Quality Report
2012/13
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2012/13
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1 INTRODUCTION

1.1 Statement on quality by the Chief Executive

Improving safety, quality and patient experience by putting patients at the heart of everything remains the Trust’s top priority. One of our overarching objectives is to be one of the safest organisations in the NHS by providing the highest quality care to every patient, every time. We aim to treat patients in a way that we would want our loved ones to be treated, by having dedicated staff who are committed to delivering the highest standards of care.

We are mindful of the challenging and changing NHS landscape, which requires greater efficiency, increased activity, greater consistency and innovation to meet the needs of the ageing population. It is our ambition to meet these challenges whilst ensuring we continue to provide the high quality healthcare the people in our localities expect. This is at the forefront of our minds following the publication of the Francis Report in February 2013. Over the coming months, we will take time to consider how we as an organisation need to respond to the recommendations, so we can learn lessons that lead to improvements in care across the healthcare community.

We have made significant progress in recent years, especially in relation to infection control rates, which are amongst the lowest in the country. It has been over three years since the Trust had a case of hospital-acquired MRSA bacteraemia and rates of hospital-acquired Clostridium difficile have reduced significantly and are at our all-time lowest.

There has also been real progress in terms of positive impacts for patients; we have seen a 50% reduction in our avoidable cardiac arrest rates and 95% of our patients are assessed for blood clots. We have successfully appointed a dementia nurse, who is working with lead clinicians to improve the care of patients with dementia. For this year we have increased the number of appropriate staff trained in dementia to 90%.

We are proud to have on-going positive patient feedback in the national ‘Friends and Family’ survey. 84% of our patients consistently say they would recommend King’s Mill Hospital to their friends and family, making us one of the highest scoring Trusts in the Midlands and East region. These results come after the Trust was deemed excellent for the patient environment, privacy and dignity and quality of food in the annual Patient Environment Action Team assessment last year.

We rightly have a duty of candour to be open, honest and transparent about the areas where we need to make improvements. We feel we still have a lot of work to undertake in relation to reducing our mortality and have not made the progress we need. We are driving this important initiative and have made it our top patient safety priority for 2013/14. We have implemented a mortality programme with the aim of reducing hospital mortality rates; priority areas have already seen great improvement. This is led by the Associate Medical Director and reports to the Clinical Governance and Quality Committee, a sub-committee of the Board.

We also feel that we have not sufficiently reduced the number of hospital acquired pressure ulcers. Pressure ulcers are painful and debilitating. We have not performed as we planned in our reduction plan and will make this our second priority for 2013/14.

Following a number of governance concerns and intervention by Monitor, in which the Trust was placed in significant breach of its Terms of Authorisation, the Care Quality Commission (CQC) undertook a responsive visit. As a consequence of their findings, the Trust was found to be compliant in CQC Outcome 4 – Care and Welfare and received a moderate concern in Outcome 16 - Governance. The Trust has taken decisive action to address these concerns and has undergone a number of reviews into quality, governance and finance, with robust plans now in place to reinforce systems and processes. We have strengthened clinical leadership to drive these changes. We are aware that cultural changes are necessary and will be the subject of an organisational development plan.
This year’s Quality Account gives us an opportunity to demonstrate our commitment to continuously reviewing and improving the services we offer. The report gives an honest account of our performance and shows our successes, as well as the areas in which we need to improve.

There are two main priorities in delivering this report:

- To describe our quality priorities for the coming year
- To update our patients, partners and the public on the progress we have made against the priorities that we set last year.

In this Quality Report we share information on the quality of the services we provide in the following three areas:

- Patient safety
- The effectiveness of treatments that patients receive
- Patient experience.

Our priorities for the coming year consider our local and national drivers to reduce avoidable harm, improve our mortality rates and ensure our patients are getting the right care, in the right place, at the right time.

In reflecting back on the previous year I am confident that, and to the best of my knowledge, the information in this report accurately reflects our performance and provides an honest and consistent appraisal of where our plans were delivered, where they were exceeded and where we have struggled to meet our high ambitions. We are not complacent and acknowledge that more work needs to be done in some areas.

The report shares the initiatives and achievements already underway which have made a positive impact on our patients, and demonstrates that we are providing first class care and treatment for our communities.

Eric Morton
Interim Chief Executive
2.0 Our priorities for improvement

2.1 What quality priorities did we set for 2012/13?

In the 2012/13 Quality Account we identified a number of quality improvement priorities to focus upon during 2012/13. Each of these is reported on in more detail under Section 3.

