



QUALITY REPORT 2010/11

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Quality Report 2010/11

Part One

Foreword

Quality is at the heart of everything we do. We truly believe it is our focus on quality that will make us stand out from other providers of health care, drive efficiency improvements through our services and inspire our staff to become more innovative and embrace new ways of working.

During the last year we have continued to develop our vision of Best Care, Best People, Best Place. This has been supported by our service improvement programme Achieving Best Care (ABC). We are extremely proud of the significant achievements that have been made this year and of the recognition some of our services have received nationally.

We know that hospital cleanliness and hospital acquired infections are issues which our patients are passionate about and so I am delighted to report that **no** patients have experienced a hospital acquired MRSA blood infection this year and that we have seen significant reductions in Clostridium difficile infections.

Safeguarding children and vulnerable adults, development of our dementia service and care of those patients with learning disabilities have remained a high priority for us, but we have given equal importance to other services and patients within our hospitals.

National stroke indicators show that our patients are receiving timely services and assessments to enhance their recovery and we continue to be fully accredited for all elements of our laboratory services, stroke care and management of acute coronary syndrome.

Our low Caesarean section rates demonstrate that mothers who choose to have their babies at our hospital are more likely to have a normal birth.

We know that our staff are our greatest asset and we are proud of all their achievements. They continue to be key to influencing the quality of care we offer our patients and they helped us in conjunction with patients and carers, governors and members to produce a set of pledges to assist in achieving our shared vision. I was delighted once again to receive our excellent staff survey results which reflect the enthusiasm and commitment our staff have to helping us to achieve our ambitions and recognise the efforts we have made to be a good employer.

During 2011/12 we will again focus on three key priority areas; 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.

We have strengthened our governance arrangements so that we can continue to provide positive assurances regarding the quality and safety of the health provision for our local population.

This report, while looking back over our achievements in 2010/11, also looks forward to the coming year which we know will be very challenging for us. With this in mind, it is even more important that

we continue to drive up our quality standards, protect our patients from harm and ensure that we continue to improve. Our commitment to this is absolute. 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 the care of patients in our services and to this report.



Carolyn White
Chief Executive
30th June 2011

Statement of Directors' Responsibilities in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are satisfied that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the Quality Report is consistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2010 to June 2011
 - Papers relating to Quality reported to the Board from April 2010 to June 2011
 - Feedback from the commissioners dated 31 May 2011
 - Feedback from Governors dated 19 May 2011
 - Feedback from LINKs dated 12 May 2011

- The 2010 National Patient Survey
- The 2010 National Staff Survey
- CQC Quality and Risk Profiles dated Sept 2010 – May 2011
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board



Tracy Doucét, Chairman, 30th June 2011



Carolyn White, Chief Executive 30th June 2011

Part Two

Priorities for Improvement in 2011/12

The Trust has made a number of significant quality and safety improvement initiatives, which we will continue to progress in 2011/12. This report gives an overview of these and also focuses on our three key priorities as we move forward.

Our key priorities for 2011/12 are based on the domains of quality and reflect the potential to improve patient safety, clinical effectiveness and patient experience. We feel these priorities will stretch the organisation further in its vision of providing Best Care, Best People, Best Place.

We have made our choices based upon our patient feedback, information taken from our patient survey responses both nationally and locally, and our quality schedule and contract, where our commissioners have chosen their priorities based upon their experiences within our local community

We will report our progress through our monthly and quarterly quality reports which are presented to:

- Board of Directors
- PCT Monthly Quality Scrutiny Panel
- Clinical Governance Committee
- Patient Quality and Experience sub-committee of the Board of Governors

Priority One - Patient Safety

Our aim is to reduce our Hospital Standardised Mortality Ratio (HSMR).

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

We will address this priority through our newly created Mortality group chaired by the Executive Medical Director.

We aim to reduce mortality levels to achieve top 25% nationally.

This will be undertaken by agreeing and understanding where mortality occurs and identifying areas for improvement.

Monitored: It will be monitored via the Mortality group.

Measured: It will be measured using the Dr Foster intelligence data.

Reporting: The monitoring will be reported to the monthly Clinical Governance Committee with exception reporting to the board.

Priority Two - Clinical Effectiveness

Our aim is to reduce ambulance turnaround time within the Emergency Department.

Delays in handover times impact on the outcome of our patient's treatment and reduce the quality of our patient's experience. They also reduce the availability of emergency ambulances for other users.

We will address this priority through organisational redesign and refining the patient pathway.

Monitored: It will be monitored by our service line reporting.

Measured: It will be measured by our performance against targets.

Reported: Performance will be reported to the board monthly by monitoring information.

Priority Three – Patient Experience

Our aim is to embed in practice the use of the Malnutrition Universal Screening Tool (MUST). Malnutrition is both a cause and a consequence of ill-health. Even people who are well-nourished, eat and drink less if they are ill or injured and although this may only be short-lived as part of an acute problem, if it persists the person can become undernourished to an extent that may impair recovery or precipitate other medical conditions.

We will address this through rigorous training programmes and performance management.

Monitored: It will be monitored by the Nutrition Board, the nursing care metrics and Essence of Care Nutrition benchmark.

Measured: It will be measured by monthly audits.

Reported: Performance will be reported to the Board of Directors by the quarterly quality report.

Further Quality Priorities that we are Recommending for 2011/12

Patient Safety

To ensure our patients are free from accidental injury due to the healthcare we provide.

We aim to:

- Maintain and improve outcomes for healthcare associated infections MRSA, MSSA, C Diff E coli and urinary infections following catheterisation.
- Implement High Impact Actions to reduce patient falls, pressure ulcers and urinary catheters.
- Maintain a zero tolerance on avoidable hospital acquired pressure ulcers and reduce the number of hospital acquired ulcers based upon 2010/11 outturn.
- Maintain a philosophy that normalises birth including monitoring Caesarean section rates, vaginal births and home births. Sustain or improve performance to ensure we remain within the national top quartile benchmarks.
- Prevent of avoidable acute kidney infection.

Clinical Effectiveness

Clinical effectiveness is the extent to which specific clinical interventions do what they are intended to do, i.e. maintain and improve the health of patients securing the greatest possible health gain from the available resources.

We aim to:

- Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE).
- Continue to improve monitoring of acutely ill patients.
- Further reduced incidents of slips, trips and falls.
- Maintain compliance with Same Sex Accommodation.
- Reduce inappropriate readmissions by improving discharge communication.
- Implement a system within the Trust which identifies people who smoke, providing brief advice and where appropriate, refers to local specialist stop smoking services.
- Improve patient outcomes in acute stroke patients.
- Improve patient pathways through the Emergency Department.
- Improve access to contraceptive services in termination and maternity services.
- Improve the number of patients asked about their alcohol intake.
- Reduce the number of under 17 year old accident and emergency attendees who are admitted into hospital.

Patient Experience

This is how our patients feel about the care they receive whilst in our hospitals.

We aim to:

- Improve patients experience for patients suffering dementia
 - Improve outcomes for end of life care
 - Improve the quality of health care for patients with learning disabilities
 - Improvement against the five national indicator measures
-
- Were you involved as much as you wanted to be in decisions about your care and treatment?
 - Did you find someone on the hospital staff to talk to about your worries and fears?
 - Were you given enough privacy when discussing your condition or treatment?
 - Did a member of staff tell you about medication side effects to watch out for when you went home?
 - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Part Three

How have we delivered our priorities in 2010/2011?

This part of the quality account details our achievements in 2010/11, commencing with an update report on our key priorities.

In 2009/10 we identified our 3 key priorities for 2010/11 as:

- Priority 1** To further reduce incidents of slips, trips and falls
- Priority 2** To reduce avoidable death, disability and chronic ill health from VTE (venous thromboembolism)
- Priority 3** To improve privacy and dignity of patients including Same Sex Accommodation

Priority 1

Patient Safety

To further reduce incidents of slips trips and falls

Description of the Issues and Rationale for Prioritising

Falls are the commonest presentation of an older person to Accident and Emergency. 30% of the population over the age of 65 will fall each year and this rises to 45% in the over 85's (1). Half of those who do fall will fall again within the year. The National Patient Safety Agency reports that falls are the commonest

reported adverse event for patients (2). Our local population appears to be at an intrinsic higher risk of falling. This work is a high priority for our commissioners.

At the Trust we recognise the importance of good assessment and risk prevention and have identified that we can improve our practices to reduce falls.

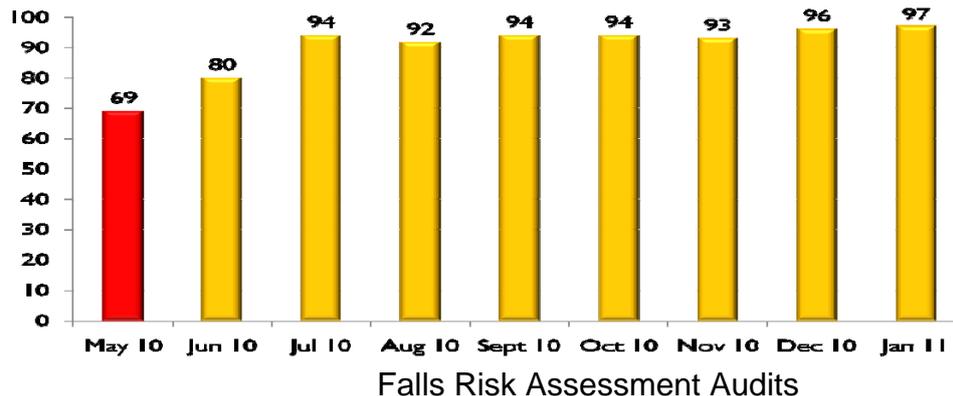
Some of the actions that we have put into place are:

- We conduct Trust-wide observational audits of risk assessment tools and care plans.
- We identify trends and high risk areas ongoing analysis of the Trust's falls per occupied bed days and comparison with National Patient Safety Agency figures.
- We analyse our information systems (DATIX) to identify trends and hotspots and from this, develop action plans using calculated falls per occupied bed days as per National Patient Safety Agency, Royal College of Physicians and National Service Framework guide lines.
- We review the falls rate data in more detail and categorise falls into 'no harm', 'low harm', 'moderate harm', 'serious harm' and 'catastrophic harm'.

