in place across all services by July 2010.

The Care Quality Commission has not taken enforcement against Sherwood Forest Hospitals during 2009/10

Sherwood Forest Hospitals was subject to periodic review by the Care Quality Commission and the last review was on 16<sup>th</sup> September 2009. The review was in relation to the prevention and control of infections. The CQC assessment of Sherwood Forest Hospitals following the review was:

CQC overall judgement

“On inspection, we found no evidence that the Trust has breached the regulation to protect patients, workers and others from the risk of a healthcare associated infection”

Sherwood Forest Hospitals has participated in a review/ investigations by the CQC following a referral from the National Clinical Assessment Service (NCAS) in relation to care on our ICCU during 2007.

#### **Data Quality**

Sherwood Forest Hospitals submitted records during 2009/10 to the secondary users service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

-Which include the patient's valid NHS number was 99.8% for admitted patient care; 99.9% for outpatient care; 97.3% for accident and emergency care.

-Which includes the patients valid GP registration code was 100% for admitted patient care; 100% for outpatient care; and 99.8% for accident and emergency care

#### **Information Governance (IG)**

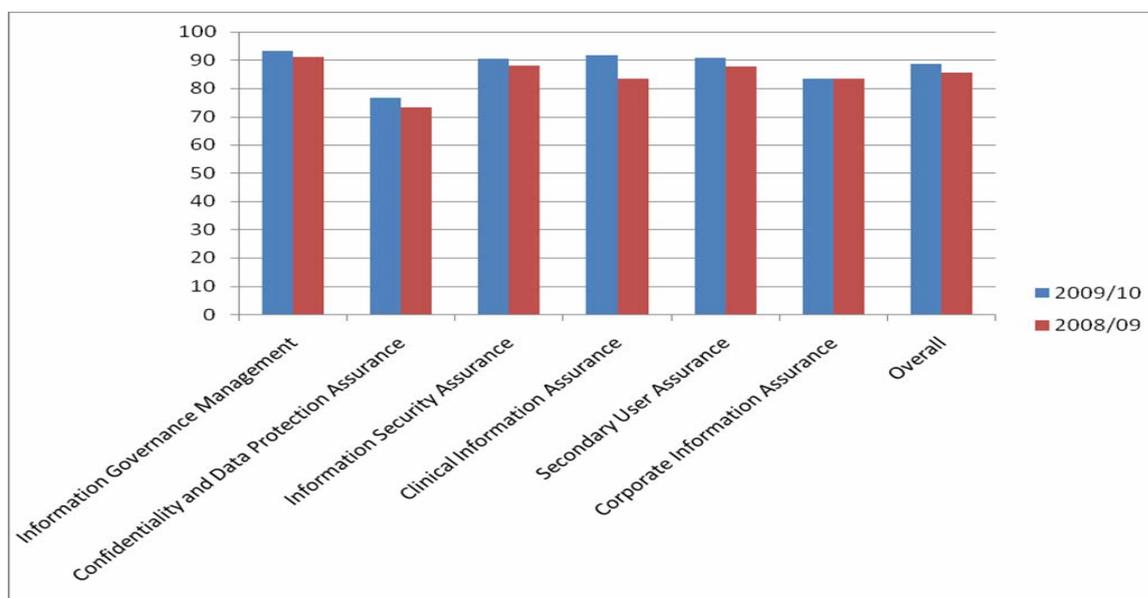
Sherwood Forest Hospitals score for 2009/10 for Information Quality and Records management assessed using the Information Governance Toolkit was 88.7%. Sherwood Forest Hospitals has demonstrated year on year improvement in relation to information governance and is pleased to report further improvement in 2009/10.

## Improvement

Overall improvement has been made across the IG Toolkit, which is outlined in the table below which compares the ratios of scores for 2009/10 against 2008/09:

	2008/09	2009/10
Level 0	0	0
Level 1	0	0
Level 2	27	21
Level 3	35	41
<b>Total</b>	<b>62</b>	<b>62</b>
<b>Percentage (%)</b>	<b>85.5</b>	<b>88.7</b>

This has resulted in an overall improvement to the total score, which has increased from 85.5% in 2008/09 to 88.7% for this year's submission. This ensures that the Trust will maintain its excellent Green rating.



## Audit

The information governance toolkit scores were audited on the 10<sup>th</sup>, 11<sup>th</sup> and 12<sup>th</sup> of February 2010, by an independent assessor. 30 out of the 62 standards were reviewed and the Auditor agreed with the attainment levels put forward by the IG department for 27 of these standards. The remaining 3 standards have been reviewed by the IG department and will form part of the 10/11 work plans.

## Payment by results

Sherwood Forest Hospitals has been subject to two Payment by Results Data Assurance Framework audits in the year. These audits are carried out by the Audit Commission and covered:

- Outpatient data quality
- Admitted patient care clinical coding

The main conclusions of the Outpatient audit were that the Trust's data quality arrangements were good in the three areas tested, only meeting minimum requirements in one area, that being that corporate objectives and targets for data quality are not clearly defined.