<table>
<thead>
<tr>
<th>QUALITY PRIORITIES 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Patient Safety</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
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<tr>
<td>Patient Experience</td>
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<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

We have indicated in the table whether we feel we met the specific targets that were set for each of these objectives. We fully achieved the majority but there are some that we need more intensive work to deliver in 2013/14. These are reflected within the priorities we have set for the coming year.
2.2 Priorities for 2013/14

We have used the following information to identify our priorities for 2013/14:

- Stakeholders and regulators feedback and comments
- Our national inpatient and outpatient surveys, as well as real time feedback from patients and governors
- Governors and members comments and ideas
- Themes within complaints and PALs
- Internal performance metrics
- Internal and external reviews, eg Board and Quality Governance Review, cancer peer reviews
- Health Service Policy
- Our staff, including clinical teams.

We have recognised that we must improve our governance processes, strengthen our leadership and make the Trust one of the safest organisations in the NHS. Our staff acknowledge that we must drive those priorities that we failed to achieve in 2012/13, whilst also striving to achieve excellence in all areas of care.

Our longer list of priorities for 2013/14 is shown below:

### QUALITY PRIORITIES for 2013/14

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority</th>
<th>Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Reduce pressure ulcers</td>
<td>Local &amp; National priority/High Impact Action/Safety Thermometer/CQUIN</td>
</tr>
<tr>
<td></td>
<td>Reduce harm from falls in hospital</td>
<td>Local priority/High Impact Action/Safety Thermometer/complaints/CQUIN</td>
</tr>
<tr>
<td></td>
<td>Maintain and improve infection control rates</td>
<td>Public feedback/Local priority/High Impact Action</td>
</tr>
<tr>
<td></td>
<td>Ensure midwife to birth ratios are at recommended levels</td>
<td>Public feedback/Local priority/High Impact Action</td>
</tr>
<tr>
<td></td>
<td>Ensure safety of medicines</td>
<td>Local priority/CQC/Local patient feedback</td>
</tr>
<tr>
<td></td>
<td>Minimise the number of inpatient transfers after 10pm for non-clinical reasons</td>
<td>Local priority/staff feedback/PALS and complaints</td>
</tr>
</tbody>
</table>

### QUALITY PRIORITIES for 2013/14

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority</th>
<th>Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Effectiveness</td>
<td>Reduce mortality rates</td>
<td>Local and national patient feedback/Local and national priority/CQUIN</td>
</tr>
<tr>
<td></td>
<td>Improve the care of deteriorating patients</td>
<td>Local priority/local patient and staff feedback/CQUIN</td>
</tr>
<tr>
<td></td>
<td>Ensure safe and appropriate staffing levels</td>
<td>Local and national priority/Francis/CQC</td>
</tr>
</tbody>
</table>
Develop 7 day working across the hospital  
Local and national priority/local patient feedback

Improve communication between the hospitals and primary care  
Local and national priority/local patient feedback/PALS and complaints

Gain staff feedback on whether they would recommend the Trust as a place to be looked after  
Local and national priority/Francis

### Patient Experience

<table>
<thead>
<tr>
<th><strong>Reduce length of stay and readmissions by improving patient flows</strong></th>
<th>Local priority/PALS and complaints</th>
</tr>
</thead>
</table>

Improve elderly care particularly for patients with dementia  
Local and national priority/local and national patient feedback/CQUIN

Ensure end of life care  
Local and national priority/local patient feedback/PALS and complaints/CQUIN

Ensure patients nutrition and hydration needs are met  
Local and national priority/High Impact Action/Francis

Ensure patients are cared for with dignity, compassion and respect  
National priority/PALS and complaints/Francis/CNO Vision

We have utilised the three dimensions of quality to determine and structure our priorities to make progress. These are:

- Patient safety
- Clinical effectiveness
- Patient experience.

As an organisation seeking to deliver high quality services and demonstrate continuous improvement we focussed on principal priorities we believe will drive forward our quality and safety improvement strategy during 2013/14. From our long list we have identified three improvement areas which we would like to give particular focus to:

- **Priority 1 – Improving the effectiveness of care we deliver by achieving a reduction in mortality (HSMR, SHMI and crude mortality)**
- **Priority 2 – Delivering Harm Free Care by reducing hospital acquired pressure ulcers**
- **Priority 3 - To reduce length of stay and readmissions by improving patient flows (i.e. reducing the number of bed movements during the patient’s inpatient stay)**

To be a safe organisation, the Trust requires effective governance at all levels within the Trust. This requires an infrastructure, which ensures that risks to both quality and financial sustainability are identified and well managed. This will ensure that timely actions are taken to improve performance and safety in a sustainable manner. Actions are currently being taken at the Trust to strengthen the governance structure and embed the new systems and processes across the organisation, from ward to Board. This will ensure effective monitoring systems to track progress against each of our key priorities identified below.