- We review serious incidents relating to inpatient falls using root cause analysis.
- We have a training programme for both to raise awareness and ensure consistent management has been implemented.
- We have developed a new ideas culture to introduce high impact, low cost changes.

Our Key Improvements / Achievements

- Our monthly audits demonstrate we have dramatically improved the number of patients who are risk assessed for falls on admission and that those at risk of falling have appropriate plans of care in place



- The average Trust falls rate is 9.21 per 1000 occupied bed days (in line with national figures), most of which result in no harm.
- Our Trust has a lower rate of moderate harm outcomes at 1% compared to the national average of 3.3%

- Our orthopaedic service has been developed to ensure appropriate patients are referred to the Falls Community Team, Falls Clinic and the Osteoporosis Nurse Service.

Further Planned Improvements for 2011/12

- We are planning a triangulation audit of 'Falls Risk Assessment/Care Plan'.
- We have improved care for our patients who suffer with dementia/delirium. We are looking at alternative methods to improve patient orientation on the wards.
- The work undertaken by the Elderly Care Assessment Team at the point of admission has meant that our patients who attend hospital following a fall receive an appropriate falls review, a follow up telephone call and appropriate referrals to the Falls Community Team, Intermediate Care and the Falls Clinic at King's Mill Hospital.

References

1. Campbell, A., Reinken, J., Allan, B., Martinez, G. (1981), "Falls in old age: a study of frequency and related clinical factors", Age and Ageing, Vol. 10 No.4, pp.265-70.
2. National Patient Safety Agency Report - Slips, trips and Falls in Hospital (2007).

Priority 2

Clinical Effectiveness

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

Description of the Issues and Rationale for Prioritising

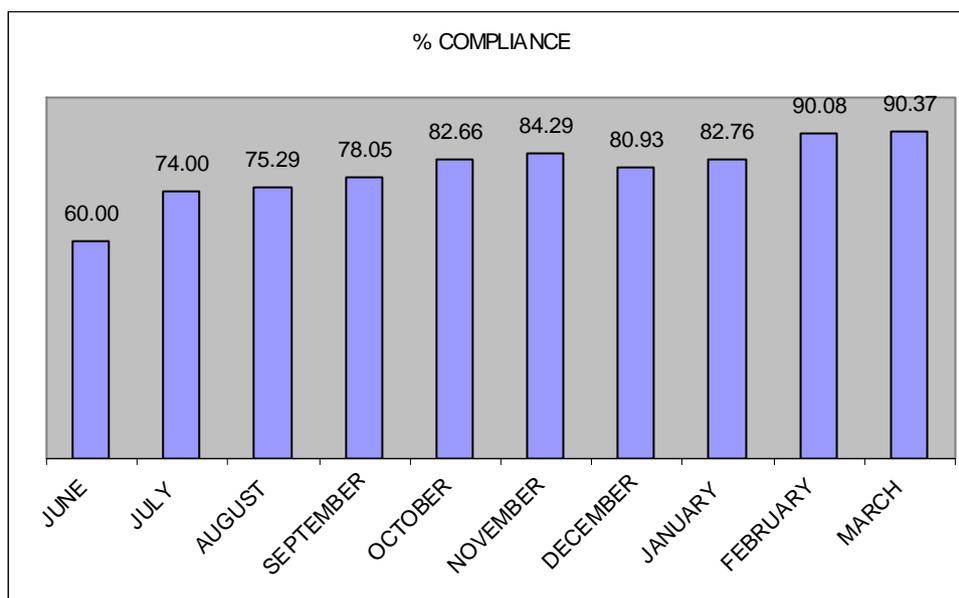
Venous thromboembolism (VTE) is the formation of a blood clot (thrombus) in a vein. It was thought that each year there are 25,000 preventable deaths from VTE in hospitals in England. The Department of Health published a thromboembolism risk assessment strategy, recommended for use with all patients on admission to hospital. The aim is that all adults admitted to hospital are risk-assessed for VTE, this is documented on the risk assessment form and where appropriate, the patient receives the right prevention measures. This priority formed part of our Commissioning for Quality and Innovations (CQUIN).

Aim

- Our aim was that at least 90% of our adult inpatients would receive a VTE risk assessment on admission.
- Where VTE / deep vein thrombosis / pulmonary embolus (PE) are diagnosed, we would instigate a root cause analysis (RCA) process, to review whether care had been appropriate, learn lessons and implement changes.

Our Key Improvements / Achievements

- Our audits demonstrate continuous improvement achieving 90% for the months of February and March 2011 for adult inpatients receiving a VTE risk assessment on admission.



- We have been reported as delivering the 'best regional performance' for four out of the five published months.
- Others have visited us to learn about our data collection as we have been identified as having exemplary processes.
- We are pleased to say there have been no care issues identified in any patients who had VTE noted on the death certificate.
- 96% of patients who had received a VTE risk assessment on admission receiving appropriate prophylaxis.

Priority 3

Patient Experience

To improve privacy and dignity of patients including Same Sex Accommodation (SSA)

Description of the Issues and Rationale for Prioritising

In January 2009 the Department of Health announced as a priority a package of measures designed to 'all but eliminate mixed-sex accommodation' by 2010. The Trust publicised a declaration of compliance with SSA on 1 April 2010. National monitoring and reporting was introduced with effect from December 2010 with details of all breaches of sleeping accommodation available to the public from January 2011, with contractual financial sanctions. This priority was part of our quality schedule and quality contract with the commissioners.

Aim

- To be compliant with the requirements of a national document - PL/CNO/2010/2, sustaining the principles of same sex accommodation for all our patients.

Our Key Improvements / Achievements

- We have reported no breaches of SSA for 51 weeks of the year.
- We are able to publicise a declaration of compliance with the new policy statement thereby confirming that we have eliminated mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice.
- Due to the breaches within our Emergency Admissions areas in December 2010, we have allocated two single occupancy side room as 'short stay' areas. This means that our patients will not be mixed together, even when the unit is busy.

Part Four

Other Quality Improvements in 2010/2011

Patient Safety

To reduce cases of healthcare acquired infections (specifically urinary tract infections and Methicillin Sensitive Staphylococcus Aureus [MSSA Bacteraemia])

Description of the Issues and Rationale for Prioritising

We are extremely proud of our successes in relation to infection, prevention and control and set ambitious targets of no Trust acquired cases of MRSA Bacteraemia and a reduction in cases of Clostridium Difficile (C Difficile). We also wanted to develop work in relation to other hospital acquired infections to ensure we achieve the same successes as those demonstrated with MRSA and C Difficile.

Our Key Improvements / Achievements

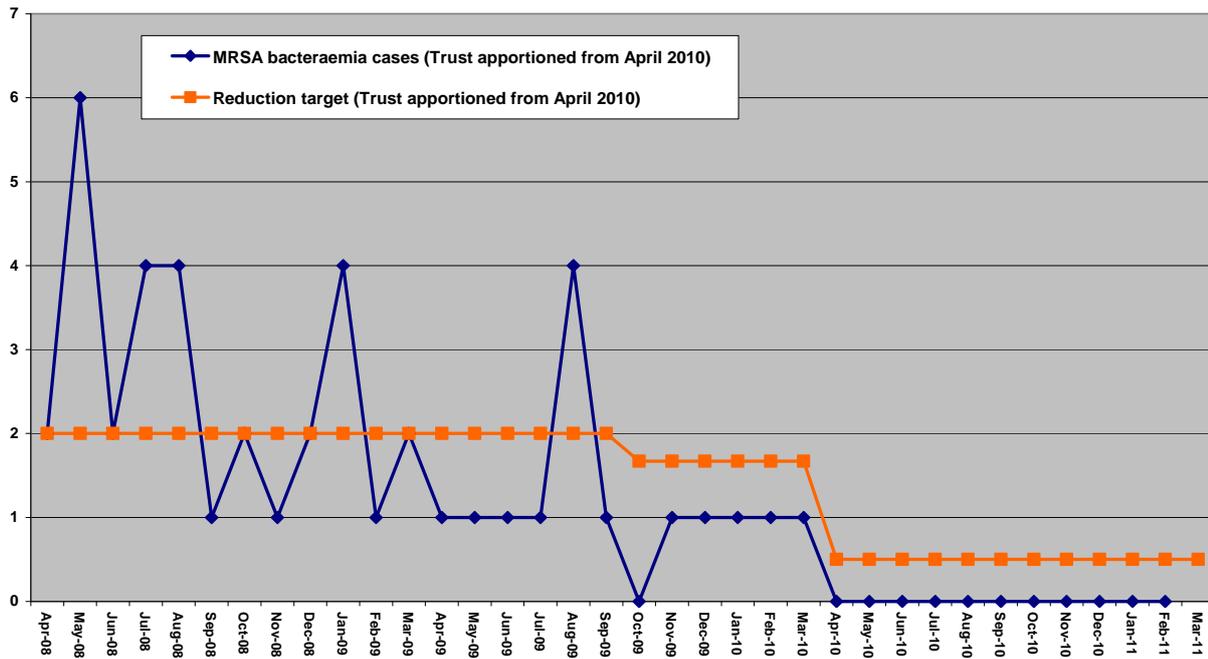
- At the beginning of the year we successfully implemented a MRSA screening programme for all our elective admissions. Over 2010/11,

- we extended this programme to ensure all emergency admissions were screened within 24 hours of admissions.
- To ensure we treat our patients with the correct antibiotics we have undertaken antibiotic audits. These demonstrate excellent results.
- We have scored very highly for our Patient Environment Action Team (PEAT) and mini PEAT inspections.