The audit found good standards of Outpatient data recording with an overall error rate of 1.2% from the sample tested.

With regards to the admitted patient care audit, the Audit Commission concluded that the Trust's performance was excellent compared to the overall performance of Trusts in 2008/09.

The Trust's HRG error rate of 5.0% compares favourably with the national average of 8.1% and 8.5% of the local Strategic Health Authority. In monetary terms, the audit identified a 1.4% error on the sample tested.

The audit concluded that coding arrangements are good, which is leading to a marked improvement in diagnosis coding accuracy. Procedure coding accuracy was identified as an area where improvement could be made.

The results should not be extrapolated further than the actual sample audited.

## Other Information

### Health Care Commission (HCC) investigation

In March 2009 the HCC investigated Mid Staffordshire NHS Foundation Trust. Following publication of the report Sherwood Forest Hospitals undertook a gap analysis of the key issues raised within the Mid Staffs report and sought evidence from clinical services that provided board assurance that similar circumstances could not occur within our own Trust. Where evidence could not be produced or was deemed insufficient specific reviews/audits were commissioned and progress monitored throughout the Executive and Board of Directors.

### NHSLA-CNST Risk management

During 2009/10 the Trust has undergone assessment for CNST level 1 for both general hospital and maternity care. The general hospital assessment scored the unusually high score of 50/50 and maternity scored 46/50.

### Clinical Audit

Clinical Audit processes at Sherwood Forest Hospitals are governed by our policy and strategy documents. These documents have been written to conform to nationally agreed "Best Practice" for clinical audit and have been implemented via the Trust's clinical governance mechanisms. The implementation and success of the clinical audit strategy's aims and objectives will be measured by the clinical audit operational plan and reported to the Clinical Audit and Clinical Governance Committee.

These aims and objective are:

To deliver an effective clinical audit plan that contributes to the continuous improvement of patient care and health outcomes.

By:

- Aligning clinical audit activity with national and local health priorities as agreed by the Trust, local health communities, Divisions and Service Lines
- Ensuring that the rationale for undertaking clinical audit relates to improvements in health care delivery.
- Providing training, support and advice for Sherwood Forest Hospitals staff in relation to clinical audit.
- Monitoring the governance arrangements through which the quality of clinical audit activity and outputs will be monitored

### Clinical Governance

Clinical Governance is the process by which NHS organisations assure themselves and others that services are safe, effective and improving. This takes a great deal of work and a lot of commitment from all our staff. All our services take clinical governance seriously and along with a large

number of single issue quality committee's work timelessly to improve the care our patient's experience.

The Clinical Governance Committee reviews performance across the Trust, ensures national guidance is followed and seeks to maximise quality improvements each year.

Clinical Governance processes are reviewed by the Audit Committee and ultimately by the Trust Board. A large number of external bodies such as CQC, Dr Foster, Royal Colleges and laboratory accreditation also monitor our performance and Sherwood Forest Hospitals works with them to learn of any new opportunities for improvement.

The Trust believes we have a sound system for Clinical Governance, population by relevant information such as quality indicators. Clinical staff are trained to understand our systems and have faith in them. Crucially we encourage a "no blame" culture and suspect all members of staff to do a good job, but also to actively find ways to do their job better.

## An overview of measures

### Patient Safety Metrics

	2009-2010	2008-2009	2007-08
The Trust has fully met the HCC core standards and national targets	23/23	24/24	24/24
Clostridium difficile year on year reduction	96	177	324
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half of the 2003/04 level	14	31	36
Never events that occurred within the Trust	0	0	0
<b>Essence of Care Benchmark (EoC)Outcomes :</b>	<b>Due 2011</b>	2008-09	Programme 1
Pressure Ulcers	<b>Due 2011</b>	81%	73%
Record Keeping	<b>Due 2011</b>	81%	75%
Effective Communication	<b>Due 2011</b>	84%	77%

### Notes

The Trust EoC programme has a 18-month to 2-year cycle and the benchmarks mentioned within the grid[s] are due to be re-audited during 2010-2011 with benchmark leads currently in the planning stages to review their specific audit tool ready for Programme 3. The migration of the wards also had an impact on the time-table for the re-audit programme and the introduction of the new benchmarks.