The Board of Directors will receive monthly and quarterly quality reports, which identify how the Trust is performing against a range of key performance indicators. The three key improvement areas will be reported at least monthly. This reporting process will be underpinned by a strengthened assurance process, reported monthly at the newly established Clinical Governance & Quality Committee. Our Clinical Commissioning Group colleagues will monitor the progress of these priorities at our monthly Quality and Scrutiny and Clinical Executive Meetings.
Priority 1 – Improving the effectiveness of care we deliver by achieving a demonstrable reduction in mortality – HSMR, SHMI and crude mortality

Why is this a priority?

When we reviewed our most recent Hospital Standardised Mortality Ratio (HSMR) it was reported as 116. This tells us that the number of patients who die at the Trust is higher than would be expected. This is unacceptable so we need to fully understand why this is and take the necessary steps to improve. Although we have made improvements in specific target areas over the past year, e.g. hip fracture pathway, we will work in a focused way to deliver sustained reduction in our mortality rates.

Why do hospitals measure mortality rates?

Mortality rates are one of the indicators of quality of care. They help us understand the risks of hospital treatments for individual patients, changes in the patterns of disease over time and can point to improvements to reduce mortality.

The Trust’s crude mortality rate looks at the absolute number of deaths that occur in a hospital in any given year and then compares that against the number of people admitted for care in that hospital for the same time period.

The Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR) allow us to see whether death rates in hospitals are changing. SHMI data includes in-hospital deaths and deaths within 30 days of discharge. Standardisation allows comparisons for different mixes of illnesses being treated between hospitals and over time. An estimate of the number of expected deaths is calculated for each hospital based on the characteristics of patients admitted. Then the actual number of deaths is compared with this figure giving a “standardised rate”.

The Hospital Standardised Mortality Ratio (HSMR) measures whether the number of people who die in hospital is higher or lower than you would expect for 57 conditions. Each group of patients is looked at to see how often, on average, across the whole country, they survive their stay in hospital, and how often they die after taking into account their age, the illness and issues such as whether they live in a deprived area.

Mortality Programme

There are a number of key work streams which have been identified following analysis of data from Dr Foster Intelligence. Dr Foster Intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public. It is a joint venture with the Department of Health and was launched in February 2006. As a result of mortality case note reviews and investigations into coroner’s cases and serious incidents we have identified a number of key areas to focus upon to improve our mortality.

Our mortality programme will continue to review the leading causes of inpatient deaths contributing the higher than expected HSMR. The work streams we have identified will include the following:

1. Improving clinical care
   - Deteriorating patient
   - Sepsis management
   - Acute kidney injury management
   - Care of pneumonia
   - Acute myocardial infarction (AMI) / congestive cardiac failure pathway
   - Stroke pathway
   - Fractured neck of femur pathway.
2. Refining clinical processes
   - Acute medical admissions
   - Handover
   - Managing results from diagnostic tests
   - Improving ward rounds in line with Royal College guidance
   - Implementing and embedding ‘Care & Comfort Rounds’ (Intentional Rounding).

What we are aiming to achieve in 2013/14?

- To reduce the Hospital Standardised Mortality Ratio (HSMR) by 10%, with a continuous year on year reduction
- To identify the deteriorating patient quickly. We have committed to invest in the VitalPAC system. VitalPAC is an electronic, wireless point of care system, which enables staff to enter patients' physiological observations using hand held devices, which triggers earlier interventions. We believe this will be a key enabler to achieve our mortality reduction ambition. This cannot be relied upon in isolation and will be implemented in conjunction with other initiatives to drive changes in practice.

Actions required for 2013/14

- External, independent expert reviews of pathways and services. The first pathways to be reviewed are our stroke pathway and myocardial infarction pathway
- The appointment of a patient safety lead to drive the patient safety programme forward
- Establish multidisciplinary, multi-professional improvement groups to drive down mortality from the six most common causes of death with a raised mortality rate. They include:
  - Implement an improved process for detection and management of the deteriorating patient (including the implementation and evaluation of VitalPAC)
  - Establish working groups to define and implement best practice for clinical processes such as ward round handover
• Expand the end of life group to include community representation and implement policies to reduce unnecessary admissions to hospital, improve end of life care and expand choices available for patients at the end of their life
• Implement the mortality coding project and ensure its sustainability
• Continue to involve GP commissioners and community colleagues in our mortality work streams.