2010/11 has been a year of many successes:

- We are the only Trust in the East Midlands that reached and surpassed a full year with no Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia which is demonstrated in the following graph.

SFHFT MRSA bacteraemia cases against reduction target

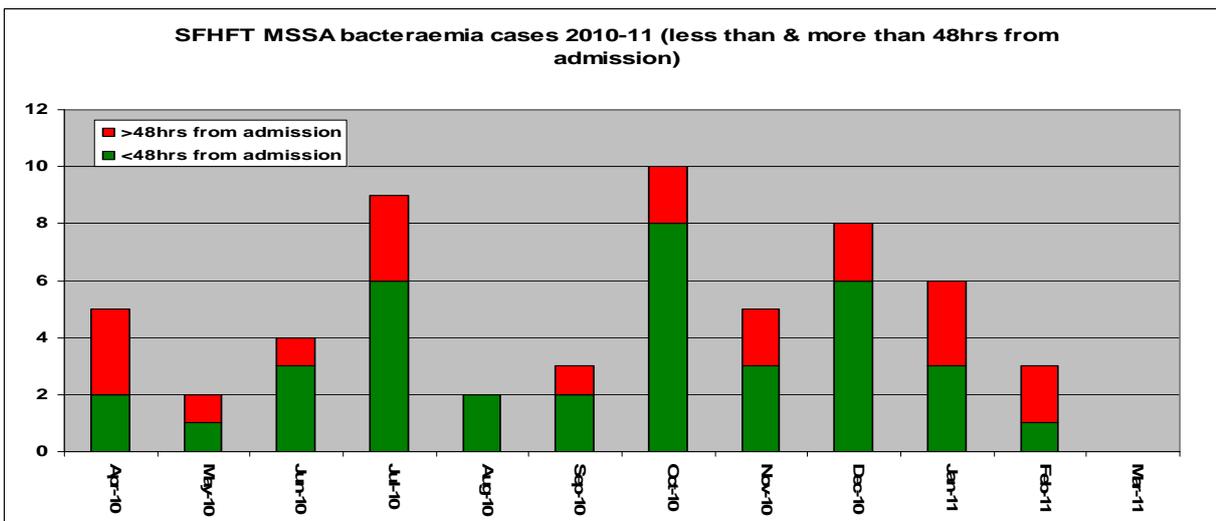


- We were set a target of no more than 63 hospital acquired C Difficile cases. We successfully managed to meet this target. We reported 54 hospital acquired cases of C Difficile. We are one of the best performing hospitals within the East Midlands.
- We screen all our inpatient admissions for MRSA.

Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

- Reporting of MSSA bacteraemia prior to January 2011 was voluntary, however, from January 2011 this reporting is mandatory. We are currently setting ourselves improvement targets.

SFHFT MSSA bacteraemia cases 2010-11 (less than & more than 48hrs from admission)



Urinary tract infections

This is a newer target which we are working towards achieving. In the absence of any national guidance/definition of a urinary tract infection associated with a urinary catheter, we are working to reduce the number of unnecessary catheterisations,

which will reduce the number of urinary tract infections. We are ensuring we achieve over 75% compliance with High Impact Intervention audits for insertion of urinary catheter.

Patient Safety

To maintain a zero tolerance on hospital acquired pressure ulcers

Description of the Issues and Rationale for Prioritising

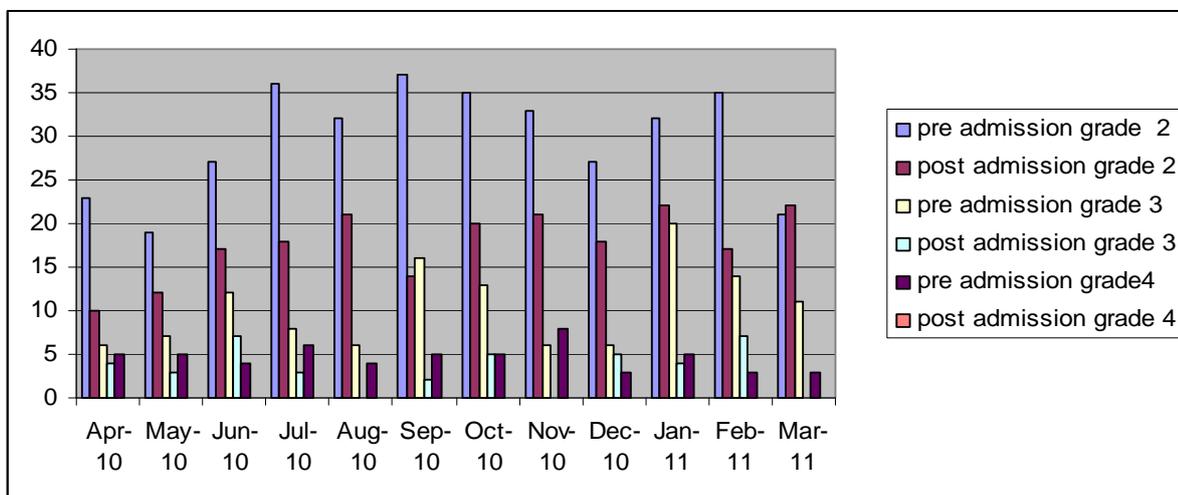
Pressure ulcers occur in 4-10% of patients admitted to hospital. Pressure ulcers can occur in any patient but are more likely in high risk groups, such as the elderly, people who are obese, malnourished, or have continence problems, people with certain skin types and those with particular underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection.

Pressure Ulcers are reported as grade 1 being least serious and grade 4 the most serious.

Our Key Improvements / Achievements

- During 2010/11 a total of 40 hospital acquired Grade 3 pressure ulcers were reported.
- We are proud to announce that no patients whilst in our hospitals developed a Grade 4 pressure ulcer during 2010/11.

Total number of Pressure Ulcers for 2010/11– Pre and post admission



Patient Safety

To implement National Best Practice standards within the Patient Safety First campaign to include specific focus on reducing slips, trips and falls.

The National Patient Safety First campaign was designed to encourage, inform and motivate clinicians to change practice, and to inspire leaders to embrace the safety culture. It was designed to reduce harm in four key areas by the implementation of evidence based interventions in clinical practice.

Safety Express is the name of the new Safe Care Work Stream and so named, in order to drive improvements forward at a rapid pace, in partnership with existing programmes, in particular 'Energising for Excellence, High Impact Actions, Patient Safety First, the Productive Series' and

the National VTE Implementation group, within each SHA region.

The Safety Express programme aims to work in collaboration with other participating Trusts within the Strategic Health Authority region to reduce harm from:

- Pressure ulcers
 - Falls
 - Catheter acquired urinary tract infections
 - Venous thrombo-embolism, (VTE)
- All of these domains have been reported within this quality report.

Patient Safety

To implement the World Health Organisation (WHO) theatre checklist.

Description of the Issues and Rationale for Prioritising

The safe surgery checklist, which was launched by WHO as a recommended guideline for safe practice, has since gained global recognition by operating theatre staff, including surgeons and anaesthetists. In January 2009, the National Patient Safety Agency (NPSA) issued a patient safety alert, requiring NHS organisations to implement the WHO Surgical Safety Checklist (SSC) for every patient undergoing a surgical procedure. The checklist has been crucial in introducing safer surgery practices to

reduce patient harm and the level of surgical complications.

Our Key Improvements / Achievements

- We implemented the SSC on 1 June 2009 in all our main theatres, across both of hospitals. The implementation followed the guidance contained within the 'WHO starter kit'.
- The layout of the checklist initially followed that recommended by the WHO, and has undergone several modifications and redesigns, to reflect our local practice and ensure

we continue to engage and support staff.

- We have audited compliance with the checklist every six months and have implemented changes following the results.
- Specific questions added to the

checklist have allowed the Trust to comply with two NPSA Safety Practice Notices, related to throat packs (Safer Practice Notice NPSA/2009/SPN001), and finger tourniquets (Rapid Response Report NPSA/2009/RRR007).

Patient Safety

To maintain improvement in Caesarean section rates to be within the top quartile of peer comparator Trusts

Description of the Issues and Rationale for Prioritising

2010/11 was again a very successful year for maternity services at Sherwood Forest Hospitals, of which we are very proud. On 9 November 2010 the new state of the art maternity unit at King's Mill officially opened the door to expectant mums. This new unit complements national accolades for Sherwood Forest Hospitals NHS Foundation Trust (SFH) maternity services in 201/11 when:

- SFH was one of only two Trusts in the East Midlands whose maternity services were rated as 'Best Performing' by the Care Quality Commission.
- NHS Information Centre figures released in 2010 revealed impressively low Caesarean section rates and higher home birth rates.

- Our Lower Segment Caesarean Section Rate for 2010/11 is 16.94%, suggesting that ladies who have their babies at SFHFT are more likely to have a normal birth. This continues to be the best in the East Midlands region (nationally around 25%).
- We have successfully maintained our Lower Segment Caesarean Section Rate for 2010/11 alongside an increasing birth rate, which has increased by 6% since 2009/10.
- As part of the NHS East Midlands Normalising Birth work-stream we are sharing our best practice to influence other birthing units across the East Midlands region. Our work is being incorporated into the 'Towards Excellence' website.
- We have introduced the WHO Checklist in maternity Theatres.

