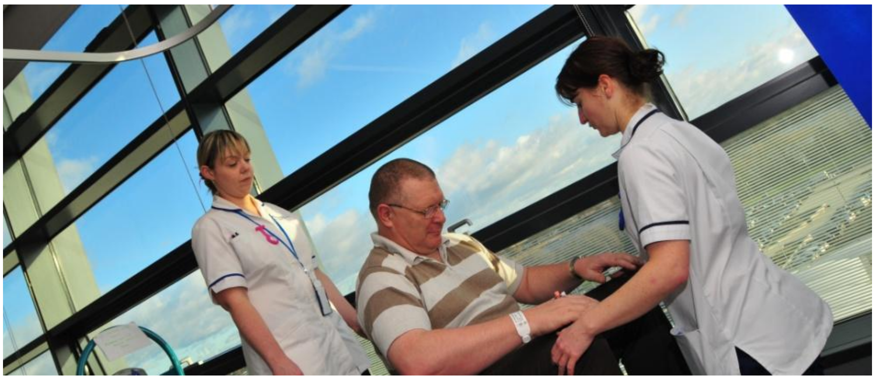
Sherwood Forest Hospitals NHS
NHS Foundation Trust



# *Quality Report*
2011/12

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# 1 INTRODUCTION

## 1.1 Foreword by the Chief Executive

Our vision is simple yet passionate: ". . . to provide the best care, with the best people, in the best place."

We have some of the best hospital facilities in the UK at present, following the massive investment and opening of the new Kings Mill hospital earlier last year. Additionally, further investments have been made in our other facilities to further improve the environments available for our patients and to provide our staff with the best possible working environment.

Having great facilities is only one part of the patient experience, however. It is the care and empathy that our staff provide to our patients that we are most proud of. We aspire to being one of the safest hospital Trusts in the country and have commenced a programme of reducing our Summary Hospital-level Mortality Indicator (SHMI) to become one of the top 10% performers, ensuring that our patients can be confident that everything we do is grounded in a patient safety culture.

We have already invested in additional clinical staff to ensure that our patients receive high quality and consistent care 7 days a week, an issue receiving national attention last summer and one which we had already recognised as needing attention . . . and have acted upon.

We have appointed a senior clinician responsible for patient safety who coordinates our many service improvement activities to ensure they all contribute to improved patient outcomes

We have commenced with an innovative scheme which enables us to return frail elderly patients back home from hospital with care cover for up to 48 hours to ensure that when patients are discharged from our hospitals their basic needs are supported and that they do not go back to a home without food or heating. This programme has already received fantastic feedback from our patients and reflects our ambition to see patients as individuals, requiring more than just professional medical and nursing care but also practical support to help get their lives back to normal.

Our focus on patient safety and quality has ensured that we are one of only 2 hospitals across the (previously defined) East Midlands SHA region that delivered the 95% A&E target throughout the year, providing additional capacity where necessary and ensuring that patients flowed through our hospital optimally, reflecting the ongoing success of our ABC (Achieving Best Care) programme that we commenced over a year ago.

There are very few hospitals in the country that can report the elimination of hospital acquired MRSA from their organisations - but Sherwood Forest has now gone for over 2 years since its last infection, an outstanding achievement and one which reflects the adoption of our zero tolerance policy.

We are naturally disappointed therefore to have only reduced our C. difficile rates by 17% during the last 12 months, reporting 45 cases against a trajectory of 43. This disappointment has, however, spurred the Trust to make further investments in its surveillance programme with additional consultant microbiologist appointments in addition to further strengthening our pharmacy and infection control nursing resource. Our ambitions warrant such a response and over the course of the last 6 months our infection rate continues to decline to one of the lowest rates in the country.

Quality, however, is not only about the care that patients receive; it is also about how they are able to access it and how they feel supported throughout their care.

We have changed the way in which our administration systems work by adopting a ‘patient pathway coordinator model’ which more closely aligns our patient administration systems to how our consultants actually work. This will enable patients to phone a single point in order to access information about their care, rather than being transferred to different departments, a key frustration often highlighted in patient feedback.

We have changed how we manage patient complaints by inviting patients and their relatives to meet up with senior management and the clinicians involved in their care in order to directly respond to their concerns, and in some instances we have invited patients and their relatives to share their experiences with the Trust Board in order to strengthen the Board's links to the experiences of our patients.

In reflecting back on the previous year I am confident that, to the best of my knowledge, the information in this report accurately reflects our actual performance and provides an honest and consistent appraisal of where our plans were delivered, where they were exceeded and where we failed in our ambition.

Our objectives for next year reflect the ambitions of the Trust Board and our staff, and the areas of priority have been agreed with our governors.

We will continue to strive for excellence as 'good enough' never is.

**Martin Wakeley**
**Chief Executive**
Sherwood Forest Hospitals NHS Foundation Trust

## 1.2 What is a Quality Report

A Quality Report is an account about the quality of services provided by an NHS healthcare provider. The report is published annually by each provider and made available to the public on NHS Choices website (www.nhs.uk) as well as on each provider's website.  The report for Sherwood Forest Hospitals is available at www.sfh-tr.nhs.uk, where a downloadable file is available.   A paper copy may be requested from e.communications@sfh-tr.nhs.uk.

In addition to publishing the Quality Report document, Foundations Trusts such as Sherwood Forest Hospitals include the Quality Report within their Annual Report & Accounts.

In a Quality Report we share information on the quality of the services we provide by looking at:

- Patient safety
- The effectiveness of treatments that patients receive
- Patient feedback about the care provided

The report will enable you to determine if you think we are providing you with the best care and treatment.

### What is covered in this report

This report includes:

- An overview of our services
- Our performance against the priorities set in last year's Quality Report
- Our priorities for further improvement for the coming year
- What others say about our Quality Report
- A statement from the Chief Executive summarising the Trust's view of the quality of the NHS services that it provides, which confirms that to the best of his knowledge the information contained in the report is accurate

## Who is involved in writing this report

Many of our staff have been involved in the compilation of this report. These people are experts in their field and are best placed to advise on the best care for our patients and more significantly what our patents tell them is important. Our staff have also helped to measure the quality of care that we have delivered over the last 12 months and have been instrumental in delivering service improvements and quality enhancements for our patients.

Our Council of Governors has received regular reports regarding the quality of care we have provided over the last year. There are three sub committees of the governors involved in reviewing quality: Performance & Strategy, Patient Quality & Experience, and Membership & Engagement. The Trust's Board of Directors also receives monthly quality reports in addition to a detailed quarterly quality report.

We have engaged with members of the public, including a considerable number of our 20,000 members, throughout the year by running various events to ensure we truly listen to their needs and requirements. These events have also helped us shape our priorities for the coming year.

We have worked with the ambulance service and other organisations during the past two years through events called 'Community in Unity'. These events are aimed at groups of people who are seldom heard and often find it difficult to get their views across. We ran a very successful event in November where people told us what mattered to them. We have also asked people on a daily basis what matters to them through the use of face-to-face surveys, which means we get a real understanding of what concerns people and, if they have any problems, we can more efficiently resolve them.

In addition to the above, views have been sought from:

- Our commissioners, NHS Nottinghamshire County Primary Care Trust
- Nottinghamshire Local Involvement Network (LINk)
- Nottinghamshire County Council Overview and Scrutiny Committee
- Our Council of Governors

# 2 OVERVIEW OF PRIORITIES

## 2.1 Priorities and Achievements for 2011/12

Under the three dimensions of quality, 'Patient Safety', 'Clinical Effectiveness' and 'Patient Experience', we identified three key areas for improvement. The following section will report our performance against those key areas. All the other quality priorities for 2011/12 have been reported on from section 2.3 onwards.

## Patient Safety - Priority 1

### To reduce hospital mortality

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. Like all statistics, HSMR's are not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it is a warning sign that certain aspects of care require further interrogation.

Our Trust HSMR was 113 for the period 2010/11, which is significantly above expectation. Just prior to the reporting of this indicator we had investigated and implemented changes to address this concern and learnt lessons from the way we collect data. The appointment of an Associate Medical Director for Patient Safety and a dedicated Mortality Group were developed to gain an understanding of the contributory factors.

Following the recommendations of the Hospital Standardised Mortality Ratios (HSMR) review, the Department of Health committed to implementing the SHMI (Summary Hospital-level Mortality Indicator) as the single hospital-level indicator for the NHS.

The SHMI has been developed by the Department of Health as one indicator of healthcare quality. It measures whether the death rate of patients admitted to a particular hospital is above or below expected, taking into account the nature of their condition and factors such as their age and the presence of other illnesses. As with many statistics, the SHMI should not be used in isolation but is one of a number of indicators to assess how a hospital is performing.

The average Hospital Trust has a SHMI score of 100. The SHMI for our organisation for the year 2010/11 was 103, which is not significantly different from the expected rate for English hospitals and deemed to be average. The data is taken from Dr Foster intelligence http://drfosterintelligence.co.uk/ and is governed by standard national definitions enabling comparisons to be made with other hospitals

We are ambitious to be one of the safest Hospital Trusts in the country and have therefore examined our services to identify how we can improve further in order to deliver better, safer care. As with many hospitals, we have identified that the outcomes of patients admitted as an emergency at weekends has not been as good as those admitted during the week. This is reflected in a higher mortality of patients admitted at a weekend compared to weekdays. We have therefore started to reorganise our services with the aim of providing the same high standard of care throughout the whole week.

In response to this we have:

- Introduced weekend ward rounds by consultants and junior doctors in many parts of our hospitals with an aim to extend this to all wards by summer 2012
- Appointed four new acute physicians (doctors) to the Trust. This will improve the quality and timeliness of assessment of patients when they are first admitted, and means that once admitted they will be assessed by the relevant specialists on a daily basis
- Increased the availability of radiological investigations at weekends so that there will be less waiting for the relevant tests
- Appointed an Associate Medical Director for Patient Safety. The role includes examination of all in-hospital deaths and serious incidents so that lessons are learnt and changes made to improve our service

We will continue to closely monitor our SHMI to ensure that we deliver our ambition to be one of the best and safest hospitals in the country, aspiring to a SHMI of 97 for 2012/13, and falling to 89 in future years.

# Clinical Effectiveness - Priority 1

## To reduce the time ambulance staff wait to handover patients

We aim to admit patients arriving by ambulance to the Emergency Department promptly, taking all the details from the ambulance staff, swiftly making the ambulance ready for the next 999 call.

All hospitals have a national target to achieve a 15 minute 'turnaround' (this is a 15 minute target from arrival to departure of every emergency vehicle). We are achieving this target at Sherwood Forest Hospitals. However, it remains a significant challenge as we have seen a substantial increase in ambulances attending the emergency department in the last part of the year. We are working closely with the ambulance service to ensure that the patient pathway, clinical handover and information recording processes are made more robust, and we have been selected as a flagship site for the East Midlands to pilot new ways of working with ambulance crews to improve the clinical handover processes.

In order to ensure our most skilled staff are available to see the sickest patients we have introduced medical support workers. They are based in the department to take the patient's blood and record heart tracings, so freeing-up nursing time. We are in the process of recruiting 6 or 7 additional support workers.

We are committed to working with the ambulance service to ensure vehicles are released on time and together we have implemented the following:

- A generic worker has been introduced to book patients into the department, preventing ambulance staff from having to book in at reception, saving time
- The ambulance service has introduced a Hospital Ambulance Liaison Officer based in the Emergency Department to further reduce the handover times
- The team are also piloting time stamping bleeps, which automatically book the ambulance staff in and out of the department as a possible time saver

Year on year we are seeing an increase in the number of patients attending our emergency department. Despite this huge increase we were one of only three hospitals in the East Midlands to have achieved the national Accident and Emergency four hours wait target.

*The 15 minute target data is collected by the East Midlands Ambulance service as part of the national Urgent care standard.*


## Patient Experience - Priority 1

### Ensure nutritional screening is undertaken for every patient

One of our primary patient experience aims is to ensure that significant improvements are made in screening all adult inpatients for risk of malnutrition. Over the past year our nursing staff have concentrated on ensuring our patients' nutritional needs are adequately assessed and supported through the use of MUST (Malnutrition Universal Screen Tool). As a consequence we have met the local and regional Commissioning for Quality and Innovation (CQUIN) targets for nutrition screening for each of the first three quarters of 2011/12 and narrowly missed the fourth quarter by 1%, even though we are able to demonstrate a continuous improvement.

This means that over 90% of our patients have received a nutritional assessment during 2011/12. Our audit results for quarter 3, which involved auditing case notes of all adult inpatients across our four hospitals, showed that 93% of patients had been screened using the MUST. The audit for quarter 4 shows a further improvement to 94%, leaving us 1% short of the 95% target. Further work will be completed in 12/13 to address this. The data is governed by local and regional definitions.

These improvements have been achieved by raising awareness and providing training to ward based staff on the use of MUST.  A training programme was delivered across the Trust which involved MUST workshops as well as ward-based teaching sessions. This gave all relevant staff the opportunity to attend.

The Essence of Care Nutrition Benchmark was re-audited during December 2011. Ten factors were assessed using three different tools as shown below:

- Staff questionnaire
- Patient questionnaire
- Observations and check records

The results for the Trust gave an overall score of 93%, which is well above the agreed minimal level of 70%. These results give an excellent picture of the improved quality of patient care and work that has been carried out since the previous benchmark in 2010.

Quotes from staff questionnaires are as follows:

- Attention has been excellent
- Quality meals - very good
- Good meals - and able to give individual patients the portion sizes they require
- A good service to patients and their family

To strengthen our nutrition guidelines we launched a Nutrition Operational Policy and a Protected Mealtimes Policy throughout our hospitals in December 2011. This means that we continue to protect patient meal times, to avoid patients being disturbed unnecessarily by any member of staff or by visitors.

We have also continued to improve the red tray system, which means that people who either need help or need their food intake monitoring are served their meals on a red tray. This ensures that all staff are aware of the nutritional needs of the patients. For those patients who need assistance with eating and drinking we actively encourage the input of relatives and carers.

**For the next year we plan to build upon this excellent work by:**

- Promoting and embedding the Nutrition Operational Policy and Protected Mealtime Policy into the ward culture throughout the hospitals. The implementation of these policies demonstrates our commitment in ensuring that all of our patients have their nutritional needs assessed, catered for and evaluated as required. Adhering to these policies ensures that the patients are provided with meals that are free of unnecessary interruptions and allows staff to be free to concentrate on helping people to eat. The nutrition team will continue to support staff with the completion of MUST for all adult inpatients. This will ensure that patients who are at risk of malnutrition receive appropriate care and support for their nutritional needs. Further training workshops have been arranged each month for staff

- Focused work will be carried out to ensure that patients who require it have an appropriate nutritional care plan, instigated in a timely manner and reviewed at recommended intervals to safeguard the quality of care they receive

## 2.2 Priorities for 2012/13

### Priorities for improvement

The Trust has established several mechanisms and sources for determining its key priorities for quality improvement. These include, but are not restricted to:

- Patient Surveys
- Trust Risk Register and Board Assurance Framework
- Outcomes of Clinical Audit
- Care Quality Commission Assessments
- Outcomes of Complaints and Incidences
- Performance information contained within the Integrated Performance Report
- The Trust's CQUINs, and quality performance indicators as contained within the Acute Services contract agreed with our commissioners
- Dialogue with Council of Governors, staff, members, local public, Trust Board and our patients

From these sources the Trust was able to identify a series of key themes and concerns mapped against its core strategic objectives. Each of these priorities had been cross-referenced against the two corporate aims that relate to the delivery of quality of care:

> Aim 1: Protect and further develop the quality, safety and effectiveness of our services and enhance the quality reputation of the Trust.
>
> Aim 2: Build and strengthen the confidence of our patients, staff, governors and the wider community in the services we provide.

The Trust believes that the monitoring and implementation of the priorities chosen for 2012/13 will have the following impact:

- Increase our transparency and lead to further engagement with our patients, members and the public
- Demonstrate to our patients that we have refocused our activities on ensuring that we provide the best care, adopting zero tolerance as a principle of driving improvement
- Make our services more efficient and better value

Our top priority under each of the headings of Clinical Effectiveness, Patient Experience and Patient Safety, respectively are:

- To reduce our SHMI to 97
- To increase the net promoter score
- To reduce Hospital Acquired C. difficile infections

Our top priorities together with our other clinical objectives for 2012/13 are described in more detail below.

## Clinical and Quality Objectives for 2012/13

| Key Objectives / Main Quality Goals | Milestones | Key Actions | Key milestones the Trust Board will use to evaluate progress against the Goals | Risks & Mitigation |
|---|---|---|---|---|
| | | **Clinical Effectiveness** | | |
| To reduce our SHMI to 97<br><br>Lead : Executive Medical Director | 2011/12 SHMI 101<br>Y1. To reduce SHMI to 97 | 1. Implement acute Physician Rota<br>2. Weekend ward rounds by all consultants to all medical wards<br>3. Rollout Orthogeriatric Service to the orthopaedic wards<br>4. Implement upper GI Rota<br>5. Increase availability of emergency radiology test at weekends<br>6. Improve the number of patients who access emergency surgery at week-ends<br>7. Increase the availability of planned emergency surgical lists at weekends to reduce waiting. | 1% fall in SHMI per quarter<br><br>Implementation of all actions | Risk- Failure to implement actions against agreed timescales<br>Mitigation- Executive Medical Director is to withdraw from clinical duties for 6 months from June to focus on delivering the SHMI action plan |
| To reduce avoidable emergency re-admissions to hospital within 28 days of discharge | 2011/12 avoidable readmissions were 2%<br>Y1 To reduce to 1.75 % | 1. Implement GP telephone access to senior clinical opinion scheme<br>2. Introduce Clinical Decision Unit to enable patients to be seen, treated and discharged without being admitted to a general ward<br>3. Strengthen surgical admissions unit to enable direct access to surgical specialist, timely decisions and where appropriate discharge home<br>4. Introduce increased range of ambulatory care services at the front door (geriatrics, cardiology, diabetes | Commence new ways of working in summer 2012<br><br>Fully operational by October 2012 | Risk- Need to agree clinical and information governance protocols<br>Mitigation- Funding agreed for acute physicians and ED consultants. Acute physicians commence in post in August 2012 to allow service to commence. ED consultants being recruited – will assume |

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| Lead : Deputy Chief Executive | | and respiratory medicine | | responsibility for the CDU in October 2012.<br>Risk- Increased diagnostic capacity required<br>Mitigation- Funding bid to Reablement Funds<br><br>Risk- Need to agree local tariff for ambulatory care with CCGs<br>Mitigation- Funding to pump-prime service capacity requested from Reablement Funds |
| To eliminate unnecessary deaths due to Venous Thrombo-embolism (VTE) by increasing the number of patients receiving a VTE Risk Assessment within 24 hrs of admission from 92% to 95%<br>Lead : Executive Medical Director | Baseline April 2012 – 92%<br>Y1 To increase VTE Risks Assessment to 95% | 1.Implementation of Electronic prescribing with mandatory VTE risk Assessment | Monthly reports to the Trust Board via the Integrated performance report, which will detail weekly results. In-depth reporting via the quarterly quality report | Risk- Failure to implement electronic prescribing as per schedule<br>Mitigation- PAS investment agreed and funded via transformation fund. Implementation of PAS to be reported to Exec Team on a fortnightly basis |
| To improve inpatient diabetes management by non-specialist teams and improve access to diabetes care by the full implementation of 'Think Glucose' | Baseline 4 wards have been involved with pilot-data compiled from National Diabetes inpatient audit which prompted the department to review Diabetes inpatient services. | 1.Diabetes team to implement and strengthen inpatient diabetes service<br>2.Phased roll out for patients to be seen and assessed using 'Think Glucose' across KMH to include EAU<br>3. All staff to refer appropriate patients using Jonah<br>4. Daily review of emergency admissions by Diabetes Team | | |

| Patient Experience | | | | |
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| To understand and respond to the experiences and feedback of patients leading to improved services for NHS customers. We aim to increase the net promoter score meaning more people would recommend the hospital to friend and family<br><br>Lead : Director of Customer Experience | Baseline April 2012 – 95.41<br>To achieve a ten point improvement or top quartile (national) performance | 1. To survey 10% of inpatients at discharge face to face or within 48 hours. This equates to approximately 60 patients per month<br>2. Collate the results into a dashboard which reports from ward to board<br>3. To interrogate qualitative and quantitative results to provide greater understanding of the concerns / issues<br>4. Triangulate the results with other quality metrics<br>5. Formulate action plans to address specific themes / concerns | Monthly reports to the Trust Board via the Integrated performance report, which will detail weekly results. In-depth reporting via the quarterly quality report | Risk 1- Weekly numbers and narrative reported to the board per ward will be very small. It will be difficult to compare ward to ward and make an informed judgement.<br>Mitigation- Trends will be observed through quarterly quality reports<br><br>Risk 2- face to face surveys may elicit 'false' positive responses<br>Mitigation- Undertake postal audit x 2 per year |
| To improve specific elements of care which are known to be important to patients<br>We aim to increase responsiveness to patients personal needs by improving:<br>1. Involvement in decisions about treatment/care<br>2. Hospital staff being available to talk about worries / concerns<br>3. Privacy when discussion condition / treatment<br>4. Being informed of medication side effects | Y1 To achieve a 80% composite score in 5 indicators | 1. To survey inpatients at discharge face to face. The sample size of 60 will be used<br>2. Collate the results into a dashboard which reports from ward to board<br>3. To interrogate the results and formulate action plans<br>4. Triangulate the results with other quality metrics and qualitative information, including complaints, incidents, litigation, PAL's and near misses<br>5. To formulate action plans to address specific themes / concerns<br>6. Increase patient counselling on medication side-effects by Pharmacy and other healthcare professionals | Monthly board reports and in depth quarterly reports | Risk – Weekly numbers and narrative reported to the board per ward will be very small. It will be difficult to compare ward to ward and make an informed judgement<br>Mitigation- Trends will be observed through quarterly quality reports |