Monitoring and Reporting

• A mortality steering group will continue to meet monthly to monitor the progress of the various work streams and the programme in its entirety. There is both internal and external representation from a range of stakeholders, with clinicians leading specific pathways/schemes of work
• Progress against the overarching programme will be reported to the Clinical Governance & Quality Committee and to the Board of Directors
• HSMR, SHMI and crude mortality are safety indicators and will be regularly reviewed by the Board via the Clinical Governance and Safety Committee
• A robust action plan is in place; actions are progressing well, with the plan being project managed as part of the Programme Management Office structure.

Nominated Lead: Executive Medical Director

Priority 2 – Delivering harm free care by reducing pressure ulcers

Why is this a priority?

Harm free care is the national programme for the roll out of the Safety Express (a national safety programme). The key principles include; Stop dealing with safety issues in silos, think about complications from the patient’s perspective and aim for the absence of all four harms to each and every patient. This programme was introduced by the National Quality, Innovation, Productivity and Prevention (QIPP) Safe Care Coalition and helps NHS teams in their aim to eliminate harm in patients from four common conditions:

• Pressure ulcers
• Falls
• Urinary tract infections in patients with a catheter
• New venous thromboembolism (VTE).

These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400million.

It is important that we strive during 2013/14 to make significant improvements in the rates of harms associated with these mentioned above. The elimination of avoidable pressure ulcers is a national goal that we believe is right for patients and we have chosen pressure ulcers as a key priority, due to our failure to make a marked difference in 2012/13. The management of pressure ulcers is an indicative measure of the quality and efficacy of care provided to our patients. Our aim is ultimately to eliminate all grade 3 and 4 pressure ulcers that have been acquired under our care.

A pressure ulcer is a localised injury to the skin and/or underlying tissue, usually over a bony prominence such as the ankle, heel, or bottom of the spine as a result of pressure or pressure combined with shear.
It is nationally recognised through the High Impact Actions that the majority of pressure ulcers are avoidable and this is supported by a call to action from the NHS Chief Nursing Officer to reduce this patient harm.

Avoidable pressure ulcers can be classified as pressure ulcers that have developed where there is no or inconsistent evidence that all the preventative plans/actions have been implemented. Pressure ulcers can be classed as unavoidable when all plans and actions are in place and evidenced where an underlying condition impacts on the ability to deliver preventative care.

What we are aiming to achieve in 2013/14?

- To have zero avoidable Grade 4 pressure ulcers
- To reduce avoidable Grade 3 ulcers so that we have zero by March 2014
- To reduce avoidable Grade 2 ulcers by 30%.

Monitoring and reporting

Accurate reporting of pressure ulcers is essential and there are four grades of pressure ulcers classified depending on severity (Grade 1 least severe – Grade 4 most severe). The prevalence of pressure ulcers is monitored through safety thermometer data collection once a month and is captured by daily reporting of the total numbers by our tissue viability team. We also monitor the processes to prevent and manage patients at risk of pressure ulcers through the monthly nursing metrics. Information we gather includes: how many patients are being risk assessed for pressure ulcers and of these, how many patients have care plans in place.

The monthly report generated will be monitored at the Senior Nursing Forum and the Divisional and Service Line operational forums. The Pressure Ulcer Strategy Group will drive the actions and monitor the reduction strategy reports will be provided to the Board of Directors via the Clinical Governance & Quality Committee.

We have developed comprehensive reporting of pressure ulcers using the computerised system which is analysed daily. This enables us to report any Grade 3 or Grade 4 pressure ulcers as serious incidents. From the training and focused work we have already done over the last year, the Trust can provide assurance of high levels of accurate reporting.

Action required

The actions we have identified for the coming year aim to build on the work already achieved and will include the following:
Nominated Lead: Executive Director of Nursing & Quality

Priority 3 - To reduce length of stay and readmissions by improving patient flows

Why is this a priority?

The way we manage patient flows impacts on all of our inpatients and determines both the standard of care they are provided and their experience. The way we manage urgent and emergency care also drives the demand for our hospital and community based services and we must ensure we have efficient and effective processes in place to maximise patient flow so it optimises patient care.

What we are aiming to achieve?