Clinical Effectiveness

To achieve the 62 day Cancer Targets

Description of the Issues and Rationale for Prioritising

It is important that patients with suspected and diagnosed cancer have appointments, tests and treatments in a

timely fashion, both to improve their outcomes and their experience in the NHS. This is a national target.

Our Key Improvements / Achievements

62 day Classic patients referred from their GP or upgraded by consultant

- We are pleased to report that our actual performance was above the national standard (85%) for the whole year.

62 day Screening patients referred from National Screening programmes

- We are able to report that our actual performance was above the national standard (90%).
- To achieve this we have:

- Continued monthly meetings with the Cancer Centre to discuss referrals from other hospitals.
- Appointed an additional Colonoscopist who is accredited for the screening programme.
- Continually reviewed performance through the 6 weekly Cancer Unit Management Board group.
- With our Primary Care Trust colleagues, we are leading a project on the education of 2 week wait pathways in GP setting and are re-launching the use of a 2 week wait patient information leaflet prior to referral.

Patient Safety

To continue to improve monitoring of acutely ill patients

Description of the Issues and Rationale for Prioritising

Monitoring patients (checking them and their health) regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems. The NICE clinical guideline describes how patients in acute hospitals should be monitored to help identify those whose health becomes worse and how they should be cared for if this happens.

Our Key Improvements / Achievements

- Our overall Trust compliance with six NICE mandatory vital signs is 88% (this has improved significantly from 46% in 2008).
- Our compliance with respiratory rate, heart rate, blood pressure, oxygen saturation and temperature monitoring is excellent (99-100%).
- All patients (100%) in our hospitals have observations recorded every 12 hours as a minimum.

Patient Safety / Experience

To improve the care of patients with Dementia

Description of the Issues and Rationale for Prioritising

Dementia is one of the most important issues we face, as the population ages. 'Living well with Dementia - a National

Dementia Strategy' was published in February 2009. It set out a vision for transforming dementia services with the aim of achieving better awareness of dementia, early diagnosis and high quality treatment at whatever stage of the

illness and in whatever setting. Raising the quality of care for people with dementia and their carers is a major priority for our Trust.

Our Key Improvements / Achievements

Strategy

- The Nottinghamshire Dementia strategy is in its first draft and has utilised the expertise of neighbouring hospitals and community services to formulate the foundations for the SFHFT document.
- The Dementia Strategy Steering Group has membership from all disciplines and is led by senior decision makers from nursing and medicine, as well as the involvement of a carer.
- The first draft of our strategy has encapsulated the importance of the individuality of dementia from a patient perspective, reflecting a whole system pathway approach

In Practice

- The lead consultant is leading the development of clinical pathways where early assessment and diagnosis takes place, to ensure that dementia patients are recognised at the earliest possible point in their pathway. We believe that early assessment and

diagnosis ensure that dementia patients can be influenced by the best Trust standards of care management.

Educational

- We are integral to the Nottinghamshire Healthcare Representatives Dementia Competencies steering group.
- The fundamental common theme that was recognised by the group was the need to set a 'core' set of educational/training level competencies that would then meet the needs of different staff groups who are directly or indirectly involved with dementia patients.

Research and Audit

- We have been involved in a national pilot research project relating to dementia patients 'Seeing through their eyes'. This research (Wards 51 and 52) reviewed patient-centred interactions with staff. The pilot was led by a Research Fellow from the Academic Unit of Elderly Care from Bradford Institute and Professor John Young.
- We have participated in the National Audit for Dementia.
- The Trust Dementia Steering Group has engaged in an audit to assess the current position in relation to the recognition of dementia patients admitted to the Trust.

Patient Safety

Safeguarding Vulnerable Adults

Description of the Issues and Rationale for Prioritising

Safeguarding Adults is about enabling adults to live safer lives. The 'No Secrets' document published by the Department of Health in 2000 gave guidance to encourage agencies to work together, and for them to produce multi-agency policies for the protection of vulnerable adults, providing a national framework of standards for good practice. Our aim is to ensure we implement excellent standards in relation to safeguarding.

Our Key Improvements / Achievements

- Our Safeguarding Adults Board has produced a local policy which is available on the intranet and as part of the rolling training programme.
- Two stage test and best interest check list documentation has been devised.
- A training programme for Safeguarding Adults, Mental Capacity and Deprivation of Liberty continues to raise staff awareness.
- An Elder Abuse awareness day took place on 15 June 2010.
- On 16 July 2010, the Trust held a Safeguarding Adults study day titled 'Working Together'. The speakers included Nottinghamshire's Coroner, Police, Social Services, Chair of the Nottinghamshire Safeguarding Adults Board, and Dr Margaret Flynn – author of Serious Case Reviews and the Independent Chair of Lancashire Safeguarding Board.
- As a result of the ongoing training for Safeguarding Adults, there is evidence of raised awareness from the referrals received.
- Lessons learnt from safeguarding concerns have been included in the Trust's Safeguarding training.
- There is increased uptake of Mental Capacity and Deprivation of Liberty training, which has resulted in the use of the Mental Capacity Act in practice.
- The availability of easy read information for Safeguarding, Mental Capacity and Deprivation of Liberty, for patients and carers.

Patient Safety

Safeguarding Children and Young People

Description of the Issues and Rationale for Prioritising

The Safeguarding Children & Young Peoples Governance Meeting (SC&YPM) provides assurance, advice and guidance to the Trust on all issues related to safeguarding children and young people in order to ensure compliance with key statutory guidance and legislation (HM Government 2010, 2008, 2007, CQC 2010). The SC&YPM is responsible for developing and maintaining the Safeguarding Children Training Strategy/ Programme to ensure compliance with national recommendations (RCPCH 2010). An annual Safeguarding Children Annual Work Plan of quality has been developed and implementation monitored.

Our Key Improvements / Achievements

- The appointment in January 2011 of a full time Safeguarding Children Midwife.
- The development of a re-admission patient alert system (RAPA) which now alerts a paediatrician if one of their current patients attends Emergency Department.
- A RAPA system has also been developed for the national missing family/children alerts regularly received by the Trust.
- Two new guidelines developed:
 - Guideline for Un-booked Pregnancies (to ensure appropriate social care checks always made).
 - Guideline for Child and Adolescent Mental Health Services referrals in patients presenting with deliberate self-harm or acute mental health issues for use in ED to ensure appropriate care.
- In conjunction with the Primary Care Trust, new paediatric liaison criteria were developed for use on the paediatric wards and neonatal unit to ensure the most vulnerable children were provided with additional information sharing and liaison between acute and community services.
- A quick reference guide Safeguarding Babies on NICU – Key Actions was also produced as an additional prompt for busy staff.
- The Social and Domestic Alert sheet used by midwives was also redesigned to meet the Trust's Situation, Background, Assessment and Recommendations (SBAR) format in order to improve the recording of safeguarding information.

Clinical Effectiveness

Further participation in national clinical audits

Description of the Issues and Rationale for Prioritising

During 2010/11, 42 National Clinical Audits (NCA) and 4 National Confidential Enquiries (NCEs) covered NHS services that Sherwood Forest Hospitals NHS Foundation Trust provides. We participated in 81% (34/42) of NCAs and 100% (1/1) NCEs which we were eligible to participate in.

Our Key Improvements / Achievements

- The 10/11 list of NCA has substantially increased from 17 to 41. It is likely that another increase will follow for 11/12.
- Participation in National Audits is not mandatory, however, Trusts should view a well designed and effective national audit program as an essential tool for them to improve services and assess performance.
- Rather than just 'increasing' participation as a priority, we are now ensuring that Trust resources are focused on key national audits following robust assessment of the quality/value of a 'national audit' by the Clinical Audit Committee.

- All national deadlines for registration and data submission were achieved.

Internal Audit

- The Trust's Internal Audit report showed that we have 'significant assurance' regarding the robust nature of clinical audit processes and systems, with a few minor weaknesses which are being addressed by an action plan. A local benchmarking report produced by Internal Audit also demonstrated that we have the highest compliance against national performance indicators for clinical audit when compared to our neighbouring Trusts.

Annual Clinical Audit Assessment Report 2009/10

- A detailed report for the previous year was produced which incorporated for the first time a quality scoring system to provide us with a gauge as to the quality and value of audits undertaken. The 2010/11 report is currently being compiled.

Patient Safety

To implement a monthly review of Hospital Standardised Mortality Ratio

Description of the Issues and Rationale for Prioritising

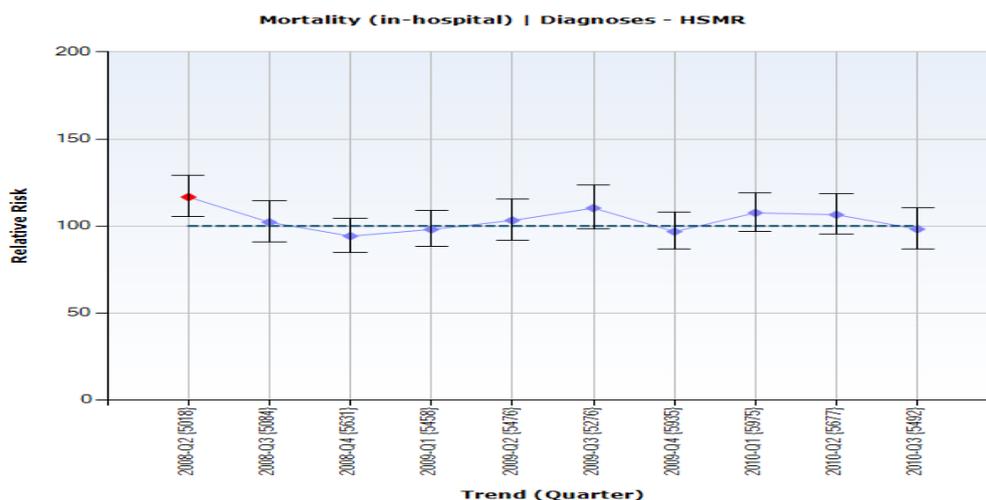
The HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death - for example, heart attacks, strokes or broken hips. HSMR relates to the 56 diagnoses that account for 80% of in hospital deaths across England. Dr Foster mortality data is an important indicator of patient safety within our hospitals.