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| 5. Being informed who to contact if worried about condition after leaving hospital<br>Lead : Director of Customer Experience | | | | |
| To increase the percentage of staff who would recommend our hospitals to a family or friends<br><br>Lead : Executive Director of Human Resources | Yr 1 OD plan sets out what organisational development and improvement is needed, and uses communications support | 1. Use team brief /website /intranet and bulletin to share 2011 staff survey results with Board and all staff<br>2. Engage with existing Trust groups, EMC and workforce committee to share 2011 staff survey results and understand what the patient survey results are telling us about staff<br>3. Using annual results groups and Divisions identify 3 top improvements for 2012/13,<br>4. Develop and agree OD plan<br>5. Maintain regular series of staff engagement workshops and focus groups to listen and move views forward, reinforce messages and the 'you said-we did 'approach<br>6. Share progress with Board and staff regularly | 1. 2012/3 staff survey staff increase in response rate and maintain engagement score Patient survey demonstrates improvement in overall impression score | <u>Risk 1</u>- -Difficult to predict what staff survey results will be given level of organisational change in progress<br><u>Risk 2</u>- Overall impression of Trust dependent on range of variable factors not just staff<br><u>Risk 3–</u>This is not viewed as a high priority by the Executive Management Committee and the focus on CIPs outweighs effect of developmental work |
| To improve the quality of care and outcomes for patients experiencing dementia<br>1. 90% of all emergency patients (exclusion criteria in CQUIN) aged > 75 will be screened for dementia<br>2. 90% of all emergency patients (exclusion criteria in CQUIN), who have been screened as at risk of dementia, have had a | To individualise dementia patients experiences across all specialities | 1. To introduce a Dementia Specialist nurse who will act as a knowledgeable practitioner and resource for referrals and to bridge the interface between primary and secondary care<br>2. The Dementia Risk Assessment tool is not yet in place nationally; once this has been developed the Trust will implement this tool across all specialities<br>3. Introduction of training on orientation and mandatory training events to | 1. Quarterly report against the CQUIN targets<br>2. Quarterly quality report to update on progress to date with identified actions | <u>Risk 1</u>- Financial support of dementia business case.<br><u>Mitigation-</u> Business case currently being re-validating for presentation to finance committee<br><u>Risk 2-</u> Lack of investment into resources such as Acute Care Mental Liaison due to increased referral rate |

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| dementia risk assessment prior to discharge<br>3. 90% of all relevant staff are trained in dementia care and the mental capacity act every 2 years<br><br>Lead : Executive Nurse Director & Executive Medical Director | | ensure maximum coverage of all disciplines<br>4. Target specific areas in level 2 training to further advance staff awareness of dementia patients requirements<br>5. Collaboration work with regional team to develop University based academic level 5 course<br>6. Rolling training programme across Trust and disciplines to embed assessment of capacity to consent and to close theory practice gap by implementing a scenario based training framework<br>7. Appropriate diagnosis of patients and referral to specialist services<br>8. Individualised documentation for patients so that their lifestyle is mapped<br>9. Greater involvement in carer contribution to patient management | | which affects the delivery of the CQUIN target.<br>Mitigation- To agree a joint strategy for referral management and escalate via PCT commissioners.<br>Risk 3- Risk of delays for Mental Liaison could increase LOS across specialities.<br>Mitigation- As above |
| **Patient Safety** | | | | |
| To deliver harm free care by reducing the risk of patients receiving a hospital acquired infection We aim to reduce Hospital Acquired C. difficile year on year<br><br>Lead : Executive Nurse Director | 2011/12 Baseline 45 cases Y1 To reduce to < 36 cases per year | 1. Continue delivery of C. difficile action plan<br>2. Improve antimicrobial prescribing (increase all HAPPI domains > 90%)<br>3. Implement new antibiotic guidance<br>4. Implement external peer review recommendations<br>5. Continue programme of education and sustained improvement<br>6. Continue delivery of rapid actions, root cause analysis and interrogation of individual cases/ lessons learnt | 1. Monthly / quarterly trajectories reported to Trust board (3 per month / 9 per quarter) | Risk 1- Norovirus outbreaks which potentially lead to increased incidence of C. difficile<br>Mitigation- Demonstrable evidence of improved response and management of norovirus 2011/12<br>Risk 2- Increased emergency activity (2011/12) and increased |

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| | | | | population of > 65 year old patients (higher risk pats)<br>Mitigation- C. difficile action plan - Improved practice and guidance on antibiotic and bowel management |
| To deliver harm free care by eliminating avoidable Grade 2,3, and 4 pressure ulcers<br><br>Lead : Executive Nurse Director | Baseline 2011/12<br>Grade 2 – 219<br>Grade 3 – 36<br>Grade 4 - 0<br>Y1 100% reduction in incidence of avoidable category 2, 3 & 4 | 1. Implement safety thermometer as tool for scoring / assessment<br>2. Develop and implement Pressure Ulcer Reduction Strategy<br>3. Implement the Safe SKIN prevention bundle<br>4. Strengthen Pressure Ulcer Steering Group<br>5. Attend all engagement events<br>6. Work alongside SHA Expert and Intensive support teams | 1. Pressure Ulcer Strategy agreed by June 2012<br>*Based upon March 2012 baseline .*<br>2. Q1 25% reduction<br>3. Q2 50% reduction<br>4. Q3 75% reduction<br>5. Q4 100% reduction | Risk- Current work has resulted in 23% reduction in Grade 3 (11/12) and 0 Grade 4 pressure ulcers for 22 months –reduction targets more challenging<br>Mitigation- Implementation of Pressure Ulcer Strategy & improved Root Cause Analysis Process to improve lessons learnt and changes in practice |
| To reduce the rate of patient safety incidents and percentage resulting in severe harm or death<br><br>Lead : Associate Medical Director for Patient Safety | Y1 Baseline position using tools from Institute of Health Improvement= Leadership in Patient Safety training (LiPS), | 1. Use incident reporting, Global Trigger Tool (GTT) and mortality case reviews to triangulate data for baseline<br>2. Implement safety walk-rounds<br>3. Continue work on current patient safety projects<br>4. Undertake new patient safety improvement projects in the priority areas identified from case reviews. Ensure sustainability and system capability in projects in order to | Monthly reports to Patient Safety Steering Group and quarterly onwards to board | Risk- Current capacity on jobs plans to undertake patient safety projects.<br>Mitigation- Workforce review of governance and assurance department |

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| | | enable implementation in relevant services | | |
| To deliver high quality, harm-free, safe use of medicines<br><br>Lead : Chief Pharmacist & Associate Medical Director for Patient Safety | Missed/delayed doses – Y1 50%<br>Medicines reconciliation<br>Y1 – 70%<br>Other specific measures under development via LIPS programme. | 1. Support the safe use and treatment of patients via introduction of weekend clinical ward Pharmacy services<br>2. Reduce the number of delayed and missed doses of critical medicines by 95% by April 2015.<br>3. Improve the quality and safety of prescribing to minimise risk and improve patient outcomes<br>4. Maximise safety gains achieved with the introduction of e-prescribing<br>5. Achieve 95% reconciliation of medicines within 24 hours by April 2013<br>6. Minimise risk to patients by ensuring medicines are stored securely throughout the Trust<br>7. Minimise number of patients sent home without discharge medicines. | Monthly report to Patient Safety Steering group and quarterly onwards to the Board. | Risk- Medicines reconciliation target dependent on 7 day working and implementation of e-prescribing<br>Mitigation- Monthly monitoring is in place, other options for increased input to admissions could be explored.<br>Risk- Minimisation of patients sent home without medicines dependent on other factors including improved discharge planning, 7 day working<br>Mitigation- Some improvement likely to be achieved but to lower level if 7 day working not achieved. |

## 2.3 Quality Overview

### A review of our services

During 2011/12 we provided services across three clinical divisions on four hospital sites equating to 51 mandated services. The Board of Directors has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2011/12 represents 78% of the total income generated from the provision of services by the Trust for 2011/12.

### How many people do we treat?

| How many people did we treat in 2011/12? | Plan | Actual |
|---|---|---|
| Elective (planned) | 36,750 | 36,580 |
| Non elective (emergencies) | 35,030 | 39,137 |
| Outpatients (appointments) | 326,990 | 334,438 |
| Emergency Care (A&E) | 101,400 | 111,940 |
| Total | 491,104 | 525,622 |

The significant increase in A&E attendances and emergency admissions to the hospital placed considerable pressure on the Trust, not only in relation to meeting its A&E target but also requiring it to increase variable capacity to accommodate the additional patients. In both instances the Board sought assurance that quality was not being compromised through reviews of patient complaints, reports detailing reducing HSMR figures and regular director visits to key clinical areas.

### Our participation in national clinical audit

Clinical audit is a simple tool to review clinical practice against best evidence standards; identifying actions to improve the quality of patient care and treatment.

During 2011/12, 41 national clinical audits and four national confidential enquiries covered NHS services that we provide. We participated in 80% (33/41) of the national clinical audits and 100% (4/4) national confidential enquiries of the National Clinical Audits and National Confidential Enquiries which we were eligible to participate in.

Since April 2011 the National Clinical Audit and Patient Outcomes Programme (NCAPOP) part of the National Clinical Audit (NCA) programme has become mandatory for all acute hospital Trusts. During this time we participated in 17/19 (89%) of the mandatory NCAPOP audits applicable to us.

The national clinical audits and confidential enquiries we were eligible to participate in during 2011/12 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of registered cases required by the terms of that audit or enquiry.

| **Name of audit** | **Mandatory NCAPOP audit?** | **Did we participate?** | Cases submitted as % of cases required |
|---|---|---|---|
| **Peri-and Neo-natal** | | | |
| Peri-natal mortality | No | Yes | 100% |
| Neonatal intensive & special care | Yes | Yes | 100% |
| **Children** | | | |
| Paediatric pneumonia | No | No | |
| Paediatric asthma | No | No | |
| Pain management **CEM** | No | Yes | 100% |
| Childhood Epilepsy Audit | Yes | Yes | 100% |
| Paediatric Diabetes | Yes | Yes | 100% |
| **Acute care** | | | |
| Emergency use of oxygen | No | Yes | 100% |
| Adult community acquired pneumonia | No | Yes | 100% |
| Non invasive ventilation -adults | No | Yes | 100% |
| Pleural procedures | No | No | |
| National Cardiac Arrest Audit | No | Yes | 100% |
| Severe sepsis & septic shock CEM | No | No | |
| Adult critical care -ICNARC | No | Yes | 100% |
| Potential donor audit | No | Yes | 100% |
| National Audit of Seizure Management | No | Yes | 100% |
| **Long term conditions** | | | |
| National Adult Diabetes Audit | Yes | No[1] | |
| Heavy Menstrual bleeding | Yes | Yes | 99%[3] |
| National Pain Audit | Yes | Yes | 100% |
| Ulcerative Colitis & Crohn's Disease | Yes | Yes | 100% |
| Adult Asthma | No | Yes | 100% |
| Bronchiectasis | No | No | |
| **Elective procedures** | | | |
| National Joint Registry | Yes | Yes | 100% |
| Elective surgery National PROMs programme | No | Yes | 87%[4] |
| Adult cardiac interventions PCI / Coronary | Yes | Yes | 100% |

| | | | |
|---|---|---|---|
| angioplasty | | | |
| Vascular Surgery Database | No | Yes | 100% |
| Carotid Intervention Audit | Yes | Yes | 100% |
| **Cardiovascular disease** | | | |
| Acute Myocardial Infarction | Yes | Yes | 100% |
| Heart failure | Yes | Yes | 100% |
| Acute stroke (SINAP) | Yes | No[2] | |
| Cardiac Rhythm Management | Yes | Yes | 100% |
| **Cancer** | | | |
| National Lung Cancer | Yes | Yes | 100% |
| National Bowel Cancer | Yes | Yes | 100% |
| Head & neck cancer (joint audit with NUH) | Yes | Yes | 100% |
| Oesophago-gastric cancer (joint audit with NUH) | Yes | Yes | 100% |
| **Trauma** | | | |
| National Hip Fracture Database | Yes | Yes | 100% |
| Trauma Audit & Research Network | No | Yes | 100% |
| **Blood transfusion** | | | |
| Bedside transfusion | No | No | |
| Medical use of blood | No | No | |
| **Health promotion** | | | |
| National Health Promotion in Hospitals Audit | No | Yes | 100% |
| **End of life** | | | |
| Care of dying in hospital (NCDAH) | No | Yes | 100% |

*Source of list: http://www.hqip.org.uk/national-clinical-audits-for-inclusion-in-quality-accounts/*

Commentary notes relating to the table above:

1. **National Adult Diabetes Audit –** The Trust is unable to participate in the National Diabetes Audit as it does not have an electronic medical record for the extraction of required diabetes data. This will depend on how soon the Trust's computer system, SystmOne is operational but we are working to be able to implement this audit.

2. **Stroke Implementation National Audit SINAP –** There are issues with the database used by all of the hospitals in the East Midlands region and the SINAP database. A regional solution is currently being sought and until that time we will continue to collect the relevant data and continuously review and act upon it locally.

3. **Heavy Menstrual Bleeding (HMB) Audit -** This audit/survey required us to ask patients if they wish to participate and to be contacted at a later stage. This figure therefore represents a recruitment rate rather than participation rate.

4. **Patient Reported Outcome Measures (PROMs)** – This is a recruitment rate, as it is voluntary for patients to take part in these surveys . We are in the top percentage of achievement for PROMs participation rates for acute hospitals.

| | Pre Operative Participation rates for 2011-12 | England average participation rates for 2011-12 |
|---|---|---|
| All Procedures | **87.0%** | **68.4%** |
| Groin Hernias | **85.6%** | **57.1%** |
| Hip Replacements | **100.0%** | **78.6%** |
| Knee Replacements | **89.0%** | **76.6%** |
| Varicose veins | **54.2%**<br>(low numbers of operations so not always statistically relevant) | **47.2%** |

**Participation in NCEPOD (National Confidential Enquiry into Patient Outcome and Death) studies**

These national confidential enquiries review potentially avoidable factors associated with poor outcomes and provide NHS organisations with key recommendations for the provision of safer patient care.

The Trust is currently participating in all NCEPOD studies that relate to services at our hospitals and the Best Practice policy has recently been updated to improve the monitoring and implementation of advice/recommendations from these reports.

The national confidential enquiries we were required to participate in are listed below:

| **Study Title** | **Did we participate?** | **Number of cases submitted as a percentage of the number of cases required** |
|---|---|---|
| Bariatric Surgery | Yes | **N/A** – We do not undertake Bariatric surgery therefore we did not submit any clinical cases– however we did submit an organisational questionnaire to cover the service we do provide. |
| Cardiac Arrest Procedures | Yes | 100% 3/3 |
| Peri-operative Care | Yes | 100% 6/6 |
| Surgery in Children | Yes | **N/A** No clinical cases requested but organisational data supplied as required. |

**Review on National Clinical Audit**

The report of 1 National Clinical Audit was reviewed by ourselves in 2011/12 and we intend to take the following action to improve the quality of healthcare provided.

Community Acquired Pneumonia (CAP)

- To reduce the delay in patients receiving antibiotics
- To reduce the amount of intravenous antibiotics used
- To ensure improved use of the CURB-65 system (CURB-65 is a clinical prediction rule that has been validated for predicting mortality in community acquired pneumonia and infection of any site)
- Participate in the British Thoracic Society re-audit in 2012

**Local Clinical Audits**

The reports of 29 local Clinical Audits were reviewed in 2011/12 and we intend to take the following action to improve the quality of healthcare provided. Re audits will be carried out throughout the year were required.

| Local Clinical Audit TITLE | Actions planned / Implemented |
|---|---|
| NICE guidelines on pre-operative tests (Inguinal hernia grade 2 surgery) | • Increase awareness of NICE guidelines |
| Bortezomib and lenalidomide in patients with myeloma | • Results 100%. Actions - no cause for concern identified |
| Patient cancellations from theatre lists (elective patients) | • Continuous Detailed Audit implemented<br>• Planned Improved Pre-operative Information |
| HIV testing - offer and uptake 2010 | • Offering and Acceptance of HIV Testing in our Department is still well above the recommended standards. |
| Review of specimens within genitourinary (GU) medicine processed as medico legal samples | • Senior GUM doctor discussions |
| Clinical care of under 16 yrs in GU medicine for Nov 2009 to Nov 2010 | • Highlight in clinical area that 2 Registered Nurses must always check medication for <16s DONE |
| Timing of intravesical mitomycin C for treatment of superficial bladder cancer | • Clear documentation in the post-op note of those who require Mitomycin C.<br>• Training more people in administering Mitomycin C (especially junior doctors), |
| Oxytocin for labour dystocia / augmentation | • Staff, both midwifery and medical, are reminded of the required assessments prior to commencing oxytocin. |
| Record keeping for removal of third molar against NICE guidance | • Ensure consent form are filled in the notes |
| Screening for coeliac disease in iron deficiency anaemia (Trust-wide audit) | • All Patients with iron deficiency anaemia should be screened for Coeliac Disease. |
| Heparin usage at SFH 2010/2011 | • Education with Doctors regarding appropriate prescribing, and ensuring patients are weighed wherever possible. |
| Lying and standing blood pressure | • Provision of a ready reckoner<br>• Individual Action Plan from Ward leaders |
| Management of early syphilis in GU medicine | • Episode is coded and entered correctly. |
| Availability of paper blood results on orion against guideline written to decide which paper results should be destroyed - Rheumatology | • Continue to sort paper blood results as per 'store/ destroy' protocol. |
| Cannulation and intravenous line documentation - compliance with NPSA and NICE | • The auditor will discuss the audit results with appropriate managers and actions identified |
| Are medics documented in medical notes that patients have a urinary catheter (UC) inserted and reason for insertion? | • Present results to medical division meeting with a view to rolling out catheter-sticker across the division |

| | |
|---|---|
| Excessive reporting of haemolysis in neonates blood samples | • Documenting this concern within a risk assessment |
| Audit of investigation of suspected deep vein thrombosis at Newark Hospital | • Improve recording of Wells score (70%)<br>• Improve proportion of patients undergoing D-dimer testing (85%) |
| Acitretin use in women of child bearing age ( 14yrs to 50yrs) in dermatology | • New initiation of acitretin sticker. Implemented |
| To ensure the correct storage and labelling of insulin at ward level | • Feedback results to service line clinical governance forums for each Division.<br>• Discuss with pharmacy staff the importance of checking stock levels of insulin before ordering more. |
| Ward based epidural monitoring | • Wards 31, 21, 32 trained Oct 2011 |
| Documentation of safeguarding children alerts within the midwifery services at SFHFT | • Review filing instructions for safeguarding children documentation done Nov 2011 |
| Child protection supervision process audit | • Meet with supervisors to discuss findings and review changes that may be necessary to improve the process Jan 2012 |
| Compliance of 'store/ destroy paper blood results guideline' and availability of the 'store/destroy' results on 'Orion' and 'ICE' 'Re-audit | • There was an improvement in correctly selecting blood results for destruction. |
| Rivaroxaban prescription and complications following total hip and total knee replacement | • Pharmacy to print and disseminate 'continued VTE prophylaxis' reminder stickers in progress |
| Midwifery and Health Visitor communication | • Meet with Health Visiting Team Leaders |
| Re-audit of Antibiotic Prophylaxis in Orthopaedic Surgery ( emergency cases only) | • Pocket card guidelines implemented |
| Patient property audit | • The results of the audits have been disseminated |
| Audit of ISOTRETINOIN use in the Dermatology department | • Initiation of isotretinoin sticker to include space for pregnancy test result - by May 2012 |

The table above denotes the principle actions. More detailed actions are available on request. Regular reports on the progress made in all national and local clinical audits are submitted to the Clinical Governance Committee from the Clinical Audit Committee. In addition to this, each Speciality Clinical Governance Forum will review reports on any national/local clinical audit applicable to them. There are robust action plans for each of the audits.