## Patient Experience Metrics

	2009	2008	2007	National average
<b>National PEAT scores (0-5, 5 being excellent):</b>				
*Environment King's Mill Hospital	4	3	4	4
*Environment Newark Hospital	4	3	4	4
*Food KMH	4	4	4	5
*Food NH	4	3	3	5
<b>Essence of Care Benchmark Outcomes:</b>				
	<b>Due</b>			
Privacy and dignity	2010/11	82%	80%	
Food and Nutrition	2010/11	81%	77%	
<b>Selected Inpatient Survey Results:</b>				Highest scoring 20% of Trusts
Did you have confidence in the doctors treating you?	89%	90%	87%	91%
Did you have confidence in the nurses treating you?	88%	88%	85%	89%
Were you given enough privacy when being examined or treated?	96%	95%	91%	95%
Did you find someone on the hospital staff to talk to about your worries and fears?	61%	65%	58%	64%
% of patients who would recommend hospital to a relative/friend	87%	80%		

**Notes**The Trust Essence of Care programme has a 18-month to 2-year cycle and the benchmarks mentioned within the grid[s] are due to be re-audited during 2010\_2011 with benchmark leads currently in the planning stages to review their specific audit tool ready for Programme 3. *The migration of the wards also had an impact on the time-table for the re-audit programme and the introduction of the new benchmarks.* The PEAT scores are the results of a PEAT mini audit the actual PEAT results will be available in June 2010

<b>Clinical effectiveness and National Targets and Regulatory Requirements</b>	<b>2009-10</b>	2008-09	2007-08	2009-10 Target
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	<b>98.8%</b>	99.3%	99.8%	96%
Maximum waiting time of 31 days from decision to treat to start of treatment - subsequent surgical and drug-based treatments	<b>Drug 99.7%</b> <b>Surgery 94.3%</b>	N/A	N/A	Drug 98% Surgery 94%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	<b>84.5%</b>	94.6%	N/A	85%
Maximum waiting time of 62 day from screening to 1st definitive treatment	<b>90.5%</b>	N/A	N/A	90%
18-week maximum wait from point of referral to treatment (admitted patients)	<b>94% (March 10)</b>	95% (March 09)	86% (March 08)	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	<b>98.7% (March 10)</b>	99% (March 09)	90% (March 08)	95%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	<b>98.7%</b>	98%	98%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	<b>63%</b>	60%	78%	68%
Screening all elective inpatients for MRSA	<b>100%</b>			100%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	<b>94.4%</b>	99.8%	99.7%	93%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all GP referrals – Breast Symptomatic*	<b>92.8%</b>	N/A	N/A	93%

\* Please note that the new Breast Symptomatic target applied for January – March 2010. The target was achieved for February and March, but was missed in January and therefore for the quarter, due to patients exercising choice in the snowy weather.

# Annex

## Assurance

### Commentary from Nottinghamshire County LINK

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Ref: LT

Mike Tasker  
Companies Secretary  
**Sherwood Forest Hospitals NHS Foundation Trust**

Date: 1<sup>st</sup> June 2010

Dear Mike

**Re: Nottinghamshire County LINK Response to the Quality Report of Sherwood Forest Hospitals NHS Foundation Trust**

The Nottinghamshire County LINK is delighted to enclose our comments on the Sherwood Forest Hospitals NHS Foundation Trust Quality Report.

We are happy with the improvements that the Trust has made to date, and are pleased and encouraged by the planned future developments. At this point, we have no negative comments to make about the content of the Quality Report.

The Nottinghamshire County LINK would finally like to thank you for giving us the opportunity to provide feedback, and hope that our comments are a valuable contribution.

Yours sincerely,



Jane Stubbings – Nottinghamshire County LINK Chair

## **Commentary from NHS Nottinghamshire County**

The Commissioning PCT has reviewed the Quality Account. The PCT recognises the key areas of improvement and the priorities for 2010/11. Quality goals have been agreed with the PCT and are embedded within the contract.

The commissioning PCT monitors quality and performance at the Trust throughout the year. There are monthly quality and performance review meetings and there is frequent ongoing dialogue as issues arise. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year. It is noteworthy that the Essence of Care pressure ulcer audits were not undertaken during the reporting period. However, these are undertaken on an 18-24 month cycle and the next audit is planned for 2010.

The Trust is working with the PCT to ensure that the Care Quality Commission registration conditions are met. The Trust has shared its action plan and a number of improvement actions have already been taken. There are some ongoing challenges in relation to data quality and robustness of investigations. However, the Trust is working constructively to address these issues. The independent investigation into allegations on the Integrated Critical Care Unit is welcomed.

The Trust has demonstrated a high level of commitment to improving patient experiences. The patient experience local surveys provide a high level of assurance in areas where they are conducted. The Trust openly shares this information with commissioners.

The PCT has an appointed governor at the Trust. This enables the commissioning organisation to better understand the views and concerns of public and staff Governors. It also assists with information exchange between the Trust, commissioners and public representatives and helps to provide additional assurance to corroborate the information within this Quality Account.

## **Commentary from the local Overview and Scrutiny Committee (OSC)**

A presentation was given to the Overview and Scrutiny Committee on the 9 March 2010. The OSC has confirmed that it does not wish to comment on this year's Quality Report.