Our Key Improvements / Achievements

- Prior to June 2010 the Trust reacted to alerts generated by Dr Foster, Imperial College or the Care Quality Commission (CQC). These alerts

required a formal response within a short timescale. As soon as an alert is generated, an investigation is commissioned by our Clinical Governance Committee. Findings are reported within three months.

- During 2010, there were nine diagnosis alerts and four procedure alerts. Six of the diagnosis alerts required further investigations. All six investigations were supported by an action plan, tracked by CGC until complete.
- Three of the four procedure alerts required further investigation, with two of these requiring improvement plans. All actions are now complete.
- We have consistently stayed within acceptable scores for our HSMR. Our HSMR as of March 2011 was 99.6%.



- In the patient safety indicators, Dr Foster named our coding outcome as: 'High adverse events, high coding rate'. The best position to be: 'low adverse events, high coding' and the worst position is 'high adverse events, low coding'. This position was

reported as a good news story because it demonstrated that we record a good level of secondary codes, which should be interpreted as a Trust who has a high level of openness and quality coding.

Patient Experience

To improve patient's dignity in theatre with more effective theatre gowns

We have altered our practice regarding transfer to theatre. Patients (if able) are encouraged to walk or travel in a

wheelchair to theatre using their own dressing gown for modesty purposes.

Clinical Effectiveness

To improve the number of procedures listed in the BADS (British Association of Day Surgery) handbook (day case procedures)

Description of the Issues and Rationale for Prioritising

Day surgery is best defined as 'the admission of selected patients to hospital for a planned surgical procedure, returning home on the same day'. Day case surgery is becoming more common and popular, with approximately 70% of all surgery performed as day surgery. The NHS Institute has worked with day surgery clinicians and the British Association of Day Surgery (BADS), to identify a list of procedures that can easily be done as day cases.

Our Key Improvements / Achievements

- We are achieving the overall national target for BADS recommended day case procedures.
- In certain specialties, day case activity is above the expected day case rate as outlined in the third edition of the procedure directory e.g. ophthalmology, maxillofacial surgery, orthopaedics.
- Our day case rate for laparoscopic cholecystectomy surgery has improved significantly from <10% to 40%. This includes patients with significant co-morbidities where the expectation for same day discharge is less.
- There has been a specific focus on achieving higher day case rates for two high volume procedures; namely tonsillectomy and laparoscopic cholecystectomy.

Clinical Effectiveness

To reduce the number of under 17 year old accident and emergency attendees who are admitted into hospital.

Description of the Issues and Rationale for Prioritising

The aim of this quality measure is to reduce the number of children (age 17 and under) with milder, self limiting diseases being admitted to children and young people's wards, following their attendance to the Emergency Department. Our work is part of an East Midlands wide project specifically reviewing children under 17 attending emergency departments.

Our Key Improvements / Achievements

- We have recently implemented a clear algorithm which enables us to quickly identify patients who we feel can be safely discharged home from the Emergency Department.
- We are developing clear nursing guidelines in relation to the early administration of antipyretic medication (temperature reducing) and oral fluids, to avoid delays for our patients.
- We are developing information to enable parents to be confident to be able to manage common conditions at home.

Clinical Effectiveness

To reduce the mean medical length of stay

Description of the Issues and Rationale for Prioritising

By reducing the time patients spend in hospitals, their overall experience is improved and the risk of healthcare associated infection and hospital acquired pressure ulcers is decreased. It is known that patients admitted for treatment with the same condition may experience considerable variation in their length of stay.

The East Midlands aim to reduce the mean length of stay for medical patients, thereby improving patient outcomes, whilst reducing the use of resources.

Our Key Improvements / Achievements

To support the reduction in length of stay for medical patients, we have concentrated on orchestrating discharge, through improving our discharge processes. We currently use Jonah (a predictive planning tool) throughout SFHFT to support discharge planning, which allows ward teams to proactively manage the patient's discharge process. To complement this and improve our discharge processes we have:

- Implemented weekly discharge performance meetings to both analyse and future plan; length of stay, morning discharges and discharges by day of the week.
- Strengthened our multi-agency meetings between health and social care. These are held weekly to rectify constraints within the patient pathway, which would delay a timely discharge.
- Initiated early morning discharge board rounds to identify patients who could be discharged that day.
- Implemented nurse led discharge.

Clinical Effectiveness

Reduction in emergency readmissions for people with long term conditions

Description of the Issues and Rationale for Prioritising

In collaboration with the East Midlands, the aim of this work is to improve the quality of care for people with long term conditions such as chronic obstructive pulmonary disease, asthma, diabetes, epilepsy, renal disease, congestive cardiac failure and angina. Patients with poorly managed long term conditions may require emergency treatment that could

otherwise be prevented through disease management.

Our Key Improvements / Achievements

- We have increased the amount of consultant support within our Emergency Department.
- Between January and March 2011, we have reduced GP admissions by 20%.

Clinical Effectiveness

To improve our post stroke death and dependency rate

Description of the Issues and Rationale for Prioritising

Since King's Mill Hospital gained accreditation in August 2009 as a primary stroke centre, work continues to further improve the service. Using a structured stroke service improvement programme we have developed specific work streams

for transient ischemic attack (TIA-mini-stroke), stroke pathways and cross county partnership working.

Our Key Improvements / Achievements

- We have specifically developed a stroke care pathway to ensure stroke diagnosis patients are admitted directly to the Acute Stroke Unit and taken to Nottingham City Hospital (if eligible) for thrombolysis.

- There has been continuous monitoring of stroke care and the following table shows data relating to dependency scores. The target was for 95% of all stroke patients to have their dependency scores undertaken within 24 hours of admission, and within 24 hours prior to discharge from hospital.
- This target has been successfully achieved over the last six months.

	Qtr 1 10/11 105 pts	Qtr 2 10/11 96 patients	Qtr 3 10/11 103 patients	Qtr 4 10/11 98 patients
% of stroke patients with no change in dependency from admission to discharge		7%	16%	9%
% of stroke patients with improved dependency levels		76%	73%	79%
% of stroke patients with dependency scores done within 24 hrs of admission		92%	99%	95%
% of stroke patients with dependency scores done within 24 hrs prior to discharge		71%	97%	95%
% of patients discharged with greater dependency		0%	1%	6%

- We have continued to develop a High Risk TIA service.
- To ensure we are delivering the best service and outcome possible, we continue to monitor stroke elements

for Sentinel key performance indicators, Accelerated Stroke Improvement indicators, CQUIN key performance indicators and Best Practice Tariff.

Clinical Effectiveness

Improvements in national sentinel process of stroke care audit scores

Description of the Issues and Rationale for Prioritising

During 2010/11 we have measured ourselves against nine Sentinel Key Performance Indicators (KPI's) which would demonstrate whether we are continuing to improve the care we offer patients who have suffered a stroke.

Our Key Improvements / Achievements

- Over the last year, the results from the ongoing measurement against the

nine Sentinel Audit KPI's demonstrate continual improvement in nearly all indicators.

- The % of patients whose care achieves all nine indicators has improved from 14% to 72% over the last year.
- Patients receiving a brain scan within 24 hours of stroke were previously identified as an area of concern. This year there has been sustained performance above the top quartile all year, whereas now 95% of our stroke patients receive a brain scan within 24 hours of a stroke.

National sentinel process of care audit scores progress report

		National quartiles			Baseline - Sentinel Audit October 2008	qtr 4 09/10 98 pts	Qtr 1 10/11 105 pts	Qtr 2 10/11 96 patients	Qtr 3 10/11 103 patients
		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%	75%	76%	74%	98%
Indicator 2	Screening for swallowing disorders <24 hours after admission	58%	73%	88%	74%	78%	87%	90%	97%
Indicator 3	Brain scan within 24 hours of stroke	44%	57%	70%	41%	82%	89%	94%	95%
Indicator 4	Aspirin or clopidogrel by 48 hours after stroke	77%	88%	96%	87%	71%	77%	87%	97%
Indicator 5	Physiotherapist assessment within 72 hours of admission	74%	88%	94%	78%	82%	86%	95%	97%
Indicator 6	OT assessment within 4 working days of admission	43%	69%	85%	15%	71%	81%	82%	79%
Indicator 7	Patient weighed during admission	61%	76%	87%	83%	91%	93%	96%	100%
Indicator 8	Patient mood assessed by discharge	43%	68%	87%	72%	63%	79%	96%	99%
Indicator 9	Rehabilitation goals agreed by the multidisciplinary team	80%	92%	97%	78%	95%	89%	96%	99%
% patients who achieve all 9 indicators						14%	27%	48%	72%

Patient Experience

To improve patients meals service, specifically meals for patients with compromised nutrition

Description of the Issues and Rationale for Prioritising

Malnutrition is both a cause and a consequence of ill-health. In February 2006, the National Institute for Clinical Excellence (NICE) produced guidance "Nutrition Support in Adults" as older people and those with any long-term medical or psycho-social problems are often chronically underweight and so are vulnerable to acute illness. Age Concern has published two reports 'Hungry to be Heard' and 'Still Hungry to be Heard' calling for improved nutritional care of the elderly in hospitals. Age UK has requested for all hospital wards to implement 'seven steps to end malnutrition'.