There was an internal audit review during June to December 2011 reviewing national clinical audit participation and outcomes. This report concluded that significant assurance could be provided that a generally sound central system of control has been established for ensuring that clinical audits are registered for inclusion on the annual clinical audit programme. It also concluded that appropriate support is provided by clinical audit staff and that the level of participation in national clinical audits on the Department of Health list is monitored.

## Patients participating in clinical research

We are really proud of our recruitment of patients into clinical research trials. We have seen a huge uptake in people recruited to the trials, see table following:

| | 2011 | 2010 | 2009 | 2008 |
|---|---|---|---|---|
| Numbers recruited | 1,008 | 250 | 135 | 64 |

The number of patients receiving NHS services provided or sub-contracted by us that were recruited to participate in research approved by the Research and Ethics Committee was 1,008.

## The quality goals we agreed with our commissioners

A proportion of our income, £2.6m in 2011/12, was conditional upon us achieving quality, improvement and innovation goals (CQUIN – Commissioning for Quality and Innovation), agreed between commissioners (NHS Nottinghamshire County PCT) and ourselves. We received 100% of this income.

The proportion of our income for the year before (2010/11) was £2.7m and we achieved 75% of this income.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available on line at [http://www.monitor-nhsft.gov.uk/](http://www.monitor-nhsft.gov.uk/)

## Our registration with the Care Quality Commission (CQC)

The CQC is the independent regulator of all health and social care services in England. Their role is to make sure that care provided by hospitals, dentists, ambulance, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.

The government standards cover all aspects of care, including:

- Treating people with dignity and respect
- Making sure food and drink meets people's needs
- Making sure that that the environment is clean and safe
- Managing and staffing services

There are 16 government standards of quality and safety. Full details are on the CQC website at **www.cqc.org.uk**. The CQC registers health and adult social care services across England and inspects them to check whether or not standards are being met. During their inspections they ask people about their experiences of care, talk to care staff, and check that the right systems and processes are in place. They judge whether the standards are being met or not and publish reports of their findings on their website.

We are required to register with the Care Quality Commission and our current registration status is registered.

During 2011/12 we received 4 visits by the CQC:

- One unannounced visit to Newark Hospital to assess standards of dignity and nutrition inspections (DANI)
- One planned visit to Newark Hospital to assess the 14 standards of quality and safety (2 had been assessed as part of DANI)
- One planned visit to King's Mill Hospital to assess the 15 standards of quality and safety. Outcome 16 (Clinical Governance) had been assessed as compliant within the previous 12 months so was not reassessed
- One unannounced visit to assess our progress in relation to the findings from visit 3

During these visits it was identified that improvements were required to meet 7 of the 16 outcomes:

- Outcome 1 Respecting and involving people who use services
- Outcome 2 Consent and care to treatment
- Outcome 5 Nutrition
- Outcome 9 Management of medicines
- Outcome 12 Requirements relating to workers
- Outcome 17 Complaints
- Outcome 21 Records

We instigated many improvements to meet the standards; including improving the way we managed our complaints service, improving our consent procedures and improving the management of medicines in our Emergency Admissions Unit. When the CQC re-visited us in October 2011, they assessed that much progress had been made and assessed that we had achieved the required standard in 5 out of the 7 outcomes.

Following the October visit from the CQC and their concerns relating to outcome 2 and outcome 21, the Trust Board commissioned an action plan to ensure that compliance would be demonstrated before the end of the year and also wished to review why the Trust's governance systems failed to recognise the repeated failure of the two highlighted outcomes.

The action plan to deliver compliance was commenced towards the end of November after having been reviewed to ensure that it would deliver compliance. Additional external support was commissioned to further strengthen the work and towards the end of March the Board felt confident that the action plan had been thoroughly and successfully implemented.

A recent Board sub-committee concluded:

- The sub-committee recommend that in regard to Outcome 21, records that the issues identified have been addressed
- In regard to Outcome 2, consent issues where patients lack capacity, whilst the Board can gain positive assurance from the significant improvements that have been made and recognise that the Trust is on the right trajectory, further work is required to ensure recent changes in practice and learning are fully embedded and can be sustained in the longer term
- The Board should consider how it will continue to gain assurance of progress as we move forward.

In relation to strengthening our internal governance arrangements the Trust commissioned an improvement review from external advisors in order to provide additional assurance to all Board members that our systems and processes in relation to the CQC were effective and resilient, and that evidence was available on an ongoing basis of compliance against all outcome measures. This work has commenced and is being implemented.

A CQC review visit was requested which took place on 27 April. The CQC reported that the Trust had made massive progress and was compliant against all outcomes. The Care Quality Commission has not taken enforcement action against us during 2011/12.

**The quality of our data**

We submitted records during 2011/12 to the secondary uses service (for inclusion in the Hospital Episode Statistics) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was as follows:

| | **Valid NHS number** | **Valid general Medical Practice Code** |
|---|---|---|
| For admitted patients care | 100% where NHS No present | 94.4% |
| For out-patients care | 100% | 93.1% |
| For emergency care (A&E) | 100% | 94.5% |

## Other important quality factors

**Performance against the Information Governance Tool Kit**

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information.

Our Information Governance (IG) assessment report overall score for the previous year 2010/11 was 62% and was graded as Red – 'Not Satisfactory'. Consequently, an action plan was devised to address the aspects that fell short of achieving Information Governance Toolkit Level 2 standards during 2011/12. The action plan has been progressed within the appropriate service areas/divisions with full support from the information governance team. Monitoring of the action plan is undertaken via the Information Governance Group, with regular escalation reports provided to the Risk Management Committee and Audit Committee. The main areas addressed are:

- Ensured IG is a mandatory training requirement for staff
- Established information asset owners and administrators throughout divisions' and provided training
- Sourced a tool to enable the Trust to pseudonymise (people who don't have a right to see data do not see the data) patient data
- Documented and implemented the procedures for the effective management of corporate records as part of this we have undertaken corporate records audit in at least 5 areas of the Trust and have subsequent action plan

**Green for governance**

Our Information Governance (IG) assessment report overall score for 2011/12 was 72%. This was graded as 'Green' – 'Satisfactory'. There is a requirement for all IG Toolkit standards to achieve Level 2 or above in order for the Trust to be graded as green. We have achieved this.

We have taken the following actions to improve data quality:

- Developed a data quality dashboard which helps to monitor external data quality reports
- There are now procedures in place for using both local and national benchmarking to identify data quality issues
- Procedures are now in place that ensure clinical staff are involved in validating medical information regarding clinical activity
- We have 2 different external auditors who will perform a 200 finished consultant episode clinical coding audit each tear
- We have an internal data quality audit procedure which has a 12 month cycle for auditing specialties covering out patients and spell data
- We also work with our commissioners in terms of ensuring any queries that are received regarding data quality are resolved
- Routine daily, weekly and monthly reports are run from our PAS system
- Any new member of staff or existing staff receives data quality awareness
- There are also monthly data quality meetings which will discuss forthcoming information standards notices, data recording, secondary users' dashboard and training documentation

**Clinical coding**

We were subject to the payment-by-results clinical coding audit during the reporting period by the Audit Commission (payment-by-results refers to the payments given for each patient based on their episode of care). The error rates are related to the errors in coding which will affect the amount of money paid for the episode of care. The audit showed that our overall error rate was 4.7% based on episodes that affect the payment compared to a national average of 9.1%. Our data was audited in March, April and May of 2011. The error rate for coding of treatments was 2.1% and for diagnostic tests was 4.8%. These results are based on a sample of case notes and should not be extrapolated further. The services reviewed within the survey were respiratory and a random sample of all specialties.

**Never events**

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Unfortunately, there have been two never events during the quarter October to December 2011. Both of these were relating to retained swabs following delivery of a baby. The first occurred following a procedure undertaken in theatre where systems and processes were not followed. The second occurred in a birthing room where the systems were not fully in place.

In both cases we identified the pack from which the swab originated and have reviewed all packs that could be used during the course of a birth and changed all swabs available to larger ones with ties. All policies have been amended to reflect best practice and reinforced to staff.

A visit by NHS East Midlands and Nottinghamshire County PCT was hosted to demonstrate the changes the service has implemented. Detailed action plans from the lessons learnt have been completed, with remedial action being taken. The Primary Care Trust visited the Trust and commented that the visit provided the assurance that the Sherwood Forest Hospitals Foundation Trust Maternity Service based at King's Mill Hospital is safe and that it has learnt lessons following the Never Events.

**NHSLA (NHS Litigation Authority)**

The NHSLA handles negligence claims (CNST : Clinical Negligence Scheme for Trusts) and works to improve risk management practices in the NHS. The Trust pays a premium to the NHSLA which is similar to an insurance premium. The NHSLA sets standards to determine if the Trust can be part of their scheme.

The acute standards were assessed on 8 February 2012 with a top score of 50/50, which means we successfully achieved Level 1 and our premiums will be discounted by 10% for two years. Level 1 means that the process for managing risks has been described and documented. The Level 1 assessment requires all minimum standards for each criterion to be described. However, the quality of the processes will not be rigorously tested until the Level 2 assessment takes place. It is important to note therefore that compliance at Level 1 is not an indication that the organisation will be able to demonstrate compliance at Level 2 or that it is effectively managing risks.

The maternity standards were assessed in October 2011 and scored 49/50 at Level 1.

The table below explains why the standards are set. As an organisation we are working hard to become a Level 2 organisation and if successful it will mean our premiums will be discounted by a further 10% for two years.

**The standards and assessment process are designed to**:

- Improve the safety of patients, staff and others
- Provide a framework within which to focus risk management activities in order to support the delivery of quality improvements in patient care, organisational governance, and the safety of patients
- Assist in the identification of risk
- Contribute to embedding risk management into the organisation's culture
- Focus organisations on increasing incident reporting whilst decreasing the overall severity of incidents
- Encourage awareness of and learning from claims
- Reflect risk exposure and enable organisations to determine how to manage their own risks
- Encourage and support organisations in taking a proactive approach to improvement
- Provide information to the organisation, other inspecting bodies and stakeholders on how areas of risk covered by the standards are being managed at the time of the assessment

During 2010/11 we settled clinical negligence claims at £1,864,580. This is comparable with neighbouring NHS Hospital Trusts of a similar size. One hospital paid out £2,770,301 and another £3,539,536 during the same time period.

## 3 OTHER PRIORITIES AND ACHIEVEMENTS FOR 2011/12

### 3.1 Patient Safety - other priorities

Since 2005/06, when infection prevention and control became our number one priority, significant improvements have been made. A dramatic shift in the culture of the organisation has been achieved, changing to one in which staff acknowledge and accept their personal responsibility for protecting all patients, visitors and staff from acquiring healthcare associated infections (HCAI).

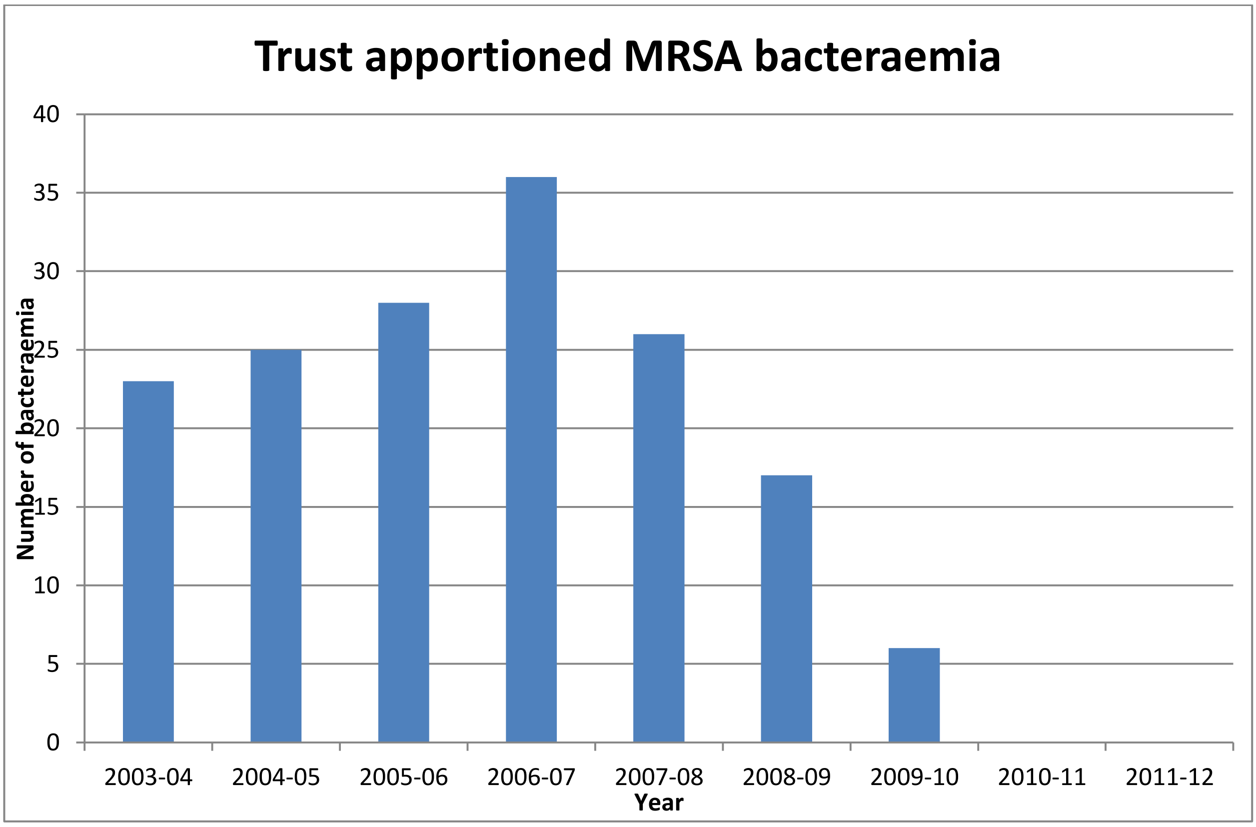
The data within this report is collected via internal mechanisms and is governed by standard national definitions.

There are two causes of HCAI that have external targets associated with them: Methicillin resistant *staphylococcus aureus* (MRSA) bacteraemias and *Clostridium difficile* infections (*C. difficile*).

***Two years without a hospital acquired MRSA***
***(The only Trust in the East Midlands to have zero MRSA)***

**MRSA**

The Department of Health mandatory MRSA bacteraemia surveillance scheme has been used to measure the effectiveness of infection prevention and control practices in all NHS Trusts. The rationale behind this scheme is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.



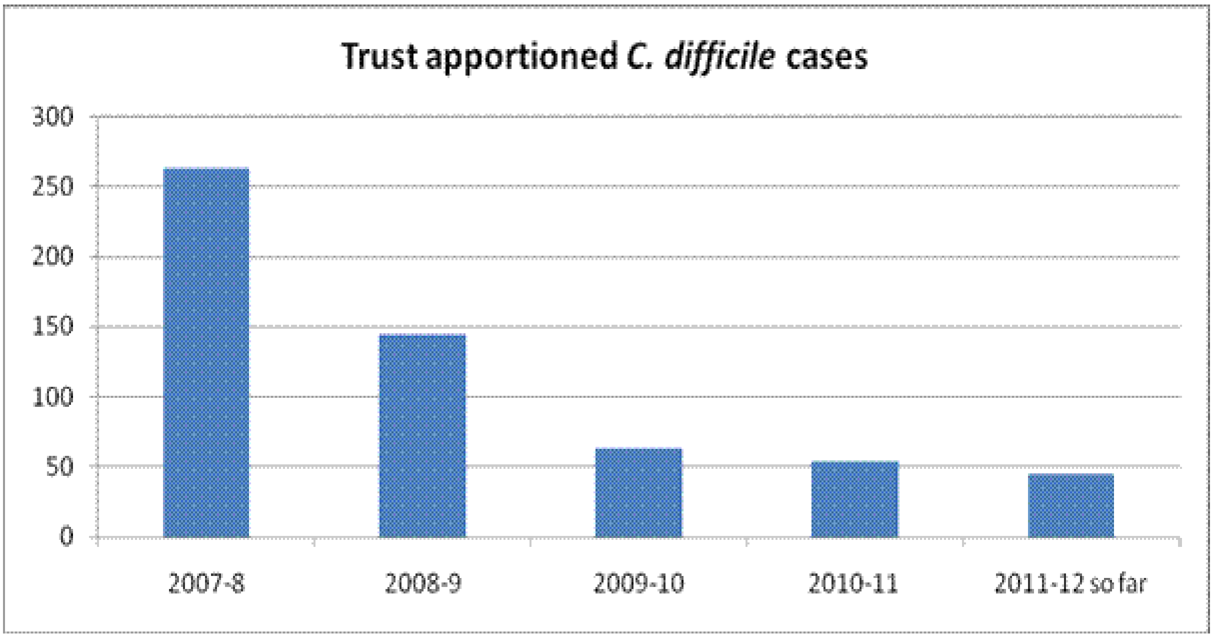
As of 30 April 2012, the Trust is able to report that it has been two years since any patient experienced a hospital acquired MRSA bacteraemia. This is a fantastic achievement and is the direct result of continuous high quality care delivered by our staff. The MRSA bacteraemia target of <3 was met for 2011/12. To put this into context and demonstrate the scale of the improvements made, in 2006/07 there were 36 reported cases of hospital acquired blood borne MRSA bacteraemias in the Trust.

The Trust is, however, not complacent and has further invested in its infection surveillance systems to ensure that this record continues along with reductions in other hospital acquired infections.

***Clostridium difficile (C. difficile)***

The target trajectories for *C. difficile* infection are set nationally by the Department of Health. During this year there have been 45 cases of *C. difficile* attributable to the Trust which has exceeded our target ceiling of 43.

The Trust is disappointed to have exceeded the target. There has been significant scrutiny and assessment as to why this has arisen and whilst the Trust can report a 17% reduction against the previous year's figures it is committed to zero tolerance of hospital acquired infection.




In response to this, the Trust Board commissioned root cause analysis of every case throughout the year which when considered as a whole indicated that the unexpected resignation of our two consultant microbiologists last summer and their replacement utilising locum consultant staff resulted in a subtle change in anti-microbial pharmaceutical prescribing along with changes in surveillance techniques.

Our response during the year provided an action plan which dramatically reduced the monthly run rate of infection from January onwards and has resulted in some of the lowest infection figures in the country during the last quarter.

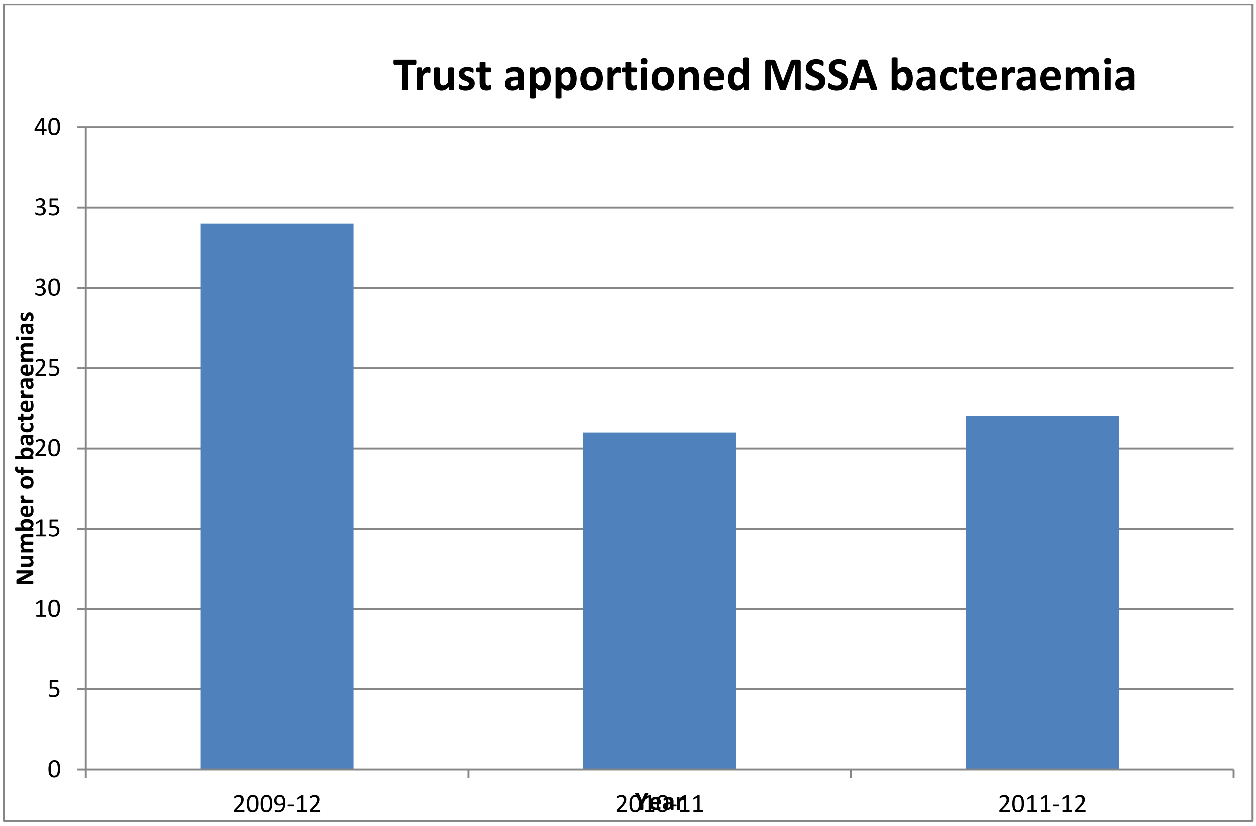
Our approach to C. difficile has since been modified and strengthened with the appointment of 2 substantive consultant microbiologists, investments in nursing staff and the use of external review to ensure that our policies and procedures mimic best in class.

Our ambition remains to eliminate all hospital acquired infection and for 2012/13 our Department of Health target is 36 requiring the Trust to have no more than 3 cases per month. During April and May 2012 we have hit this target and remain committed to further reductions.

**Meticillin sensitive *staphylococcus aureus* (MSSA) bacteraemias**

The Trust has monitored MSSA bacteraemias detected from blood cultures since 2006/07.  Since April 2008 the Trust has participated in the voluntary surveillance of MSSA bacteraemia and reported figures to the Department of Health via the HCAI Data Capture System.

This became mandatory in January 2011.  The graph below shows the annual number of MSSA bacteraemias in the Trust since 2006/07; this highlights that since 2009/10 there has been a year-on-year reduction in the number of MSSA bacteraemias.

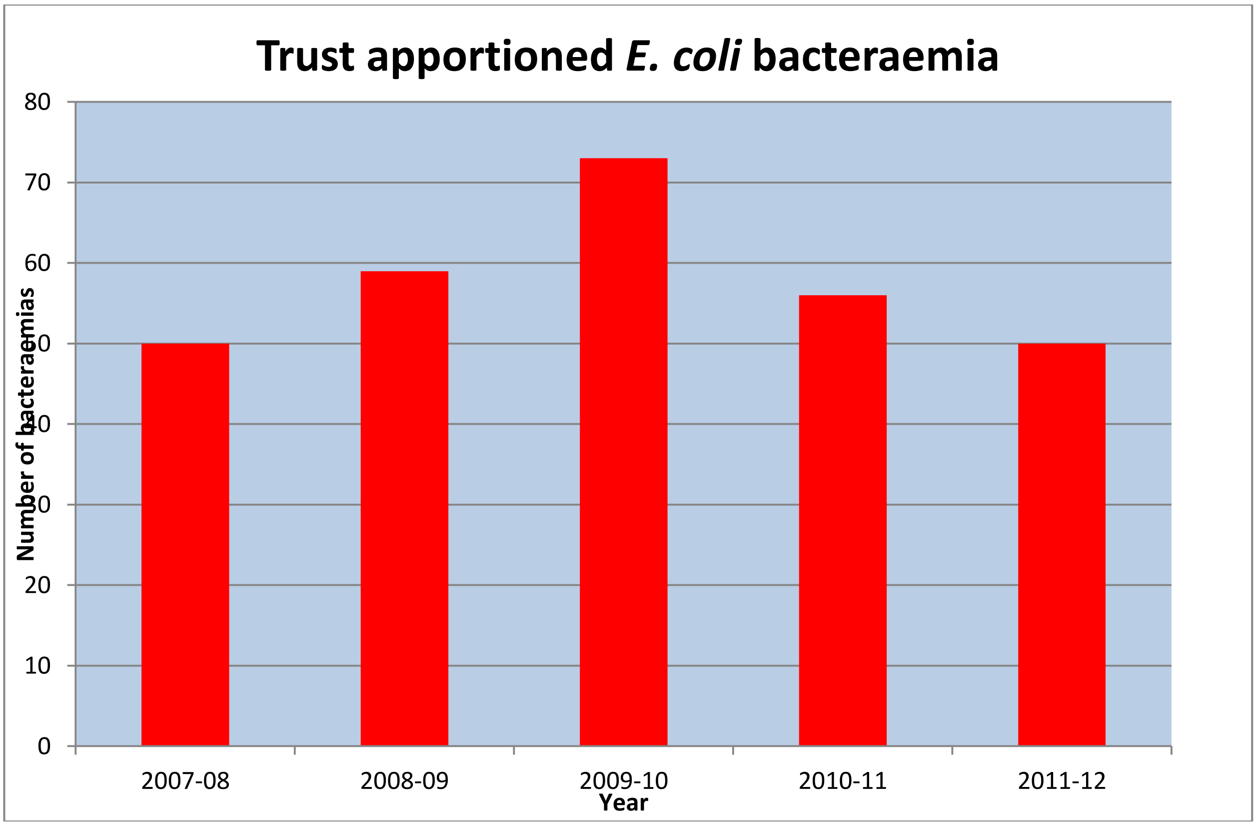



MSSA bacteraemia has the potential to become resistant and develop into MRSA bacteraemia; therefore the Trust treats these bacteraemias as ‘near misses’ for an MRSA bacteraemia.  A Root Cause Analysis (RCA) is carried out for each intravenous line related MSSA bacteraemia, with analyses of the RCA’s from these incidents resulting in action plans to enable further reduction in the numbers to be achieved. This process means that patients can be assured that as an organisation we actively investigate to help prevent them happening again.

**A spacious 4 bedded bay**

## ***Escherichia coli*** **(*E coli*) bacteraemia**

*Escherichia coli (E coli)* is one of the most frequent causes of many common bacterial infections such as urinary tract infections, food poisoning and bacteraemia (when the bacteria gets into the bloodstream). Since June 2011, as part of ongoing information gathering we have submitted data on *E coli* bacteraemia to the Health Protection Agency, in a similar way to MRSA. As the graph below demonstrates, the Trust has had a year on year reduction since 2009/10.



## Urethral catheter associated infections

Using the Commissioning for Quality and Innovation (CQUIN) the Trust's aim was to reduce the incidence rate of Trust apportioned urethral catheter associated bacteraemias (blood borne infections). The Trust's 2010/11 surveillance highlighted that there were 40 hospital-acquired urethral catheter associated bacteraemias. The Trust prioritised: reducing the number of catheterisations, applying best practice to those with a urethral catheter and to monitor patients with a catheter for episodes of urinary tract infection. This approach has seen a significant reduction in the number of Trust apportioned urethral catheter associated bacteraemias from 40 in 2010/11 to 12 in 2011/12.

## Norovirus

Norovirus (winter vomiting disease) causes sporadic cases as well as outbreaks of gastroenteritis in people of all ages. Norovirus outbreaks are common and are predominantly, although not exclusively, a winter time pathogen, and Norovirus is highly contagious. During 2011/12 the Trust had 12 wards affected by Norovirus, with 139 patients and 86 staff affected overall. Several wards were closed during the outbreak, with an average closure of 11 days and a range of 9-17 days.

Ward staff swiftly reported suspected cases, which led to prompt assessment and implementation of control measures. The kinds of measures undertaken on all wards include:

- Close ward or bay immediately to prevent the spread of infection
- Segregate nursing and medical teams to care for affected and non affected patients
- Ensure enhanced cleaning takes place immediately
- Decontaminate the area with hydrogen peroxide vapour once patients have recovered.
- Restriction of visitors

Ongoing infection prevention and control includes the following:

- Managing Norovirus outbreaks to reduce the risk of the virus being transmitted across the organisation
- Supporting clinical staff during periods of increased incidents
- Development of patient information leaflets: norovirus, norovirus once discharged, C. difficile, mumps, influenza, influenza visitor guidance
- Continued mandatory surveillance: MRSA/MSSA/E coli/C. difficile
- Continued infection prevention and control audits: environmental, hand hygiene, commodes, raised toilet seats
- Working with estates in relation to water management: in particular related to legionella and pseudomonas
- Working with Medirest (our soft FM – Facilities Maintenance – providers eg cleaning and catering) in relation to 24/7 hydrogen peroxide vapour decontamination programme
- Working with microbiology in relation to provide *a* C. difficile testing 7 day service
- Providing infection prevention and control (IPC) service to Ashfield and Mansfield Community Hospitals
- Development and implementation of the C. difficile action plan
- Providing mandatory, introduction and ad hoc IPC training sessions – extended this to include human resources and voluntary services (plan to extend this into other areas during 2011/12 i.e. Medirest, estates)
- Identifying and replacing commodes that are not fit for purpose

- Working with an external company in the design of a bespoke raised toilet seat (ongoing)
- Working towards standardising sharps containers: improve compliance with disposal of sharps (ongoing)
- Working with health and safety in relation to implementation of the EU (European Union) directive for safety devices in relation to sharps (ongoing)
- Working towards the roll-out of using ATP for environmental and hand hygiene compliance: Standard Operation Procedures formalised, database designed, audit programme being formulised (ongoing)

**PEAT (Patient Environment Action Teams) scores**

The PEAT Audit is an annual assessment of inpatient healthcare sites in England and is undertaken on all sites with more than 10 beds. It is self assessed and measures standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors in all patient areas). The assessment was established in 2000 and is a benchmarking tool to ensure improvements are made in the non-clinical aspects of a patient's healthcare experience. PEAT highlights areas for improvement and shares best practice across the NHS.

NHS organisations are each given scores from 1 (unacceptable) to 5 (excellent) for standards of privacy and dignity, environment and food within their buildings. The NPSA (National Patient Safety Agency) publish these results every year to all NHS organisations, as well as stakeholders, the media and the general public.

We inspect a wide range of clinical areas and assess against best practice standard national definitions. The team of assessors is made up of hospital staff and our governors as well as members of the public.

One of our governors, included in the audit this year, said:

*"I'm amazed at how well run the hospitals are. I'm delighted to be part of the audit process and also to be able to pass this on to my constituents in Derbyshire as well as to friends and Trust members via member events. As I also attend monthly meetings at the Trust I receive feedback on improvements to the patient experience that are being made, throughout the year"*

The scores for last year are shown below:

| Site Name | Environment | Food Score | Privacy & Dignity Score |
|---|---|---|---|
| King's Mill Hospital | Good (4) | Excellent(5) | Good(4) |
| Newark Hospital | Good(4) | Good(4) | Excellent(5) |
| Mansfield and Ashfield Community Hospitals | Excellent(5) | Excellent(5) | Excellent(5) |

| **Environment** | **2010** | **2009** | **2008** | **2007** |
|---|---|---|---|---|
| KMH | 5 | 4 | 3 | 4 |
| Newark | 4 | 4 | 3 | 4 |
| **Food** | **2010** | **2009** | **2008** | **2007** |
| KMH | 5 | 4 | 4 | 4 |
| Newark | 4 | 4 | 3 | 3 |
| **Privacy & Dignity** | **2010** | **2009** | **2008** | **2007** |
| KMH | 4 | 4 | 3 | 4 |
| Newark | 5 | 4 | 4 | 4 |

Our progress over the last year:

- The building works are now completed on the King's Mill site which has significantly reduced the amount of dust being generated on site. This has resulted in the cleanliness being maintained to a very high standard. This year's PEAT audit took place during February. The final ratified scores are not available until around June but we are very hopeful that we will achieve similar scores to last year
- We have seen an increase in the number of people smoking outside the hospital entrances despite our status as a Smoke Free site. As a result we have revised our policy and have agreed to provide some designated areas which will be away from the main doors, where smokers can be directed to if they wish to smoke
- The refurbishment of Newark Hospital outpatients department has commenced with a scheduled completion date of June 2012. This area was in need of modernisation and this will significantly improve the patient experience when visiting the hospital
- King's Mill introduced Steamplicity, individual plated meals which are cooked fresh at ward level. The menu consists of a choice of 24 main meals, 7 types of sandwiches and 15 deserts. They are free from artificial additives and preservatives. This service was introduced at King's Mill at the same time as the rollout of the ward hostess role. This has resulted in very positive feedback from our patients regarding the quality and variety of food available

- The food service is observed as part of the PEAT audit and includes food tasting. This is the first top score of 5 we have achieved. We are echoing this achievement by rolling out hostesses and Steamplicity at both Mansfield and Newark hospitals in the near future
- Our volunteers demonstrate helpfulness when directing patients and visitors around the site
- We will continue to undertake our own mini PEAT audits throughout the year to ensure that these high standards are maintained

## How we have reduced the amount of people who fall

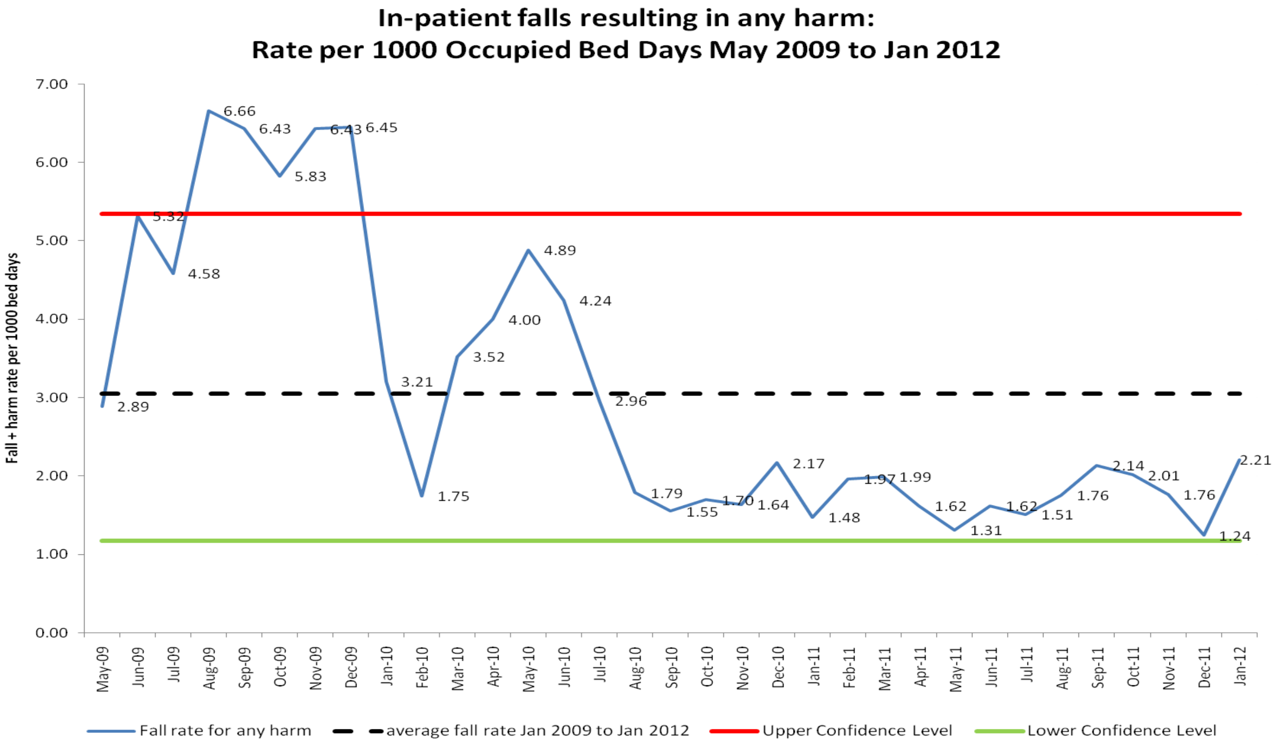
Reducing the amount of patients who fall whilst in hospital is vitally important to us. We know when patient's fall it could lead to a physical injury but it also leads to reduced confidence and a potential reduction in independence for the person. We have worked hard this year to reduce the amount of falls.

We have developed a group whose job it is to concentrate on falls and find ways of preventing them. The Falls and Safety Group continues its work, checking monthly that falls risk assessments are completed on all patients, that falls care plans are in use for people who need them and that people are assessed to see if they need a bed rail.

We have achieved a 6.9% reduction this year in the number of falls (per 1000 occupied bed days) by patients who are in hospital. We believe this reduction is due to improvements we have made such as an increase in dementia and delirium training for ward staff and the use of 1:1 nursing (one patient, one nurse) where indicated.

The data is calculated from incident forms and is governed by the National Patient Safety Agency national definitions.

The amount of people who fall causing harm continues to be below the national average.



This coming year we are going to launch a pilot of a specialist falls team that wards can contact when they have identified a patient with a high risk of falling. This team will provide additional assessments and support. We are also going to be developing a policy to prevent patients moving from one ward to another in the night, unless it is for medical reasons.

## How we have reduced pressure ulcers

We want to ensure that our patients come to no harm when they are in our hospitals. Pressure ulcers are painful and debilitating and we aim to reduce the number of hospital acquired pressure ulcers, year on year. This year we have worked extremely hard to reduce the amount of pressure ulcers our patient experience.

Nationally it is recognised that pressure ulcers occur in 4 -10% of patients admitted to hospital. They cause pain and misery to patients, extend their hospital stay, and can be associated with an increased risk of secondary infection.

Pressure ulcers are graded from 1 - 4 and the more serious the ulcer the higher the score.

| | |
|---|---|
| Grade 1 | Reddening of the skin |
| Grade 2 | Blister or superficial break in the skin |
| Grade 3 | Full thickness of skin |
| Grade 4 | Involving muscle or bones |

***"No grade 4 pressure ulcers for the last two years . . .
and we are seeing a
year on year reduction in all other pressure ulcers"***

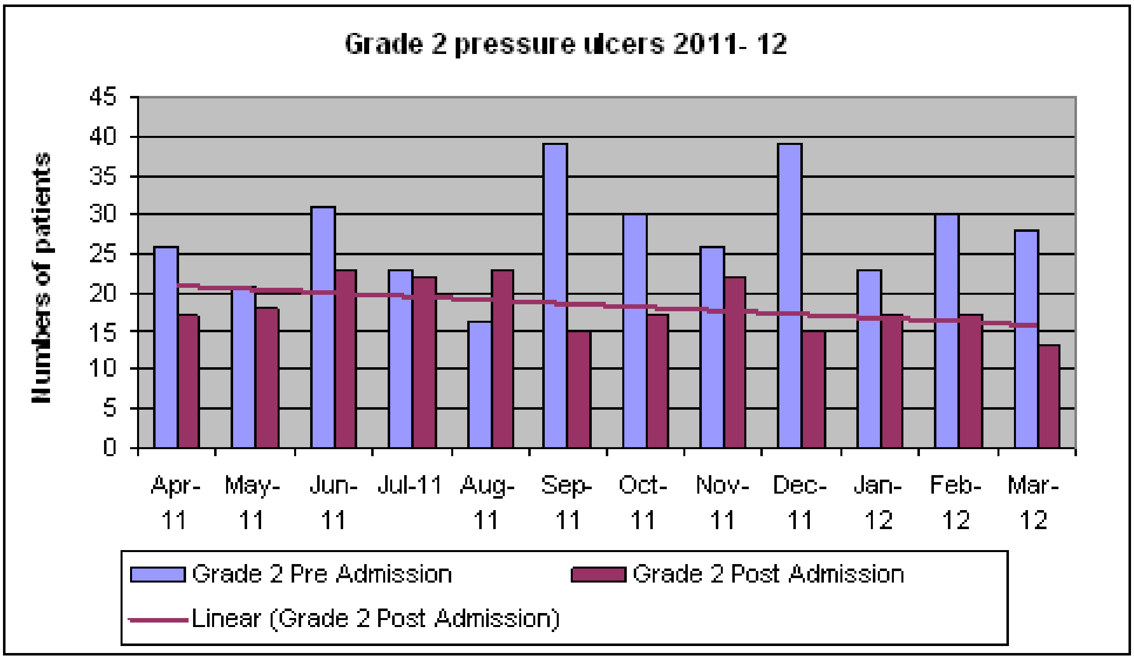
A national quality target, governed by standard national definitions, was introduced last year to increase the number of patients who are assessed for their risk of developing pressure ulcers. The second part of the target was set locally, and is to reduce the number of patients developing pressure ulcers whilst in our care.

We are pleased to report that there have been fantastic improvements on assessment, with 95- 97% of patients being risk assessed and the numbers of patients acquiring pressure ulcers in hospital has fallen to below the agreed target. We have instigated nursing metrics which measure the number of pressure ulcer assessments, increased the number of pressure relieving mattresses, implemented Root Cause Analysis investigations for all Grade 3 ulcers and plan to implement SSKIN Bundles (national best practice) to improve the documentation, assessment and evaluation of care.