Our Key Improvements / Achievements

We have implemented the nationally recommended Malnutrition Universal Screening Tool (MUST).

- Nutrition education is now part of the nurse induction programme and ward based sessions with all staff grades are ongoing.
- In support of Age UK Campaign 'seven steps to end malnutrition', we have introduced mealtime assistants onto all of our Care of the Older Person wards. These volunteers are trained to assist with feeding and provide help at mealtimes.
- The Essence of Care Nutrition Benchmark, completed in October 2010, shows an overall improvement (85%). There is an improvement in all factors with the exception of Factor 10 (eating to promote health) which scored 57%.
- As recommended by Age Concern, we have developed red tray guidance (when to support patients with eating).

Patient Experience

To improve our ambulance turnaround times

Description of the Issues and Rationale for Prioritising

This is a local initiative in partnership working with East Midlands Ambulance Service (EMAS) to address the concerns regarding length of time it takes to transfer responsibility of care from EMAS

staff to hospital staff at each organisation's Emergency Department.

Our Key Improvements / Achievements

- Excellent performance at our Newark Hospital site
- We have made this objective a key priority for 2011/12

Patient Experience

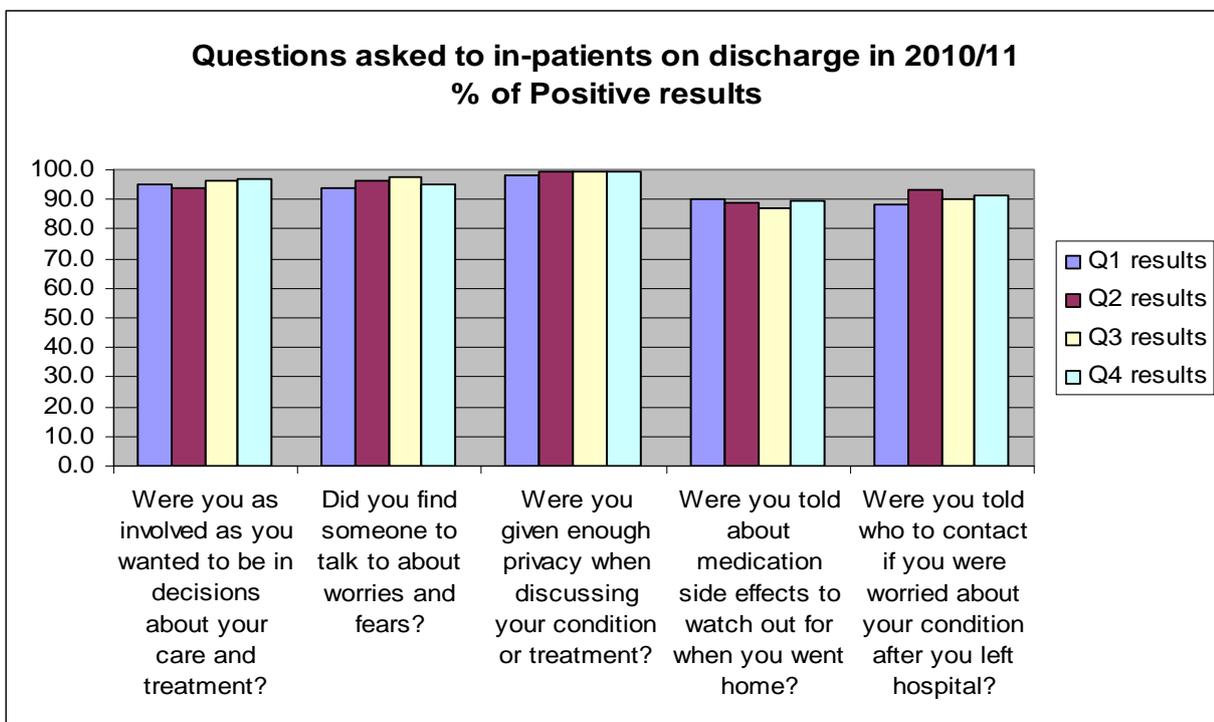
To improvement against the five national indicator measures

Description of the Issues and Rationale for Prioritising

These five questions are national CQUIN indicators called responsiveness to patients need and capture the patients experience in relation to their personal needs. All hospitals are required to capture this data and the questions are generated from the national inpatient survey carried by the Care Quality

Our Key Improvements / Achievements

The questions shown in the graph below have been asked to patients on discharge from hospital. The results are available per ward and have been shared with staff to enable them to make any improvements. Quarter 1, for example, relates to April, May and June 2010.



We are very happy with these results as it shows that we are meeting patient's expectations. We have highlighted the need to make sure patients know about

the medication side effects. We have also improved patient information which includes a section with contact details.

Patient Experience

To participate and develop action plans in relation to the East Midland Patient Experience project

The East Midlands Patient Experience Service (EMPES) is a system that aims to bring together patient experience and outcome data to enable us to continuously improve services. This service is being run across the East Midlands and has been collecting data from patients who have had either

varicose vein, hernia, hip or knee replacements operations. Sherwood Forest Hospitals NHS Foundation Trust has participated in this data collection that began in the latter part of the year. We wish to thank those patients who have taken the time to provide us with feedback.

Patient Experience

Continue to use real time data to improve the customer experience and identify themes and trends for service improvement

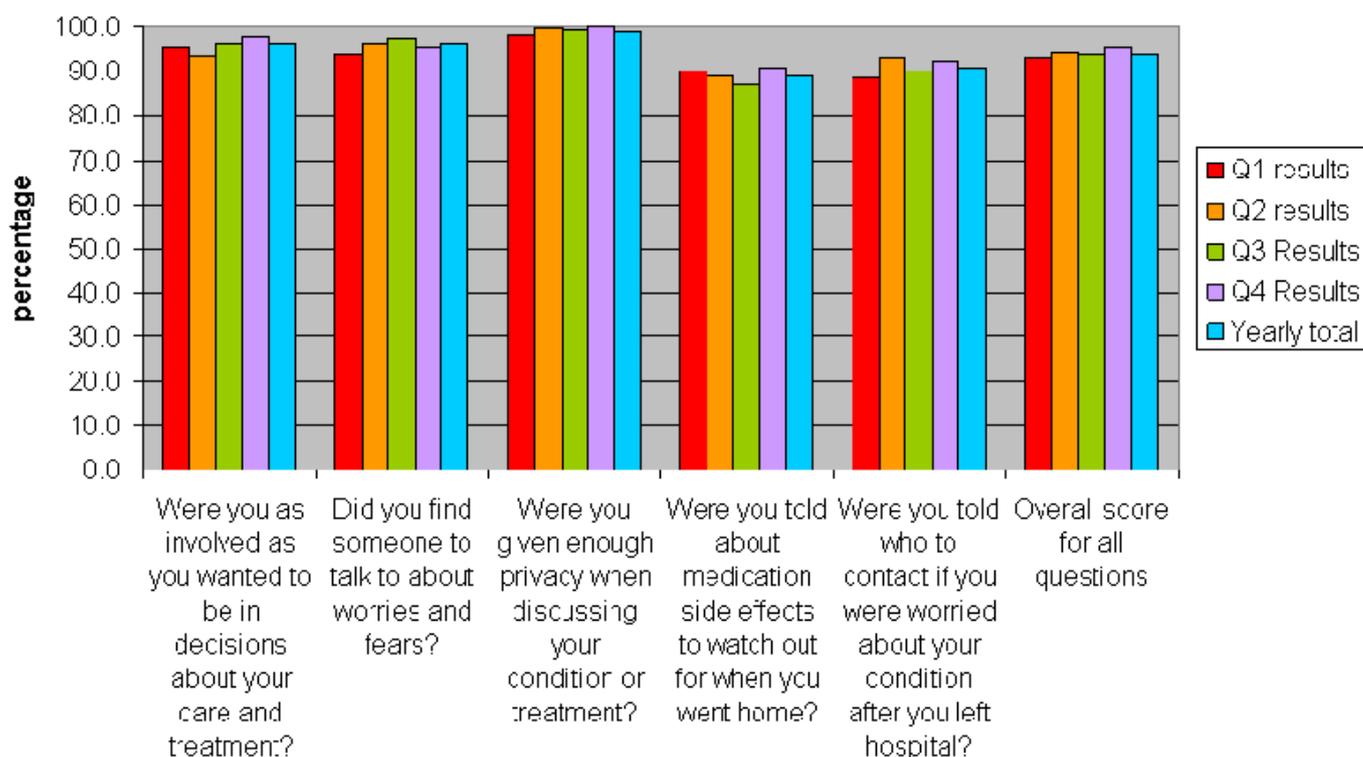
Description of the Issues and Rationale for Prioritising

During the last year we have asked people who have attended the outpatients department a set of questions and the results are shown below.

Our Key Improvements / Achievements

8,627 people were asked the questions, with most results improving month on month. There has been an issue identified regarding people not knowing why they have to wait over 30 minutes. Clinic staff have been asked to explain the reason for the delay to people, posters have been developed and electronic screens are in the process of being purchased. The main aim is to see people within 30 minutes

CQUIN results 2010/11



Plans for 2011/12

The questions asked to outpatients will change and questions will be asked to ensure we are achieving the pledges we have developed with patient and carers.

Pledges to Patients and Carers

- **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 questions to be asked for 2011 will be:

- Were our staff courteous and helpful?
- Do you feel you were treated as an individual?
- Do you feel you were given enough information?
- How would you rate the cleanliness of the hospital?
- If a family member or friend required hospital care would you recommend us?

Patient Experience

To continue to develop the role of volunteers in enhancing the customer experience

Volunteers continue to enhance and complement the services provided at our hospitals. Support is provided in 29 departments and services.