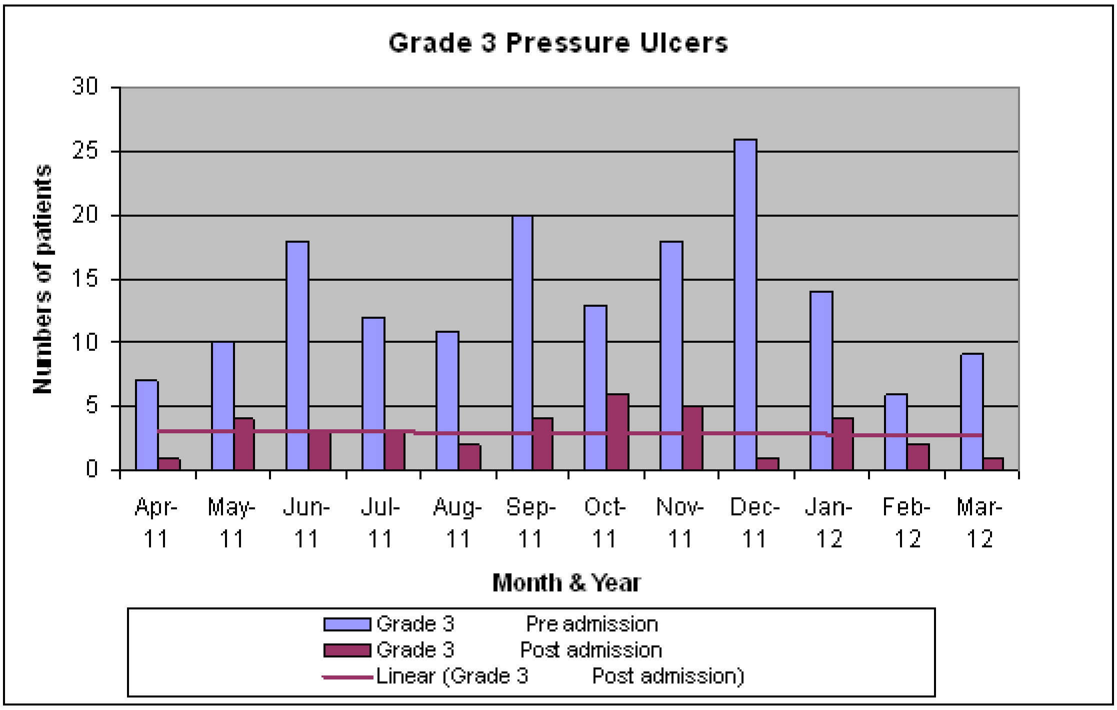
We will continue to drive this forward with an aim to meet the Pressure Ulcer Ambition project which is to have no avoidable grade 2 , 3 or 4 pressure ulcers within the Trust by March 2013.
Hospital acquired pressure ulcers are on a downward trend in line with the 5% CQUIN reduction target for 2011/12.

The graph below shows the total number of hospital acquired pressure ulcers (HAPU's) as a percentage against the total number of patients admitted that month.

**Grade 2 Pressure Ulcers**




**Grade 3 Pressure Ulcers**




**Grade 4 Pressure Ulcers**

There were no hospital acquired grade 4 pressure ulcers in 2010/11.

**Pressure Ulcer Steering Group**

Grade 3 and 4 hospital acquired pressure ulcers are investigated by Service Line Heads of Nursing, along with relevant members of the clinical team and a Tissue Viability Specialist Nurse, using root cause analysis (RCA). Findings from RCA's are presented at the pressure ulcer steering group meetings by the relevant head of nursing. Subsequent action plans are developed and shared to promote improvement and good practice.

An intensive drive on education, tighter guidelines and a new fleet of top of the range mattresses are some of our initiatives, coupled with an increased profile around the Trust in order to help meet this important target. The tissue viability team will continue to review all patients with a grade 2,3 or 4 pressure ulceration and will also see those with grade 1 damage from May 2012.

## How we have maintained high quality maternity services

Our maternity services have continued to be a popular choice for women during 2011/12 and we have given care to over 4,000 women and their families across North Nottinghamshire and surrounding areas.

We offer community based services, obstetric ante natal and post natal services from King's Mill and Newark hospitals, and childbirth facilities at King's Mill. Our services are complimented by the work of colleagues in the early pregnancy unit, sonographers, physiotherapists and other medical colleagues in paediatrics and anaesthetics.

We continue to monitor closely aspects of our services that help assess quality. Our aim is to have the same midwife working with the lady and her family throughout the pregnancy. During 2011/12 our audits showed that we maintained 95% continuity of midwife during the antenatal period and 93% during the postnatal period. This enables women to develop trusting relationships with the midwife and influences our birth outcomes.

Our birth outcomes are outlined in the table below and continue to place our maternity services as one of the best nationally.

| | 11/12 | 10/11 | 09/10 |
|---|---|---|---|
| Birth Numbers | 3499 | 3427 | 3281 |
| % rise from previous year | 2.1% | 6% | 4.4% |
| Midwife to birth Ratio | 1:32.9 | 1:32.3 | 1:30 |
| Caesarean Section Rate | 17.92% | 15.74% | 15.68% |
| Vaginal Birth Rate | 82.08 | 84.26% | 84.32% |
| Home Birth Rate | 5.5% | 6.76% | 7.75% |

We are really proud of these outcomes which we achieve by the strong philosophy of care the maternity team share. They have also been enhanced by our fabulous new environment, the availability of facilities for water births and aromatherapy. These complement the traditional services available from midwives, obstetricians, paediatricians, anaesthetists and neonatal services.

Midwife to birth outcomes are measured quarterly in order to assess our services in comparison with others across the East Midlands and nationally.

This is work that supports evidence that midwifery staffing levels affect outcomes for patients. The data is governed by standard national definitions and the recommendation is a midwife birth ratio of 1:28 the chart below demonstrates our rates at Sherwood Forest Hospitals.

| | Total Year 10/11 | Quarter 1 11/12 | Quarter 2 11/12 | Quarter 3 11/12 | Quarter 4 11/12 | Total Year 11/12 |
|---|---|---|---|---|---|---|
| Births | 3427 | 898 | 914 | 889 | 798 | 3499 |
| Midwifes | 106.29 | 106.29 | 106.29 | 106.29 | 106.29 | 106.29 |
| Ratio | 1:32.3 | 1.33.8 | 1.34.3 | 1.33.4 | 1.31.7 | 1:32.9 |

We also value the views of our services users. We collate comments that women have made about their birth experience in their post natal records, monitor themes and trends of our incidents and complaints to inform service improvements.

We also ask women to share their experiences with us relating to their care in labour. It has been demonstrated that women who have a dedicated midwife available to them when they want one during their labour improves birth outcomes. Over the last year over 90% of our women reported a positive experience in relation to one to one midwifery care.

Our challenges are regarding broader public health targets such as breast feeding initiation rates and smoking cessation rates in pregnancy. Despite many initiatives, performance is still poor nationally. We continue to work to promote breast feeding and talk to women about smoking, encouraging them to stop and to accept the support of the local specialist stop smoking service.

## How we aim to prevent acute kidney injury

Following on from the NCEPOD (National Confidential Enquiry into Patient Outcome and Death) 2009 report 'Adding Insult to Injury' the organisation established an Acute Kidney Injury (AKI) work group whose task it was to implement both the standard national NCEPOD recommendations based on national definitions and meet CQUIN indicators (as mentioned earlier in this report). The group has established a database of cases, a system to identify patients with AKI (Acute Kidney Injury) and flag them up to specialists' attention, and completed training to raise awareness of AKI in both acute admissions and patients on the wards. The data is extrapolated from the Orion system (internal information system)

**Awareness and educational actions to date**

- Information has been sent to all ward leaders regarding AKI and the importance of accurate fluid balance
- All inaccuracies/mistakes on fluid balance charts are addressed by the critical care outreach team
- Discussion with the training and development department to ensure that fluid balance is covered appropriately with the non registered nurses and that the department are aware of recurring problems
- Issues to be discussed at the Professional Advisory Group, a regular meeting of senior clinicians

**Awareness and educational actions for the coming year**

- From April 2012 AKI is to be covered on the nurse induction programme
- An ongoing rolling programme of education for all registered and non registered nurses is planned, exact details still under discussion
- Consider an AKI link nurse for each adult acute ward
- Continue to raise issues with the relevant people as they arise

## How we safeguard children and young people

The safeguarding children and young people team set high targets to achieve for 2011/12 and are delighted to report, the majority of the developments and improvements in Safeguarding Children Work Plan for 2011/12 were completed and delivered on time with the completion of the remaining few anticipated in early 2012/13.

**Key achievements for 2011/12**

The development of a Child Protection Supervision Policy for Staff has increase the range and number of staff who undertake child protection supervision.  This has contributed to an even greater awareness amongst key staff of the needs of vulnerable children and young people.

In addition, all staff employed by the Trust have a Safeguarding Children clause in their contracts to ensure they are aware of their responsibilities when safeguarding children.

At the beginning of 2011/12 the Trust Safeguarding Children Training Programme was reviewed and updated in response to new guidance.  In addition to the core programme training on Domestic Violence, Multi-Agency Risk Assessment Conferences (MARAC) are provided for midwives and

Common Assessment Framework (CAF) Awareness sessions are provided for children and neonatal nurses. A new initiative to support and enhance the training programme was the development of Safeguarding Children Competency Packages for midwives and for registered nurses working in children's wards, neonatal care, emergency department and genito-urinary medicine.

A policy for children and young people who do not attend appointments was also developed. A Trust wide audit of this policy has now been initiated and will be completed in early 2012/13. A robust audit programme is an essential element in ensuring the quality of safeguarding work so as well as the DNA (Did Not Attend) audit, six other audits were undertaken and completed during 2011/12. These were on:

- Completion of Midwifery Safeguarding Documentation
- Effective Communication between Midwives and Health Visitors
- Midwifery Safeguarding Supervision
- Midwifery Routine antenatal and postnatal inquiry (domestic abuse)
- Completion of Paediatric & Neonatal Safeguarding Documentation
- Effective use of the Paediatric Liaison Criteria in the emergency department

In addition to planned work, a Paediatric Safeguarding Children Dashboard was also developed in late 2011/12 to provide quarterly monitoring of key paediatric and midwifery outcomes.

**Key Priorities for 2012/3**

- Maintain the Safeguarding Children audit programme
- Implement the Safeguarding Children Competency Packages
- Continue to maintain and develop the Paediatric Safeguarding Dashboard

## How we safeguard adults

Safeguarding adults is fundamental to delivering quality healthcare. The Trust has developed a Safeguarding Adults Board and this continues to meet monthly, and is very well attended.

**Key Achievements for 2011/12**

- The organisation has appointed an additional safeguarding adults nurse to strengthen the service
- Mental Capacity Act training is ongoing, with the emphasis on embedding the mental capacity act into practice
- Vulnerable adults' study day developed and now runs three times each year. This includes real case examples and reflects the learning needing to take place. This is evaluated extremely well by staff
- The organisation collected themes from safeguarding concerns which were around transfer of care and discharge information. This had led to a review of our discharge/transfer information recommendations which started to be implemented from May 2012
- The organisation is now ensuring that leads in vulnerable patient groups (eg those with learning disabilities, dementia, domestic violence victims) work together more and feed back to one central place to safeguard vulnerable patient groups

**Key Priorities for 2012/13**

- Review safeguarding documentation
- Audit use of mental capacity in the organisation and learn from best practice
- Review safeguarding and Mental Capacity Act training
- E-learning package for safeguarding and learning disabilities to be introduced

The training programme of safeguarding adults and Mental Capacity Act (MCA) continues to raise awareness. This includes an intensive training programme for MCA to ensure it is used in practice. An MCA poster awareness campaign ran across all our hospitals in March. Lessons learnt from safeguarding have been used to change practice.

## 3.2 Clinical Effectiveness - other priorities

### How we reduced the amount of people developing blood clots

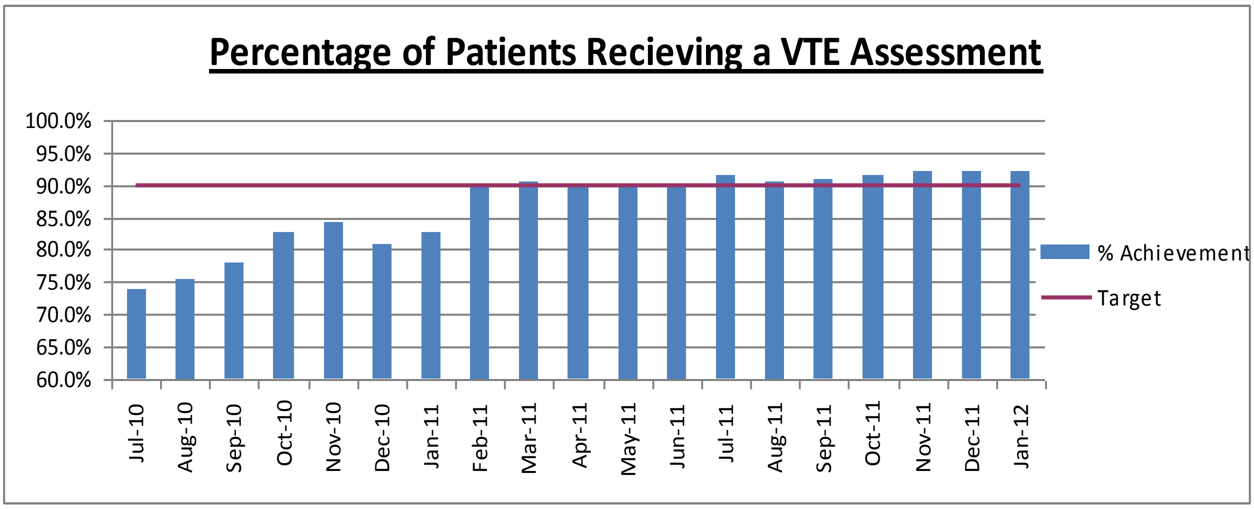
Over 90% of our patients should be assessed when they come into hospital to determine the chances of them getting a blood clot (venous thromboembolism). We are then able to treat those at risk and reduce their chance of developing a blood clot.

The data is taken from an audit of all assessment forms against a list of all admitted patients. The data is governed by standard national definitions.

We reached our target of 90% by February 2011, ahead of all the other Trusts in the region and have maintained an excellent performance.

The target for next year has increased to 95%, this includes a further requirement to measure the number of people where treatment has been started, which will be challenging. Currently we are at 93% and implementing improvement plans.

The graph shows a fantastic increase in the number of people being assessed therefore increasing the number of people who were prevented from developing a blood clot.




### How we continue to improve the monitoring of very ill people

ACAT (Augmented Care Assessment Tool) is the organisation's early warning system that alerts us to the patients who are at risk, or who are actually deteriorating. If we intervene early in the course of their deterioration we may be able to instigate treatment that will prevent further deterioration or prevent the need for an intensive care admission.

The patient's vital observations are carried out, such as blood pressure, temperature, pulse, respiration, oxygen levels, urine output and consciousness levels (consciousness levels are recorded by the AVPU tool – Alert, Voice, Pain, Unresponsive). The results are then calculated and a score given. If the score is above a certain level a doctor is called. Audits are carried out throughout the year, in terms of assessing nursing notes and charts, to ensure this tool is being used effectively. The data is governed by local definitions.

Overall Trust compliance with all elements of the observation and ACAT audit was 95%. This represents an increase of 1% since the last audit in March 2011.

Good compliance (99-100%) was maintainedin five of the six mandatory vital signs. The target is to achieve 100% compliance with the recording of all 6 mandatory observations and the ACAT score thus increasing the opportunity for identifying the deteriorating patient early in the course of their deterioration

There was less compliance with recording of AVPU where there is still a need for further improvement (84%).

**How we will continue to improve on ACAT?**

- Attendance at LIPS course by the nurse consultant facilitated the prioritising of acutely ill patients as part of the improving patient safety agenda agreed at Board level
- Projects worked up in preparation for this using PDSA (Plan Do Study Act) methodology eg improving compliance with observations, monitoring unplanned admissions to intensive care using global trigger tool to identify (and learn from) events
- Strategy day planned for critical care outreach team for planning
- Audits are now carried out by the senior nurses and incorporated monthly into an audit tool known as nursing metrics. This is in a pilot phase and will be reported fully in next year's account.

A new support service for junior doctors and nursing staff has also been introduced to ensure that acutely ill patients whose condition worsens receive the fastest possible treatment by medical specialists. This is called the Acute Response Team and was introduced in December. The groundbreaking new service is based on models in use at Sydney, Australia and at Aintree Hospital in Liverpool. This service is available 24 hours a day, seven days a week. The Acute Response Team provides immediate assistance to ward staff for any acutely ill adult inpatients whose condition begins to deteriorate.

A memorable bleep number enables ward staff to call the team, which offers a new middle level of support in between calling the cardiac arrest team and the critical care outreach service, to get senior medical help to the sickest patients faster. Members of the new Acute Response Team include a medical registrar, intensive care registrar or consultant, critical care outreach nurse and resuscitation training officer.

## How we provide privacy through same sex accommodation

***"None of our patients have been cared for in mixed sex accommodation for at least 16 months"***

We have made significant improvements to our environment and can report that we have had no same sex breaches. This means that where we have a bay of four or six patients they are either all women or all men. At King's Mill Hospital we also have 50% single ensuite bedrooms for our patients. You can rest assured that your privacy and dignity is maintained when admitted to one of our hospitals and King's Mill is the only hospital in the East Midlands offering this.

## How we avoid readmitting people who do not need to be in hospital

When patients attend hospital they expect to be discharged home, well, and having received the correct treatment that enables them to return to their lives. For a small number of people they find themselves having to be readmitted to hospital either as a result of a recurrence of their original condition or as a complication or indeed a new condition.

We need to ensure that we do not discharge patients home if there is a risk that their original condition has not been successfully treated or that they have a complication. We, therefore, have systems and processes to ensure that this does not happen.

The hospital has a discharge team who identifies people who are readmitted within 28 days and look into the reasons why. People who are admitted to the hospital many times are identified by the Repeat Admission Patient Alert (RAPA) system. This enables these people to be seen quickly and to identify if the reasons for readmission are medical or social need or both. The integrated discharge team and other specialist nurses work with the multidisciplinary team, including community matrons and the community nursing team, to identify strategies to support patients in the community and, if admitted into acute care, have a care plan in place to assist prompt discharge home or to an appropriate destination.

There are many developments we have introduced over the last year to support a reduction in people being readmitted to hospital for the same condition. These are:

**Reablement**

- EDAASS (Emergency Department Admission Avoidance Support Scheme) launched in March 2011 and explained further in this report
- Urology outreach service (launched Sept 2011). This enables urology patients to be seen at home
- Dedicated geriatric support in Emergency Department (launched Dec 2011)
- End of Life support in the Emergency Department (launched Jan 2012)

**Medical staffing**

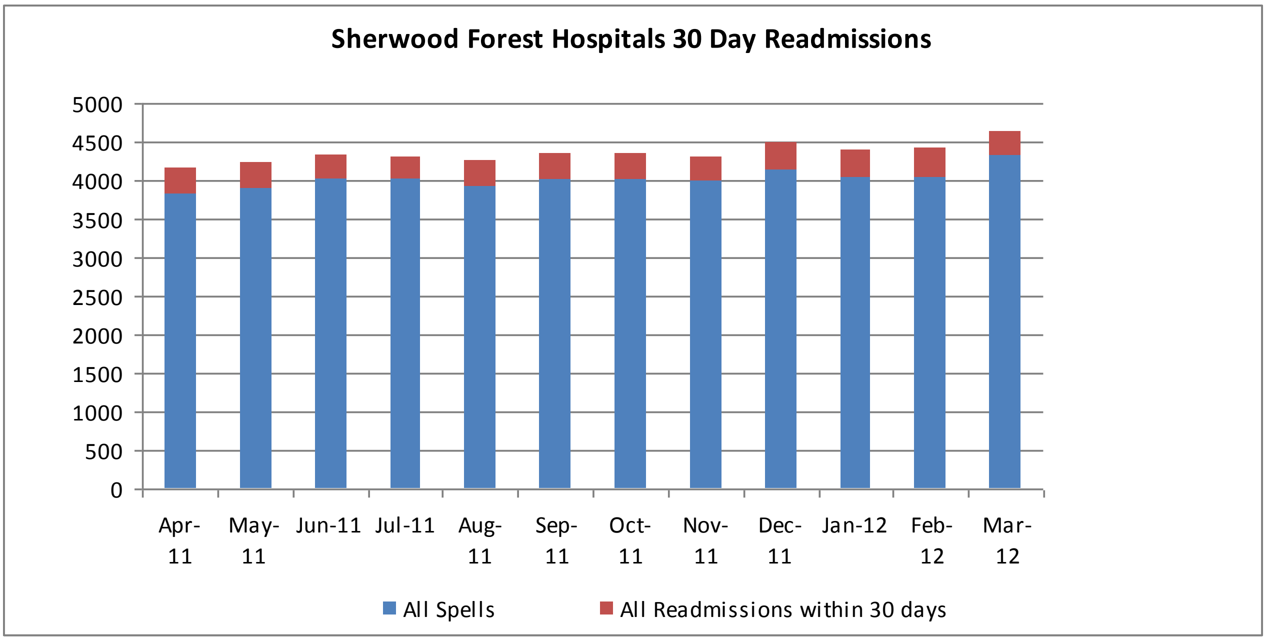
- Increasing the number of Emergency Department consultants from 6 to 11
- Establishing acute physician service (4 whole time equivalent doctors appointed to start between August and November 2012)

**Emergency Care Service Innovation**

- Single Point of Access – this means that all patients are seen in the Emergency Department and then treated according to their needs. Sometimes they do not need admitting (launched in December 2010). This has led to a significant reduction in GP admissions
- Develop a Clinical Decision Unit (estimated implementation summer 2012)
- Increased access to Radiology in the Emergency Department (in discussion and first development launched in April 2012)
- Develop Ambulatory Specialty services in Emergency Department.
- Community Geriatrician in Newark and Sherwood (interviews in April 2012)

This information provides a summary of the breadth of developments achieved and planned.