Our Key Improvements / Achievements

- Volunteers provide a key front of house service and we have improved our communication strategy to ensure that the team receives timely notification of change and information.
- Volunteers assist with the collection of valuable real time data. A selected team receives training and support from our Patient Advice and Liaison Service team to enable data collection can be used to inform service improvements.

Internal vehicle provision

- Hours of the service extended to meet demand for visiting during evenings and weekends.

Extending Café operating hours

- Operating hours have extended to meet the needs of the patient and visitors

Meet and Greet volunteer role developed for Welcome Treatment Centre

- Volunteers are available to befriend and support patients attending outpatient services. This includes the provision of a refreshment service for both patients and their carers.

Day case support volunteer

- Volunteers are available to provide support and assistance to the patients and their carers as they await/recover from treatment.

Health care of the older person support volunteer

- Volunteers have been recruited to support meal times on the health care of the older persons ward to encourage patients to eat and drink. Social interaction is often required during meal time.

Our Assurances

Review of services

During 2010/11, Sherwood Forest Hospitals NHS Foundation Trust provided 50 Clinical services. The Board of Directors at Sherwood Forest NHS Foundation Trust has reviewed data made available to it in relation to the quality of care of services.

The income of clinical services represented 75 % of the total income generated from the provision of services by the Trust for 2010/2011.

Audit and Research

During 2010/2011, **42** national clinical audits (NCA) and **4** national confidential enquiries (NCEs) covered NHS services that Sherwood Forest Hospitals NHS Foundation Trust provides.

During that period Sherwood Forest Hospitals participated in **79% (33/42)** NCAs and **100% (1/1)** NCEs of which it was eligible to participate in. The national clinical audits and national confidential enquiries that SFH participated are listed below.

Participation in National audits

Title and organisation

Number of cases or continuous / % submitted of expected total

Perinatal mortality (CEMACH)	Continuous	100%
Neonatal intensive and special care (NNAP)	Continuous	100%
Paediatric fever (College of Emergency Medicine)	N=50	100%
RCPH National Childhood Epilepsy Audit	<i>Audit currently underway</i>	
Diabetes (RCPH National Paediatric Diabetes Audit)	N=117	100%
Emergency use of oxygen (British Thoracic Society)	N=72	100%
Adult community acquired pneumonia (BTS) 2011	<i>Audit currently underway</i>	
Non invasive ventilation (NIV) - adults (BTS) 2011	<i>Audit currently underway</i>	
Cardiac arrest (National Cardiac Arrest Audit)	Continuous	100%
Vital signs in majors (College of Emergency Medicine)	N=50	100%
Adult critical care (Case Mix Programme) ICNARC	Continuous	100%
Potential donor audit (NHS Blood & Transplant)	Continuous	100%
Heavy menstrual bleeding National Audit	<i>Audit currently underway</i>	
Ulcerative colitis & Crohn's disease (IBD Audit)	<i>Audit currently underway</i>	
Adult asthma (British Thoracic Society)		
Hip, knee and ankle replacements (NJR)	Continuous	100%
Elective surgery (National PROMs Programme)	Continuous	100%
Adult cardiac interventions audit PCI/ BCIS	Continuous	100%
Peripheral vascular surgery (NVD Database)	Continuous	100%
Carotid interventions (Carotid Intervention Audit)	Continuous	100%
Familial hypercholesterolaemia Audit	N=9	100%
Acute Myocardial Infarction & other ACS (MINAP)	Continuous	100%
Heart failure (Heart Failure Audit)	Continuous	100%
Acute stroke (SINAP)	<i>Audit currently underway</i>	
Stroke care (National Sentinel Stroke Audit)	N=56	93%
Renal colic (College of Emergency Medicine)	N=50	100%
Lung cancer Audit	Continuous	100%
Bowel cancer Audit Programme	Continuous	100%

Head & neck cancer (DAHNO)	Continuous	100%
Hip fracture (National Hip Fracture Database)	Continuous	100%
Severe trauma (Trauma Audit & Research Network)		
National Falls & Bone Health Audit	N=26	100%
National Audit of Dementia	N=40	100%
Platelet use	N=5	100%

The reports of two National Clinical Audits were reviewed by the provider in 2010/11 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided:

- Improve education of frontline staff
- Improve senior clinicians' input/involvement
- Improve training for clinical staff
- Policy development to address gaps

A further 10 national Clinical Audits are awaiting final reports and action plans.

The reports of 34 Local Clinical Audits were reviewed by the provider in 2010/11 and Sherwood Forest Hospitals intends to take the following actions to improve the quality of healthcare provided:

- Review and update relevant guidance.
- Recommendations are taken forward by the appropriate clinical team.
- Review patient pathways.
- Ensure training and education is addressed as required.

In 2011/2012 the Trust will ensure that the audit programme reflects the Trust vision with a strong focus on the three domains for quality of care.

Clinical Research

The number of patients receiving NHS services provided by Sherwood Forest Hospitals NHS Foundation Trust that were

recruited during 2010/11 to participate in research approved by a research ethics committee was 250. This demonstrates a sustained increase over the last three years.

Sherwood Forest Hospitals NHS Foundation Trust				
NHS Year	2008/2009	2009/2010	2010/2011	Grand Total
Sum of Total	64	135	250	449
Sherwood Forest Hospitals NHS Foundation Trust				
NHS Year	2008/2009	2009/2010	2010/2011	Grand Total
Design Type				
Interventional	19	22	40	81
Observational	45	113	210	368
Grand Total	64	135	250	449

Source:

050100150200250300TotalTotal NIHR portfolio recruitment at SFH by NHS

Year2008/20092009/20102010/2011050100150200250InterventionalObservationalNIHR portfolio recruitment at SFH by Design Type & NHS Year2008/20092009/20102010/2011

Commission for Quality and Innovation (CQUIN)

A proportion of Sherwood Forest Hospital's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Sherwood Forest Hospitals and NHS Nottinghamshire County Primary Care Trust through the Commissioning for Quality and Innovation payment framework. Quality payments were received and in addition, the Trust received an incentive payment for a stretch target for C Difficile rates, which it has also achieved.

The monetary total for the amount of income conditional upon achieving the quality improvement and innovation goals for 2010/11 was £2,688,000 and £150,000 for achieving C Difficile targets; the total amount achieved was £2,028,085.

Care Quality Commission (CQC)

Under Section 11 of the Health and Social Care Act 2008, the Trust is required to register with the Care Quality Commission (CQC) in order to provide regulated activities associated with health care. The Trust has been registered (from 1 April 2010) by the CQC to provide the following regulated activities:

- Diagnostics and screening procedures
- Family planning
- Maternity and midwifery services
- Nursing Care
- Surgical procedures
- Treatment of disease, disorder or injury
- Termination of pregnancy

The Trust has to maintain compliance with sixteen out of twenty eight regulations (outcomes) which relate to essential standards of quality and safety in order for its registration with the CQC to remain without conditions.

The Care Quality Commission has not taken enforcement against Sherwood Forest Hospitals during 2010/11.

During 2010/11 the Trust successfully removed conditions applied at the end of 2009/10. These conditions were related to **Outcome 16** (reg10) assessing and monitoring the quality of service provision:

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' agreed Actions Plans to ensure that concerns identified by the CQC were resolved by the end of July 2010.

- Specifically to improve clinical governance systems in ICCU to support continual improvement and clinical excellence by end 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.

To review progress against the conditions, Sherwood Forest Hospitals was subject to an unannounced review by the Care Quality Commission in early August 2010. This was an extremely successful visit and conditions against our registration were quickly removed.

As part of the CQC's planned assessments, in March 2011, the Trust submitted compliance assessments for King's Mill and Newark Hospitals on outcomes **2,6,7,8,10,13** and **16** as well as answering specific questions on Outcomes **12,17** and **21**.

As part of the national programme assessing outcomes **1 & 5**, we received an unannounced visit to Newark Hospital specifically looking at dignity and nutrition for older people. We are still awaiting our report but verbal feedback on the day of the visit was very positive.

Data Quality

Sherwood Forest Hospitals NHS Foundation Trust submitted records during 2010/11 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; 96.7% for accident and emergency care
- which includes the patient's valid GP registration code was 100% for admitted patient care; 100% for outpatient care; and 99.7% for accident and emergency care

Information Governance

The following describes the progress against the Information Governance Toolkit version 8. This represents a significant change in requirements from the previous year's toolkit.

It is important to note that the work has focused on the Key Requirements, of which there are 22, which apply to the Statement of Compliance. This is an essential licensing requirement for Foundation Trusts.

The Trust's position is that we have achieved Level 2 across 21 of the 22 Key requirements, with an action plan in place for requirement 8-307. As a Foundation Trust we are therefore currently within our terms of authorisation.

Out of the scores for the 22 Key requirements, Internal Audit agreed that the Trust had achieved compliance i.e. Level 2 or above, with 21 requirements and noted that the Trust had provided strong evidence that demonstrated a reasonable level of assurance in relation to Information Governance processes. One Key Requirement (8-307) will remain at a Level 1 for this financial year. This requirement relates to the appointment of Information Asset Owners and Administrators and the development of a formal reporting structure for managing risks in relation to information assets within the Trust. This will form part of the work plan for 2011/12 to ensure that this requirement will meet Level 2 prior to 31st March 2012.

For all remaining requirements that have not achieved a minimum of Level 2, i.e. nine requirements, these will be incorporated into the work plan which will support the delivery of these standards during financial year 2011/12. Overall, with both Key and remaining requirements combined to create 45 requirements, the Trust has scored six requirements at a Level 3, twenty nine at a Level 2, seven at a Level 1 and three requirements at a Level 0. This provides Sherwood Forest Hospitals NHS Foundation Trust with an overall percentage of 58% which, although is comparable with other Trusts in the East Midlands, is viewed by Connecting for Health as 'Not Satisfactory.'