The data below is governed by standard national definitions and is generated by the hospital PAS (Patient Administration System) system.




The blue bars above show how many people were admitted during that month. The red bars on the top show how many readmissions we had that month. As you can see the readmission rates are small when compared to the first admission rates.

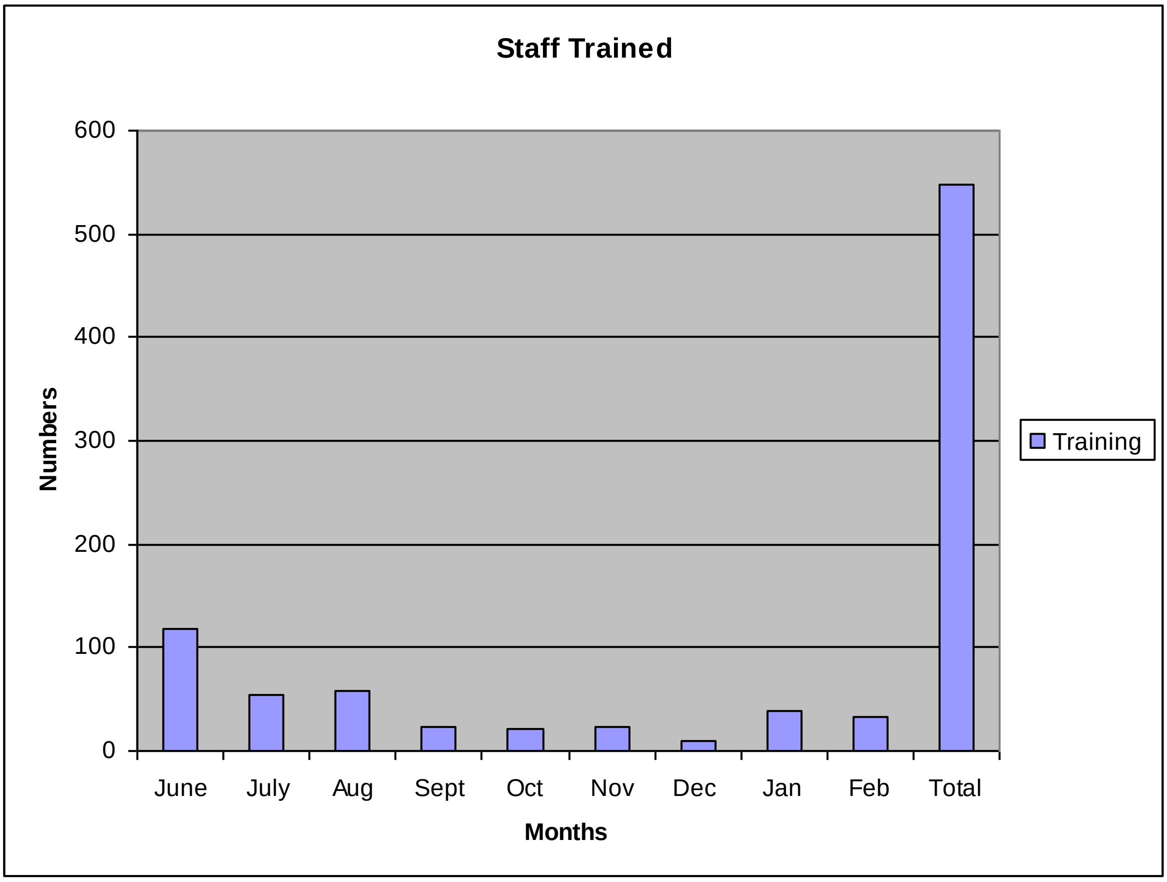
## How we actively support people to stop smoking

Time for a QUIT chat

In line with both national and local quality improvement programmes, Sherwood Forest Hospitals has been working to implement a system which identifies people who smoke and provide Brief Advice about quitting and where appropriate refers to the Local Specialist Stop Smoking Services. This is based on research which shows that brief conversations between patients and clinicians on lifestyle issues such as smoking can stimulate change.

'Time for a QUIT chat' is a new scheme that has been training staff to identify patients who smoke and motivate them to accept a referral to stop smoking services. An in-house trainer was recruited.

Frontline staff attend one hour training sessions in Brief Advice skills from accredited trainers. The graph below shows how many staff have been trained each month.

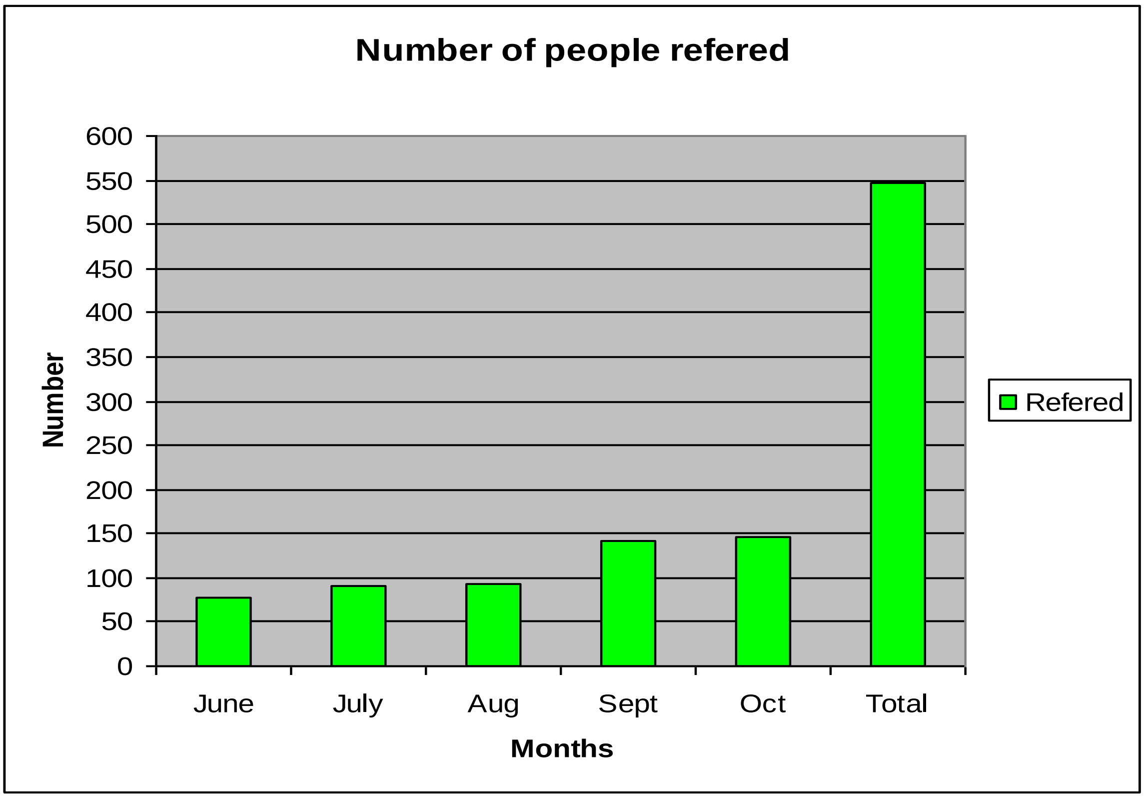



An electronic referral process to stop smoking services continues to work well in maternity services and has been extended for use within inpatient areas also.

Extensive research shows stopping smoking amongst more patients can reduce length of stay for patients. It also improves overall health and wellbeing and reduces post operative complications.

We monitor the number of referrals from the hospital to Local Specialist Stop Smoking Service and ensure feedback to staff through Time for A Quit Chat newsletters.

The graph below shows how many people have been referred each month.




Staff and patients have been involved in surveys to evaluate the effectiveness of the programme.

## How we have improved outcomes for stroke patients

The hospital has worked hard to be able to provide a thrombolysis (clot busting drug) service to patients who have suffered a stroke caused by a blood clot in their brain. This means that when these patients are admitted they can be given this treatment to disperse the blood clot and in many cases the patients make a full recovery. Previously patients would have needed to travel to another hospital to receive this treatment.

A patient told us:

> ***"I was having a stroke, my wife called the ambulance, I came to King's Mill and received this new clot busting drug - my life is nearly back to normal"***

A recent accreditation visit proved to be positive and highlighted areas of good practice and areas that the stroke unit was required to continue to work towards. These areas are all being actioned proactively.

Since King's Mill Hospital gained accreditation as a primary stroke centre, work continues to further improve the service, using a structured stroke service improvement programme, including specific work streams for TIA (transient ischaemic attack or mini stroke), pathways and cross county partnership working.

The results from the ongoing measurement against the nine Sentinel Audit Key Performance Indicators, governed by standard national definitions are in the table below, and show continued improvement in almost all indicators.

Brain scan within 24 hours of stroke was previously identified as a risk, but there has been sustained performance above the top quartile.

| | National Quartiles (Sentinel Audit 2010) | | | | | | |
|---|---|---|---|---|---|---|---|
| **Sentinel Indicators** | **25% of sites score below** | **Median** | **25% of sites score above** | **Qtr 1** | **Qtr 2** | **Qtr 3** | **Qtr 4** |
| Patients treated for 90% of stay in a Stroke Unit (as calculated) | 46.4% | 62.2% | 72.7% | 95% | 89% | 95% | 95% |
| Screened for swallowing disorders within first 24 hours of admission | 75.5% | 84.1% | 94.2% | 95% | 98% | 100% | 99% |
| Brain scan within 24 hours of stroke | 58.6% | 70.5% | 79.7% | 96% | 98% | 100% | 100% |
| Commenced aspirin by 48 hours after stroke | 59.2% | 94.1% | 98.0% | 98% | 98% | 100% | 100% |
| Physiotherapy assessment within first 72 hours of admission | 87.6% | 93.0% | 96.9% | 89% | 97% | 95% | 98% |
| Assessment by an Occupational Therapist within 4 working days of admission | 72.7% | 87.1% | 96.2% | 83% | 87% | 91% | 94% |
| Weighed at least once during admission | 78.2% | 89.2% | 96.3% | 100% | 100% | 100% | 100% |
| Mood assessed by discharge | 68.8% | 84.4% | 94.1% | 100% | 100% | 100% | 100% |
| Rehabilitation goals agreed by the multi-disciplinary team by discharge | 92.6% | 97.3% | 100.0% | 99% | 100% | 100% | 100% |
| Average for 9 indicators | 71% | 85% | 92% | 95% | 96% | 98% | 98% |

**To ensure we deliver an excellent stroke service** at Sherwood Forest Hospitals . . . we are planning to work towards implementing a 24 hour thrombolysis service at King's Mill Hospital. This will be supported by:

- Strengthening the partnership working with Nottingham University Hospitals NHS Trust
- Progressing towards implementing a 7 day high risk Transient Ischaemic Attack (TIA) service in partnership with Nottingham University Hospitals NHS Trust
- Continuing to familiarise staff with the telemedicine equipment and resolve connectivity issues
- Increasing the substantive stroke consultant establishment

**We have during 2011/12 implemented:**

- A 5 day high risk TIA service providing a one stop clinic where patients are assessed, investigated and treated
- A thrombolysis (clot busting) service at King's Mill Hospital, Monday to Friday 8am to 5pm, with patients being repatriated directly to Nottingham University Hospitals outside these times

To ensure we deliver the best possible care to our patients we continue to monitor stroke performance.

## How we have improved the pathway in Emergency Department

The hospital achieved delivery of the national emergency access standard of 95% for patients being treated, admitted or discharged within four hours of their attendance. The score for the hospital was 96.21%. This is despite a significant increase in demand for services during 2011.

The Emergency Department has managed this increase within existing resources by re-profiling staff hours to better match peaks in demand and redesigning the workforce to shift from a dependency on high cost agency medical staff to substantively employed staff.

One example of this is the successful appointment to three new Advanced Nurse Practitioner roles which support the delivery of high quality patient care in the majors section of the Emergency Department.

The next phase of the workforce strategy is to increase the number of consultants delivering the service from 6 to10. This is one of a number of actions being taken to improve our performance to improve the quality and speed with which patients are cared for.

During the last year we commenced EDAASS (Emergency Department Admission Avoidance Support Scheme). This was introduced for patients who attend the Emergency Department and Emergency Admissions Unit who do not require admission to a ward. This scheme avoids unnecessary admission and improves quality of care.

The scheme provides transport home and helps to settle in the patient at home. It may also include prescription collection and shopping and can provide 48 hour follow-up if necessary. The team initially consisted of five part time support workers who provide a 9am to 9pm service 7 days a week. Due to the success of the service the staffing levels have increased to 7 full time people. The aim is to extend the service to the wards, enabling people to be discharged even if their care package is not in place for 48 hours as the support workers can fulfil this role. The support workers will hand over the patient's care to the community team when the care package commences. This will ensure a seamless service for the patients.

The EDAASS team ensures that care packages are re commenced in the community. They can refer to intensive home support, rapid response, social services and the falls team.

During the last 12 months over 600 patients have been cared for by the EDAASS team.

"I used to worry about sending patients home who may not have family to arrange those little things like ensuring the house is warm and there is food available. I no longer have to worry about this thanks to EDAASS"

**EDAASS achievements**

There has been a qualitative survey of a small sample of patients and carers between March and May 2011.

- 100% felt the service helped them to be discharged earlier from hospital
- 60% felt the service avoided the need for them to be admitted as they were provided with the necessary support in the community
- 100% said the service met their individual needs and wishes
- 100% said they would recommend the service to others
- There has been an increased number of referrals to the falls service
- Unnecessary admissions have been avoided
- Estimated savings in excess of £266k, as patients do not require a longer than necessary hospital stay
- The EDAASS team provide a valuable bridge between health and social care

A recent patient said:

*"Excellent, excellent. It reassured me. The EDAASS support worker was remarkable. The two ladies that I met were so thoughtful – lovely ladies. They assisted me and I was grateful for it. I would definitely recommend the service to others; in fact I already have recommended it"*

## How we have improved access to contraception

In line with National Policy in reducing unplanned pregnancies, we have been working to improve access to and information about contraception across two key groups of patients. All patients who access the hospital for termination of pregnancy services are counselled regarding their choices for future contraception. They are signposted to appropriate services and if the patient chooses we initiate contraception at the time of the termination. We consistently deliver information to more than 95% of this group of patients.

We offer an emergency contraceptive service to complement the community services available on public holidays, which whilst use is small, is effective for those who use the service.

Within maternity services the post natal documentation available to our women has all the information regarding contraceptive choices post birth and signposts women to the appropriate services to access their choice. Our records demonstrate that between 80-90% of our women have this documentation and we will work on improving this uptake.

## How we ask more people about their alcohol intake

Screening all hospital patients for alcohol misuse and providing brief interventions is well recognised as appropriate and supported by a significant evidence base. The data is governed by standard national definitions set out in the NICE (National Institute for Health and Clinical Excellence) guidance.

| Standards | Quarter 2 2011/12 Baseline n=50 | Q3 2011/12 N=100 | Q4 2011/12 N=100 |
|---|---|---|---|
| Standard 1 all patients admitted via the emergency admissions unit will be screened for alcohol problems using a recognised validated screening tool (target 65% of patients meeting this standard) | 16/50 screened<br><br>32% compliance | 78/104<br><br>75% compliance* | 82% compliance overall |
| Standard 2 all patients identified via standard 1 as drinking to excess (but falling short of being potentially alcohol dependent) will be offered brief advice in relation to alcohol (target 90% of patients meeting this standard) | 1/16 identified 0/1 offered BA or offer of referral<br><br>0% compliance | 2/3<br><br>66% compliance | 2 of 4 = 50% |
| Standard 3 all patients identified via standard 1 as drinking to excess (but falling short of being potentially alcohol dependent) will be offered a referral to the Alcohol and Drug Liaison Team (ADLT) (target 90% of patients meeting this standard) | Zero patients identified in this sample | 0 /3<br><br>0% compliance | 1 of 4 = 25% |
| Standard 4– for all patients identified via standard 3 and accepting a referral to ADLT, such a referral will be made (target 90% of patients meeting this standard) | Zero patients identified in this sample | Zero patients identified in this sample | Zero patients identified in this sample |
| Standard 5 all patients identified via standard 1 as potentially alcohol dependent will be automatically referred to ADLT (target 90% of patients meeting this standard) | Zero patients identified in this sample | 4/4<br><br>100% compliant | 1 of 1 = 100% |
| Standard 6 for all patients seen by ADLT a letter will be sent to the patient's GP summarising alcohol intake and interventions delivered (target 90% of patients meeting this standard) | Zero patients identified in this sample<br><br>Quarterly ADLT figures: - see above | 2/2<br><br>100% compliant | Zero patients identified in this sample |

*The additional scrutiny applied in the Quarter 3 and 4 audit reveals that nurses are indeed screening for alcohol misuse in 75% and 82% of cases; this is to be commended as this is perhaps as high as anywhere in the NHS.

**What have we achieved during 2011/12**

- Provided bespoke educational sessions for staff on the emergency assessment unit and the wider hospital workforce, including doctors, nurses, allied health professionals, students. This ensures they are aware of expectations for Alcohol QSP standards
- Listened to feedback from nursing colleagues and reformatted the alcohol screening tool to make it more user friendly
- Established audit processes to monitor compliance and our team directly audit patient health records on a quarterly basis to monitor compliance
- Directly received referrals from wards and departments for patients who drink alcohol to excess and provided direct interventions for over a 1,000 patients – of these we have referred on to specialist community alcohol services when appropriate and have dealt 'in house' when this is sufficient

**What are we aiming to achieve during 2012/13**

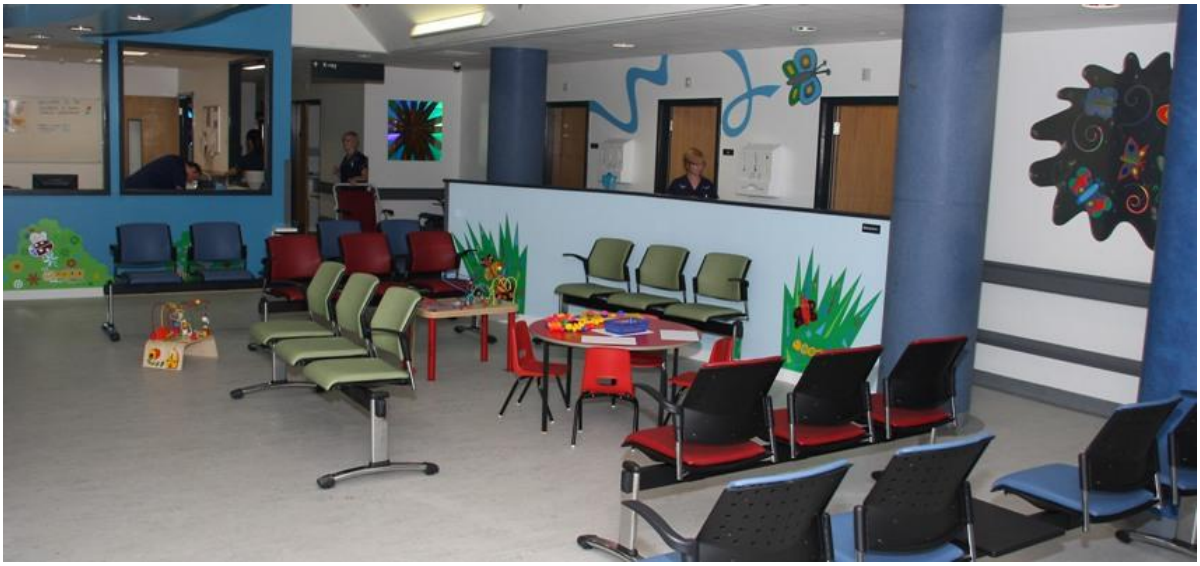
- We aim to implement a new guideline for screening that is NICE compliant
- We have designed a workbook for all clinical staff (other than doctors) that provides all the information nurses and allied health professionals need to ensure compliance with alcohol standards
- We have also commenced a programme of education for all emergency department nurses that again covers alcohol requirements and other alcohol and drug related issues (for example: responding to young people who may have alcohol or drug related problems)

Local alcohol and drug services are being significantly restructured as a 'Recovery Partnership'. This is a coming together of previously disparate substance misuse services so as to better meet the holistic needs of people with alcohol and drug problems and their families, friends and communities. The Alcohol and Drug Liaison Team is central to ensure that our organisation is recognised as a central player in our local health and social care community's response to local substance misuse problems. As such, and in the spirit of continuous quality improvement, we are building on our already established and well respected roles and functions. By way of example we plan to further utilise the Alcohol Liaison Nurse Clinic (based in the Emergency Department). We have also recently developed an Alcohol Liver Disease Clinic to seek to address local problems – Ashfield and Mansfield are in the worst ten areas of the UK for female alcohol liver disease deaths.

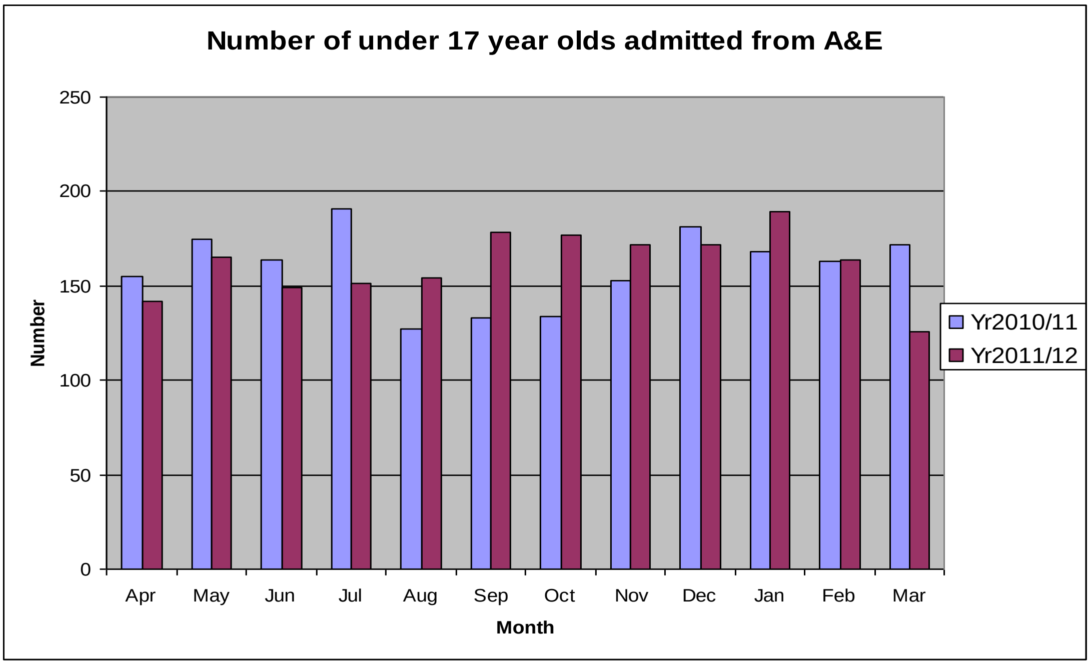
We have also developed and led on an excellent multi-agency response to High Volume Service Users (HVSU - people who attend ED either 3 times in a month or 5 times in six months - many of which have alcohol problems). It is perhaps fair to say that the Trust and the wider Recovery Partnership have developed a response to HVSU that is considered the best nationally.

## How we aim to reduce the number of children who are admitted to hospital via the Emergency Department

Children's waiting room in the Emergency Department



We have identified that we are still admitting patients from the Emergency Department (ED) onto our children's ward, and whilst this is the right thing to do for many patients we believe that we may be able to prevent some of these admissions. We are looking at solutions which would enable children and young people to have a more in-depth assessment in ED. One idea being considered is to have a children's doctor based in the emergency department to assess all children and young people to establish what alternatives to admission can be arranged.



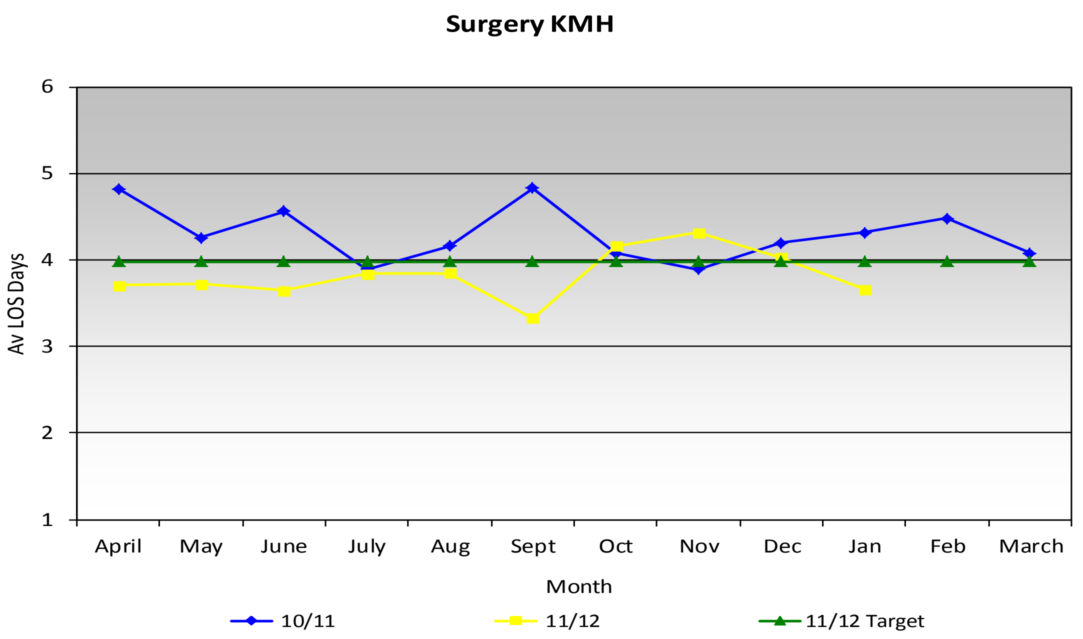
## How we have reduced the time people spend in hospital

**April 2011 to March 2012**

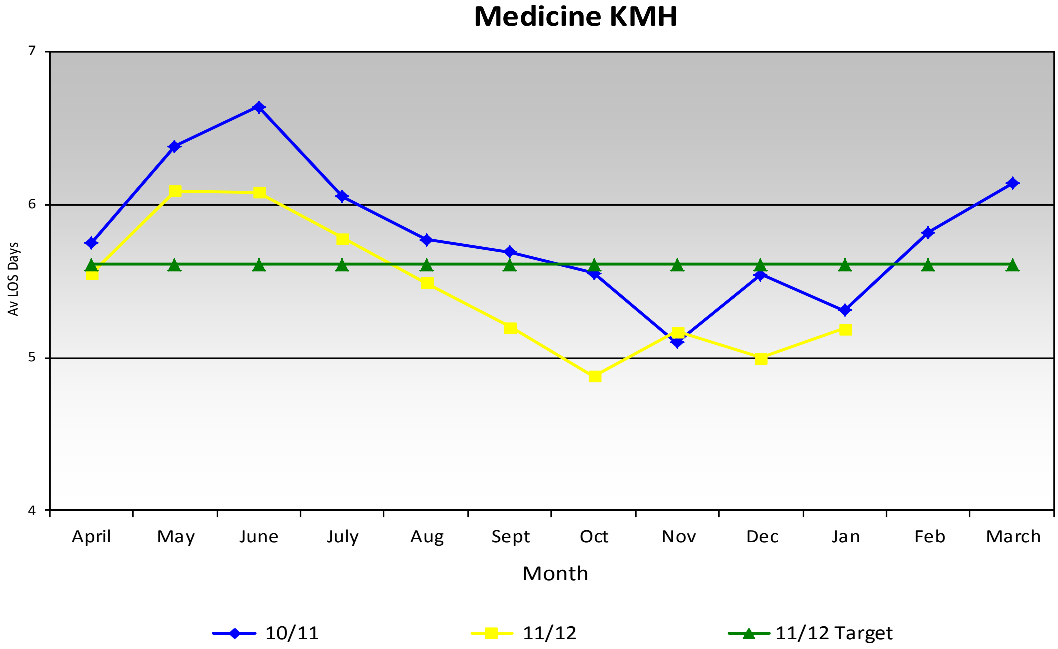
The average length of stay for patients on medical and surgical wards at King's Mill Hospital has fallen when compared with the same period in 2010/11 and we are hitting the targets set for 2011/12. The data is taken from PAS and is set locally.

It is not possible to compare average length of stay at Newark Hospital with 2010/11 on a like for like basis, due to the change in the types of patients seen there during the year.

The average length of stay charts for medical and surgical wards at King's Mill hospital are included below to illustrate the improvement:



| Surgery | Average length of stay | Medicine | Average length of stay |
|---|---|---|---|
| 2010/11 | 4.30 days | 2010/11 | 5.81 days |
| 2011/12 target | 3.98 days | 2011/12 target | 5.61 days |
| 2011/12 actual | **3.84 days** | 2011/12 actual | **5.49 days** |




The priority for next year will be to reduce the amount of people who are in hospital when they could be somewhere else, such as their normal place of residence or an alternative care setting.
No patient wants to spend more time in hospital than they need to and it is important that we treat patients as efficiently as possible ensuring that we communicate with them and their families about how long we need for them to stay in hospital for us to treat them.

Over the past 12 months we have consistently reduced length of stay in both medical and surgical specialties and we will continue to seek further reductions whilst at the same time monitoring quality metrics such as readmission rates and day case rates for surgery in order to triangulate patient outcomes and experience.

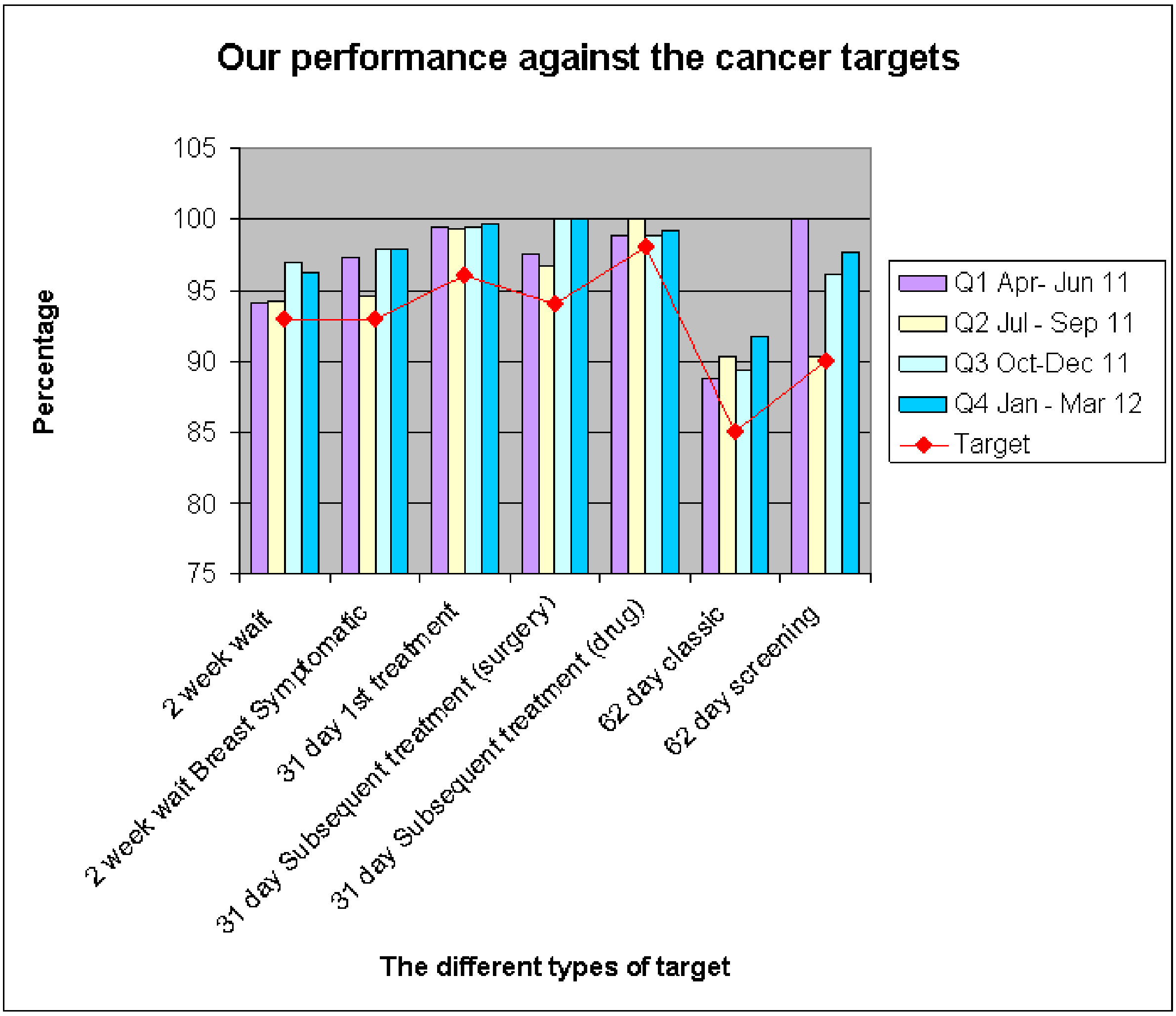
## How we have achieved our cancer targets

Patients with or suspected of having cancer expect to have prioritised treatment as this will be one of the most traumatic parts of their lives. The targets that have been set for such patients reflect the importance that the public in general expect for ensuring that priority is given and that hospitals organise themselves to deliver this care.

During the past 12 months the Trust has consistently met these targets, although it has experienced some difficulty with the 62-day target as the numbers of patients treated is small, so that any delay for a patient is reported as a high percentage failure.

The Trust remains one of the best performing in the region and will continue to ensure that this area of its activity remains a key priority.

We are constantly achieving our targets and remain one of the best performing hospitals in the East Midlands. See graph below:




- The **2 week wait** refers to people who are suspected of having cancer; they need to be seen within 2 weeks
- The **2 week wait for breast symptomatic** means any patients who have breast symptoms who are not suspected of having cancer need to be seen within 2 weeks.
- **31 day to first treatment** means any patients with a diagnosis of cancer will be treated within 31 days of the decision to treat them
- **31 days subsequent-surgery** means 31 days from decision to agreement to have surgery following initial treatment to having the surgery
- **62 day classic** means 62 days from referral to receiving the 1st treatment
- **62 day screening** means 62 days from referral from the screening programme to the patient receiving their first treatment.

**Our Key Achievements/Improvements**

- We continue to review performance and patient pathways through the six weekly Cancer Unit Management Board group
- We continue to track all patients referred with suspected cancer against the National Cancer Waiting Time standards
- We have presented at local Primary Care Group meetings about cancer services and pathways
- All cancer teams participate in the annual National Cancer Peer Review/Accreditation programme

## 3.3 Patient Experience - other priorities

### How we have improved the experience of patients with dementia and delirium

There has been a great deal of work undertaken during the last year to ensure that our patients with dementia and delirium receive the very best care. We have looked at the standards set by the National Institute of Health and Clinical Excellence to ensure that the services we provide to our patients meet those standards. We have taken part in a number of audits (including the National Audit of Dementia) and have used the results to plan and change services for this group of patients. We are developing personalised patient documentation for patients with dementia and taking steps to involve carers and family members once patients are admitted to hospital.

Over the past year a programme of dementia education for staff working across the Trust has been rolled out successfully; the aim being to ensure that all members of staff have the appropriate knowledge and skills to allow them to provide a high standard of care for patients with dementia.

The Trust's Dementia Group is a committed group of staff who care passionately about the experience of patients with dementia in our hospitals. The group has written a Dementia Strategy and Care Pathway for patients with dementia who use the services provided by the Trust and these will be launched shortly. The Dementia Group meets regularly to review what is happening across the hospitals and plan how to ensure that improvements are continually made.

Quote from a member of staff**:**

> *"I find the training really good, I am more confident when treating patients with dementia"*

- We achieved the dementia CQUINs for last year: providing dementia training to staff and ensuring that all elderly patients admitted to the Trust had a cognitive assessment carried out (using the AMTS – Abbreviated Mental Test Score)
- Looking ahead, the ACLT (Acute Care Liaison Team) is being expanded to provide seven day working
- We invested in a significant programme of training and review with regards to MCA (Mental Capacity Act) training across the Trust to raise the awareness of mental capacity and dementia to ensure that all of our patients are treated with dignity and respect and that their basic rights were always maintained

### How we have improved care for patients who are dying

Using the Commissioning for Quality and Innovation (CQUIN), the Trust's main aim was to ensure that significant improvements were made in improving choice at the End of Life.

We participated in the National Care of the Dying Audit - Hospitals (NCDAH) and have looked at the key performance indicators to try and ensure that the services we provide to our patients meet those standards.

Following on from this report, the Trust has appointed an end of life care co-ordinator, whose role is to train and support staff to maintain and sustain quality for patients and their relatives/carers who are entering the end of life phase, regardless of diagnosis.

### Awareness and Educational Actions to Date

- Information has been sent to all ward leaders regarding the role of the end of life care co-ordinator
- Discussion with the training, education and development department to ensure end of life care is covered appropriately with all new and current members of staff, through the mandatory update and induction programme
- Established audit process to monitor compliance of the Liverpool Care Pathway
- Directly receive referrals from wards for patients who have been commenced on the Liverpool Care Pathway and provided direct support for patients, relatives and staff

### Awareness and Educational Actions for the Coming Year

- From April 2012 End of Life Care is to be covered in our compulsory training programme, as well as continuing to be covered within the induction programme
- We have designed a workbook for all clinical staff that provides all the information nurses need to ensure compliance with providing quality end of life care
- Recommence link nurse support group
- Finalise a new policy for the Liverpool Care Pathway for the dying patient
- In response to 'The End of Life Care Strategy' (2008) re-establish the General Palliative and End of Life Care steering group, this provides a decision making forum for driving forward effective general palliative and end of life care within the organisation

## How we have improved the quality of healthcare for patients with a learning disability

We have a dedicated nurse who provides training and education for staff to ensure quality care services for people with a learning disability. She has developed policies as well as practical tools to help people with a learning disability access our services.

- The Learning Disability (LD) Policy was ratified in October 2011. This explains to people that pathways across inpatients, emergency and outpatients may need to be adjusted to meet the needs of people with a learning disability
- We have implemented a 'Hospital Traffic Light Assessment' which is a patient held document to share information with staff about the needs of the person with a learning disability
- The Risk, Dependency and Support Assessment has been implemented across the hospitals to highlight if any additional support is required for a hospital stay
- A Learning Disability Steering Group takes place quarterly with representation of people with a learning disability, family, carers and hospital staff
- People with learning disabilities have helped to produce an 'easier read' questionnaire to capture patient experience – this will be implemented during 2012
- During the following year the steering group is looking at producing accessible information and an alert card to raise awareness of learning disability to be launched in 2012

**Highly Commended by the National Nursing Times**

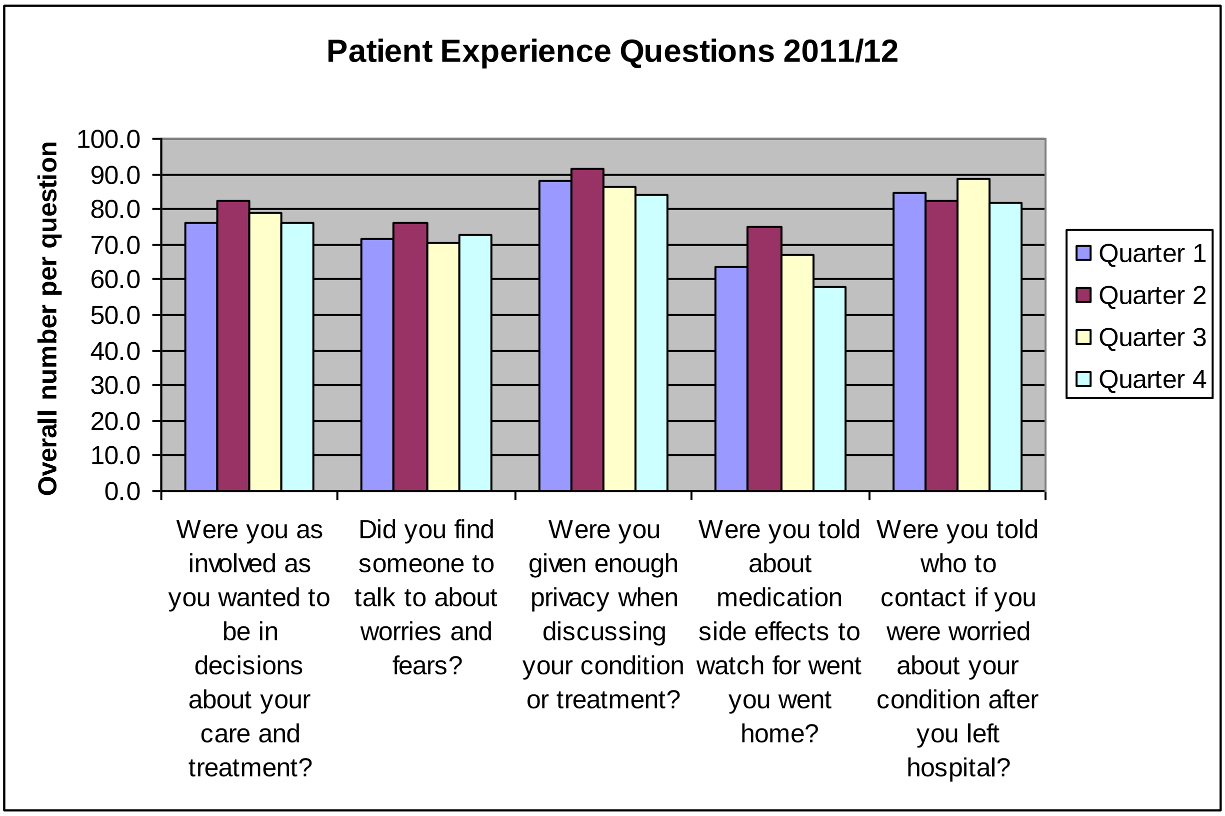
The Learning Disabilities Nursing Project was entered in the National Nursing Times Awards and was highly commended. The project was developed to improve end of life care for people with learning disabilities.