The work plan for 2011/12 will result in compliance across all Key Requirements, with regular reports provided to Performance and Information Committee, to Risk Management Group from a risk perspective, and as a regular report to

Audit Committee, detailing the overall progression of the IG Toolkit.

Payment by Results

During 2010/11 the Trust was not subject to an Inpatient or Outpatient PbR Audit by the Audit Commission, they have moved to a more risk based approach on areas reviewed over the last three years and are focusing resources on Trusts that need to improve the most. Sherwood Forest Hospitals is within the top 5% performing Trusts with regards to clinical coding data accuracy and capture. As an organisation we constantly strive for high quality robust data. The Trust commissioned an external audit by CHKS which took place during March 2011; the remit was to review 200 sets of case-notes. The Clinical Coding audit resulted in an Information Governance Requirement attainment level of 2. The results should not be extrapolated further than the actual sample audited.

Primary Diagnosis - 12 errors from 200
Primary Diagnosis Codes = 6.0%
Secondary Diagnosis - 27 errors from 618
Secondary Diagnosis Codes = 4.4%
Primary Procedures - 7 errors from 116
primary procedure codes = 6.0%
Secondary Procedures - 1 error from 169
primary procedure codes = 0.5%

Other Information

NHSLA - CNST Risk Management

During 2010/11 the Trust has maintained CNST level 1 for both general hospital and maternity care. We have had three interim visits, two in general hospital and one in Maternity and have a workshop planned soon whilst we continue to work towards level 2 assessment in both areas.

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 SFH 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 to improve the care of 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 Board of Directors. A large number of external bodies such as CQC, Dr Foster, Royal Colleges and laboratory accreditation, also monitor our performance and SFH works with them to learn of any new opportunities for improvement.

The Trust believes we have a sound system for Clinical Governance, populated 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

	2010/11	2009/10	2008/9	2007/08
Clostridium difficile year on year reduction	54	96	177	324
MRSA - maintaining the annual number of MRSA bloodstream infections at less than half of the 2003/04 level	0	14	31	36
Never events that occurred within the Trust	2	0	0	0
Essence of Care Benchmark Outcomes :			2008-09	Programme 1
Pressure Ulcers	85%	N/A*	81%	73%
Record Keeping	87%	N/A*	81%	75%
Effective Communication	Due 2011	N/A*	84%	77%
Nutrition	85%			

Note:- EOC benchmarks are undertaken in a programmed way and were not undertaken 09/10

Patient Experience Metrics

	2010	2009	2008	2007	National average
National PEAT scores (0-5, 5 being excellent):					
*Environment King's Mill Hospital	5	4	3	4	4
*Environment Newark Hospital	4	4	3	4	4
*Food KMH	5	4	4	4	5
Food NH	4	4	3	3	5
Essence of Care Benchmark Outcomes:					
	Due 2011	N/A	82%	80%	
Privacy and dignity		N/A	81%	77%	
Food and Nutrition	85%				
Selected Inpatient Survey Results:					
					Highest scoring 20% of Trusts
Did you have confidence in the doctors treating you?	89%	89%	90%	87%	
Did you have confidence in the nurses treating you?	89%	88%	88%	85%	91%
Were you given enough privacy when being examined or treated?	95%	96%	95%	91%	88%
Did you find someone on the hospital staff to talk to about your worries and fears?	62%	61%	65%	58%	95%
					64%
% of patients who would recommend hospital to a relative/friend	98%*	87%	80%		

Note:- EOC benchmarks are undertaken in a programmed way and were not undertaken 09/10.

This year's figure is from Day Case patients only.

Clinical effectiveness and National Targets and Regulatory Requirements	2010-11	2009-10	2008-09	2007-08	2009-10 Target
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	99.6%	98.8%	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	Drug 99.2%	Drug 99.7%	N/A	N/A	Drug 98%
	Surgery 97.3%	Surgery 94.3%			Surgery 94%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	89.7%	84.5%	94.6%	N/A	85%
Maximum waiting time of 62 day from screening to 1st definitive treatment	93.1%*	90.5%	N/A	N/A	90%
18-week maximum wait from point of referral to treatment (admitted patients)	94.86%	94% (March 10)*	95% (March 09)	86% (March 08)	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	98.12%	98.7% (March 10)*	99% (March 09)	90% (March 08)	95%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	97.69%	98.7%	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)	73.44%	63%	60%	78%	68%
Screening all elective inpatients for MRSA	100%	93.6%			100%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	94.2%	94.4%	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	95.1%	92.8%	N/A	N/A	93%

***Notes:-**With regard to 18 weeks performance for March 10 please be aware that the reduction in achievement is due to the fact that we have revised the methodology used to include the clinical assessment service start date.
-that **changes in the reporting framework took place in Q4 Jan - Mar 11** which means that Consultant Upgrade performance is included with screening, so the 93.1% relates to Q1-Q3 for screening only and Q4 for Consultant Upgrade and screening

External Assurances

NHS Nottinghamshire County is responsible for commissioning high quality services that treat today's ill health alongside services to enable people to live healthier lives in the future. This statement has been requested in accordance with the regulations which state that as the lead commissioner of NHS Services provided by Sherwood Forest Hospitals NHS Foundation Trust they must take reasonable steps to check the accuracy of the information in this document and note other information they consider relevant to quality.

Written Statement from our commissioners: NHS Nottinghamshire County

"NHS Nottinghamshire County 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 that arise. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year. During the year the Trust worked successfully to remove Care Quality Commission (CQC) conditions applied to its registration at the end of 2009/2010 following an unannounced visit by the CQC in August 2010. A further unannounced visit was undertaken at Newark Hospital as part of a national review of dignity and nutrition for older people.

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. The Trust has considerable financial and organisational challenges in 2011/2012. Commissioners will seek further assurance of service quality as efficient programmes and workforce changes take effect".

Written Statement from Nottinghamshire County LINK

The LINK feels that this Quality Account is a fair reflection of the healthcare services provided by Sherwood Forest Hospitals. Throughout the document there are clear indicators of improvement and where problems have been identified the LINK feels confident that appropriate action plans have been implemented to aid improvement.

The inclusion of graphs and baseline figures make it easy for LINK to comment on performance and it is clear to see that Sherwood Forest Hospitals are consistently meet or exceed the national target.

The LINK would like to take this opportunity to express how pleased we are to see that hospital practice has been altered to "improve patient's dignity in theatre with more effective theatre gowns" and that there have been significant improvements in clinical effectiveness.

Commentary from the overview and Scrutiny Committee

The committee notified us on 11th May 2011 that they are not intending to review our report this year and therefore we are not expecting any feed back.



Carolyn White
Chief Executive
30th June 2011

Glossary

Term /Abbreviation	Description
Care Quality Commission (CQC)	The independent regulator of Health and Social Care in England. Its aim is to ensure better care for everyone where ever that care is given. They replaced the Health Care Commission
Clinical Governance	Clinical governance is the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services
Clinical Negligence scheme for Trusts (CNST)	A scheme for managing negligence claims within the NHS
Clostridium Difficile (C Diff)	Naturally occurring bacteria that causes no harm in healthy people. However some antibiotics used in health care can interfere with the balance of “good“ bacteria in the gut. When this occurs the C Diff multiply causing symptoms of diarrhoea and fever.
Commissioning for Quality and Innovations (CQUIN)	A payment Framework to ensure that the income for providers of health care is influenced by the improvement in quality and innovation in care.
Escherichia Coli (E Coli)	Bacteria normally found in the gut but under certain conditions can cause problem and complications.
Health care acquired infections(HCAI's)	A generic name for C Diff ,MRSA etc
Methicillin - Resistant Staphylococcus Aureus (MRSA) Methicillin -Sensitive Staphylococcus Aureus (MSSA)	Staphylococcus Aureus is often found on the skin and nose of 3/10 people. It causes problems when the bacteria enter the body through a break in the skin. Resistant and Sensitive indicate changes in the bacteria which make treatment more difficult.
Monitor	This is the regulator of NHS Foundation Trusts. It is an independent body directly accountable to Parliament.
National Health Service Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA) was established in November 1995, as a Special Health Authority, to administer the “Clinical Negligence Scheme for Trusts” (CNST), and set rigid quality standards for healthcare to aspire to.
National Patient Survey	Undertaken by the CQC to ask patient about how they view their care across a range of settings.
Payment by Results(PbR)	Payment by Results (PbR) was introduced to improve efficiency , increase value for money , facilitate choice , enable service innovation and improvements in quality , and reduce waiting times .
Quality Account	A statutory annual account of quality, which provides external assurances that the Trust board has assessed and monitored quality across services and is driving improvements.
Secondary User Service (SUS)	The NHS data system for recording all NHS patient activity.
Veneous Thrombo embolism	This is a blood clot developing. Whilst in hospital patients are more at risk of them as they are not as mobile as they usually are. If one occurs during a hospital stay it may prolong the length of the stay or lead to increased complications.

External Audit Opinion



Independent Assurance Report to the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Sherwood Forest Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor") and dated 31 March 2011.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011
- Papers relating to Quality reported to the Board over the period April 2010 to May 2011
- Feedback from the Commissioners dated 31 May 2011
- Feedback from Governors dated 19 May 2011
- Feedback from LINKS dated 12 May 2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2 June 2011
- The 2011 national inpatient survey
- The 2011 national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 April 2011
- CQC quality and risk profiles dated March 2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust as a body, to assist the Board of Governors in reporting Sherwood Forest Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their

governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Sherwood Forest Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual dated 31 March 2011.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP

KPMG LLP

Chartered Accountants

Birmingham

Date: 28 June 2011