The project, jointly led by us and Nottinghamshire Healthcare Trust, also shortlisted for the Medipex NHS Innovation Awards, has a local focus across Nottinghamshire. The project team has produced a number of resources to support end of life care, including a DVD about receiving bad news, which raises awareness of how to support someone with a learning disability.

The project also aims to improve support for GPs, consultants and nurses, as well as staff in residential units. These changes ensure current support and care are identified and planned at an early stage, thereby reducing inappropriate use of health services and decreasing emergency admissions to hospital.

## How we have listened to our patients

Over the past year we have asked a set of questions each month to 200 people who have recently been discharged from hospital. These patients have been home for a few weeks and so are better placed to reflect on their experiences. The graph below shows the scores over the past year. Quarter 4 results will be available in July 2012. The data is gathered by the use of postal questionnaires and is governed by national standard definitions.

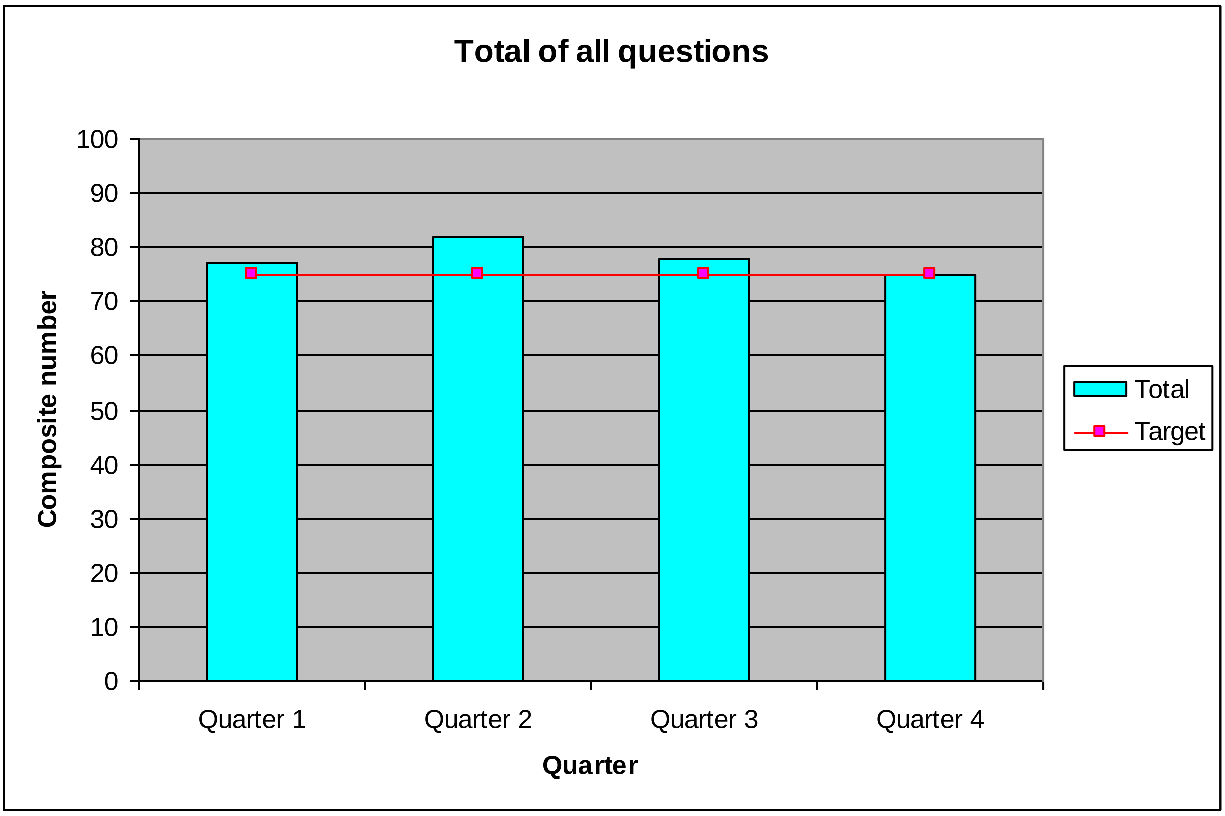



The results show there is room for improvement. Over the past year we have been working with the senior nurses in the organisation and developed a programme for them to ask 10 patients per month a set of questions. This enables them to gain the patient experience at first hand. The senior nurses then discuss their findings with the ward leaders to ensure improvements are made where needed.

Pharmacy is piloting small cards to give to patients to encourage them to ask questions about their medication if they are unsure at any stage.

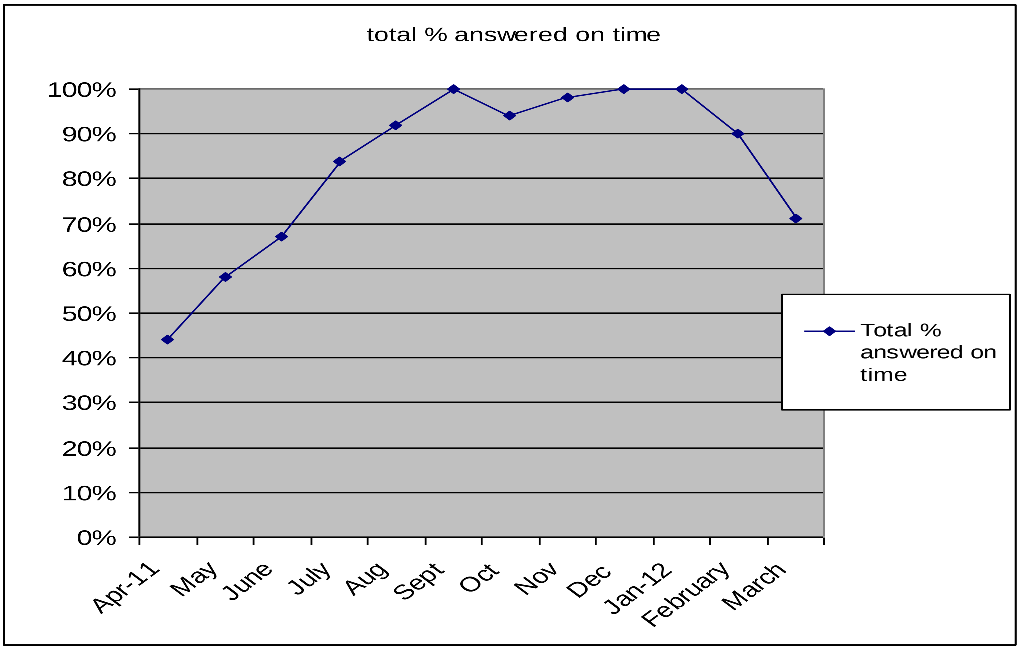
An area for concern is not being able to influence the patient's experience as the questions are asked after discharge. For the coming year the questions will be asked before the patient leaves the ward. This will ensure that if they give a negative answer or if they do have worries these can be addressed before the patient leaves the ward.

The table below shows the cumulative results for the five questions above and the target set for the year. The results are positive but we are striving to do even better for the following year. The overall target for next year has increased to 80%.

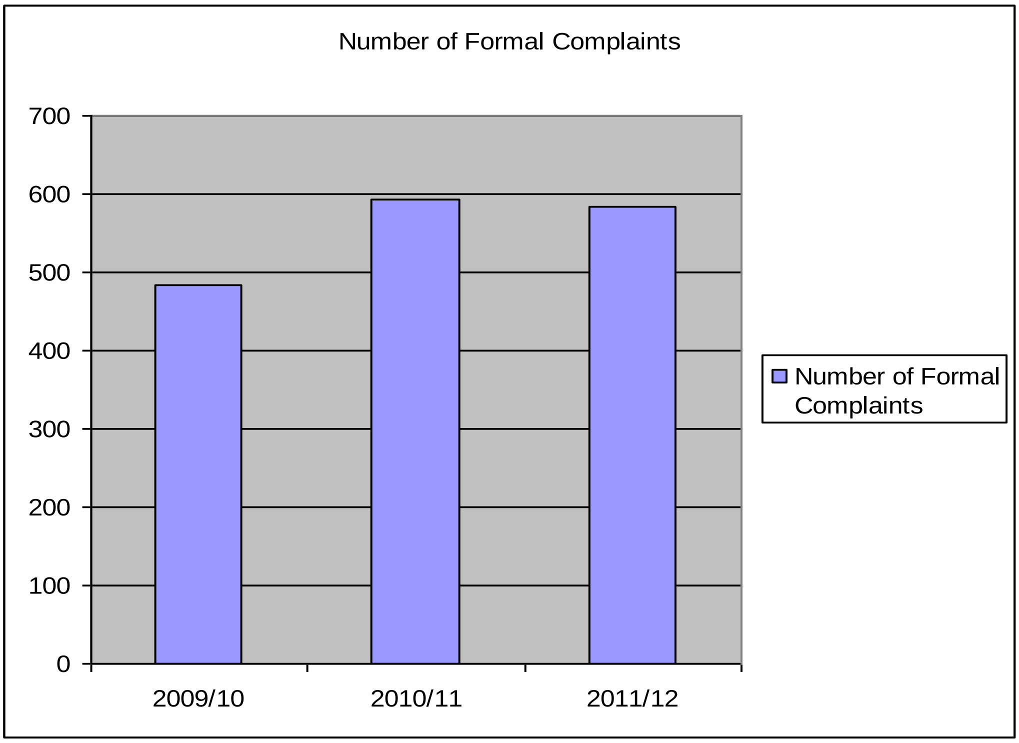



**How we have improved the time we respond to people who make a formal complaint**

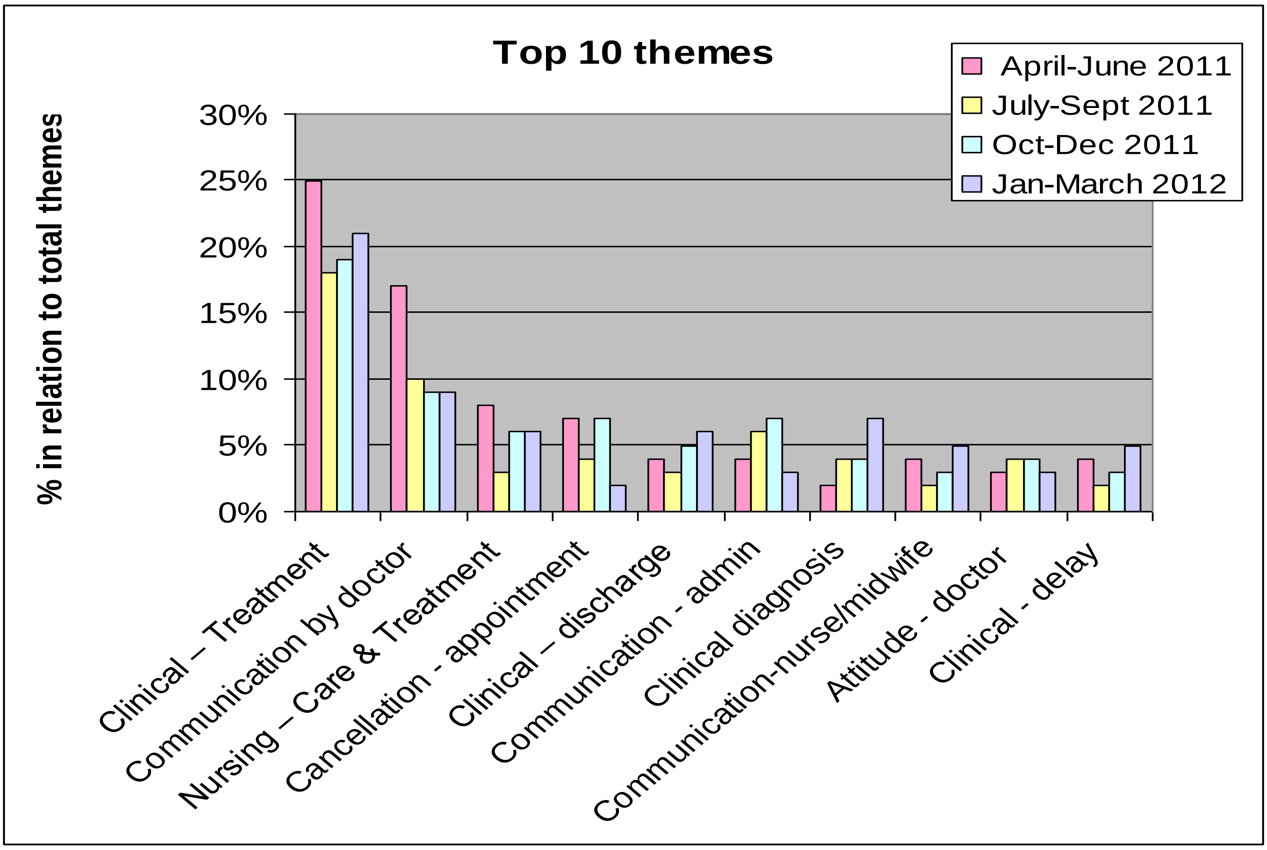
The graph below shows the percentage of people who received a response to their complaint letter within the agreed time frame. Performance was poor at the beginning of the year. An increase in staffing levels and service redesign saw a dramatic increase in the performance. The drop in performance experienced in February and March was in relation to sickness and other competing priorities within the organisation. We have seen more patients admitted and the need for more people to prioritise immediate patient care. We monitor the performance monthly and anticipate an improvement over the coming months.




The graph below shows the number of formal complaints logged for each financial year.




During next year we are working on capturing the lessons learnt from complaints to ensure we learn from what our patients are telling us and are able to make service improvements.




The graph above shows the themes from the letters of complaint for the last year. The percentage is the amount of times each theme was mentioned as a percent of the total subjects mentioned.

## 3.4 An overview of measures

Quality measures that are reported monthly to the Trust Board.

| Integrated Performance Measure | | Reportable to | Threshold | 2011/12 | 2010/11 | 2009/10 | 2008/9 | 2007/08 |
|---|---|---|---|---|---|---|---|---|
| Referral to Treatment: Admitted Patient Care *patients treated within 23 weeks* | | Monitor | 23 weeks | N/A | 94.86% | 94% | 95% | 86% |
| Referral to Treatment: Non Admitted Patient Care *patients treated within 18.3 weeks* | | Monitor | 18.3 weeks | N/A | 98.12% | 98.70% | 99% | 90% |
| Referral to Treatment: Admitted Patient Care *(95th percentile - patients treated within 23 weeks)* | | Monitor | 23 weeks | 18.14 weeks | N/A 95th percentile reportable from 11/12 | | | |
| Referral to Treatment: Non Admitted Patient Care *(95th percentile - patients treated within 18.3 weeks)* | | Monitor | 18.3 weeks | 16.14 weeks | N/A 95th percentile reportable from 11/12 | | | |
| A&E Clinical Quality: Total Time in A&E Dept *(% <4 hour wait)* | SFHFT | Monitor | 4 hours > 95% | 96.21% | 97.70% | 98.70% | 98% | 98% |
| Re-admissions (within 30 days) Emergency | | Internal | - | 7.92% | - | - | - | - |
| A&E Clinical Quality: Unplanned re-attendance rate within 7 days of original attendance | | Internal | =<5% | 6.17% | - | - | - | - |
| A&E Clinical Quality: Left without being seen rate | | Internal | =<5% | 2.09% | - | - | - | - |
| A&E Clinical Quality: Time to Initial Assessment for patients arriving by emergency ambulance (95th percentile - <15 Minutes) | | Internal | =<15 | 49 | - | - | - | - |
| A&E Clinical Quality: Time to Initial Assessment for patients arriving by emergency ambulance (Median Minutes) | | Internal | =<16 | 7 | - | - | - | - |
| A&E Clinical Quality: Time to Treatment (Median minutes wait from arrival to treatment) | | Internal | =<60 | 55 | - | - | - | - |
| Cancer 2 week wait: All Cancers | | Monitor | 93% | 95.32% | 94.20% | 94.40% | 99.80% | 99.70% |
| Cancer 2 week wait: Breast Symptomatic | | Monitor | 93% | 96.39% | 95.10% | 92.80% | - | - |
| Cancer 31 day wait: from diagnosis to first treatment | | Monitor | 96% | 99.60% | 99.60% | 98.80% | 99.30% | 99.80% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cancer 31 day wait: for subsequent treatment - surgery | Monitor | 94% | 98.98% | 97.30% | 94.30% | - | - |
| Cancer 31 day wait: for subsequent treatment - drugs | Monitor | 98% | 99.70% | 99.20% | 99.70% | - | - |
| Cancer 62 day wait: urgent referral to treatment | Monitor | 85% | 89.54% | 89.70% | 84.50% | - | - |
| Cancer 62 day wait: for first treatment - screening | Monitor | 90% | 96.35% | 93.10% | 90.50% | - | - |
| Infection Prevention Control: MRSA Bacteraemia *(No. of cases attributed to Trust)* | Monitor | 0 | 0 | 0 | 14 | 31 | 26 |
| Infection Prevention Control: Clostridium Difficile Infections *(No. of cases attributed to Trust)* | Monitor | 43 | 45 | 54 | 96 | 177 | 324 |
| Access to Healthcare for people with learning disabilities | Monitor | Compliant | | | | | |

## 3.5 What do other people say about this Quality Report?

**Comments from the Overview and Scrutiny Committee**

The committee notified us that they did not intend to review our report this year and therefore we are not expecting any feedback.

**Comments from the Primary Care Trust**

"NHS Nottinghamshire County Primary Care Trust (PCT) monitors quality and performance at the Trust throughout the year. There are monthly quality and performance review meetings and frequent ongoing dialogue as issues arose. A number of visits to wards and other patient areas have taken place in response to in-year issues. The PCT also has an appointed Governor at the Trust therefore enabling us to better understand the views and concerns of public and staff Governors. The information brought together from these different sources has been used to support assessing our level of assurance.

"Towards the end of the year the Trust successfully implemented improvements which have led to the removal of concerns raised by the Care Quality Commission relating to patient records and consent (especially assessments associated with the Mental Capacity Act).

"The Trust continues to demonstrate a high level of commitment to patient safety and experience. This report describes the areas of good practice reported to us and areas of concern we have monitored the Trust against. Including the failure to achieve the required reduction in Clostridium Difficile (an infection acquired whilst in hospital) and the two Never Events. We are assured that the Trust has reviewed its processes and implemented change in response to both issues.

"The Trust has considerable financial challenges in the year ahead and we will seek further assurances of service quality as changes take effect."

**Comments from the Local Involvement Network**

"Overall Nottinghamshire County LINk is impressed with the in-roads that Sherwood Forest Hospitals NHS Foundation Trust has made into infection control, with particular reference to MRSA. However, we are disappointed to find that some of the data is incomplete and inconsistent throughout the document which means we are unable to fully comment on the report. The LINk would like to commend your achievements in the reduction of pressure ulcers, the use of same sex accommodation and your focus on safeguarding".

*Explanatory note: This Quality Report was shared with stakeholders on 10 April for a requested 4 week response, as detailed in the Monitor guidelines. The draft document at that time did not include all year-end figures as they were not available. The LINk have been given the opportunity to comment on a more recent draft, but declined as they did not have a Board meeting scheduled in the required timeframe.*

## 3.6 Statement of Directors' Responsibility in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (quality Accounts) Regulations 2010 as amended 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 preparation of the quality report.

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12
- Papers relating to the quality reported to the board over the period April 2011 to June 2012
- Feedback from the commissioners dated 21 May 2012
- Feedback from the governors dated 24 May 2012
- Feedback from LINks dated 3 May 2012
- The Trust's complaints report published under regulation 18 of the local authority social services and NHS complaints regulations 2009, dated June 2011
- The latest national patient survey dated April 2011
- The latest staff survey dated March 2011
- The Head of Internal Audit's opinion over the Trust's control environment dated April 2012
- CQC quality and risk profiles dated 2011/12
- The quality report presents a balanced picture of the NHS Foundations 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) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

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

**Tracy Doucét**
**Chairman**
29 May 2012

**Martin Wakeley**
**Chief Executive**
29 May 2012