- Ensure all patients have access to the right bed in a timely way.
- Ensure we have the right number of beds in the right places
- Ensure our patients are in hospitals only as long as they clinically need to be
- For patients to receive the best care, by right staff with the necessary skills to manage and support their illness

Monitoring & Reporting

This is a challenging but fundamental ambition and it requires a staged delivery plan that spans not only the coming year but next three years. It is important that, in order to achieve this, we set specific objectives for us to achieve and also work with our community colleagues to commission joint pieces of work to deliver the care our patients require in the right setting. More specifically, in order to monitor the progress of the project we will be using a number of metrics. They include the following:

- Snap shot audits of patient demographics, specialty requirements and location to measure whether we have the right patients in the right beds each month.
- Monthly monitoring of length of stay, readmission rates and discharge delays
- Monitoring of our mortality and patient harm rates
- Staffing numbers and skill mix
- Sickness and Absence
- Readmissions and 4 hour access target performance (Bed Breaches).
**Actions Required**

- With numerous strands to this goal, the initial step is to review the processes on our Emergency Admissions Unit, reconfigure beds and work with primary care to reduce admissions and facilitate access to community services for those patients who are better managed in the community
- Extend our Emergency Department Admissions Avoidance Support Scheme further across both acute sites
- Increase Consultant time to front door and on calls. Already this is underway and about to be increased to having 2 consultants on the night and late shifts on our highest volume days (Monday and Friday).
- Review the proposed blue print for the future commissioning of acute care and frailty work streams.
- Implement a robust Capacity Plan
- Undertake accurate bed modelling and resource allocation to those areas

**Nominated Lead: Clinical Director for Emergency Care & Medicine**

**2.3 Statements of Assurance from the Board 2012/13**

**2.3.1 Mandatory Quality Statements**

All NHS providers must present the following information in their Quality Account. This is to allow easy comparison between organisations. Some of the indicators overlap with our own priorities and will therefore also be discussed in Section 3.

**2.3.2 Review of Services**

During 2012/13 Sherwood Forest Hospitals NHS Foundation Trust provided services across three clinical divisions on four hospital sites equating to 51 mandated services.

Sherwood Forest Hospitals NHS Foundation Trust 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 2012/13 represents 83% of the total income generated from the provision of relevant services by the Trust for 2012/13.

<table>
<thead>
<tr>
<th>How many people did we treat in 2012/13?</th>
<th>Annual Plan</th>
<th>Actual to Month 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective (planned)</td>
<td>34,755</td>
<td>36,454</td>
</tr>
<tr>
<td>Non elective (emergencies)</td>
<td>37,165</td>
<td>40,508</td>
</tr>
<tr>
<td>Outpatients (appointments)</td>
<td>299,795</td>
<td>339,918</td>
</tr>
<tr>
<td>Emergency Care (A&amp;E)</td>
<td>108,887</td>
<td>108,275</td>
</tr>
<tr>
<td>Total</td>
<td>480,602</td>
<td>525,155</td>
</tr>
</tbody>
</table>

** activity volumes above are thus based on the 12 month position to 31st March 2013.

**2.3.3 Participation in Clinical Audit**

Clinical audit is a simple tool to review clinical practice against best evidence standards and then to identify actions to improve the quality of patient care and treatment.
During 2012/13, there were 34 national clinical audits (NCA) and 6 national confidential enquiries (NCE) related to the services we provide at Sherwood Forest Hospitals NHS Foundation Trust. There were 40 that this Trust was eligible to participate in.

During that period we participated in:
- 17 (95%) Mandatory National Clinical Audits,
- 14 (88%) Non-mandatory National Clinical Audits
- 6 (100%) National Confidential Enquiries

Therefore we participated in 37 (93%) of the NCA/NCE we were eligible for. This is an improvement of 11% upon 2011/12.

### National Clinical Audits

<table>
<thead>
<tr>
<th>Service</th>
<th>Title of National Clinical Audit</th>
<th>Mandatory</th>
<th>Participated</th>
<th>% cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>TARN (Trauma Audit &amp; Research Network)</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Adult Community Acquired pneumonia</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Adult Critical Care</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Emergency use of oxygen</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-invasive ventilation</td>
<td>No</td>
<td>Yes</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>National Joint Registry</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Renal Colic</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Blood</td>
<td>Potential donor</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>2012 Audit of blood sampling and labelling</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Oesophago-gastric cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Head and Neck Oncology</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Bowel cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Lung cancer</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac</td>
<td>Vascular surgery NVD</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Cardiac Arrest</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Cardiac Arrhythmia</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Acute Myocardial Infarction MINAP</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Coronary Angioplasty</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Pulmonary Hypertension</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Fractured Neck of Femur (ED)</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>National Hip Fracture Database</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Older people</td>
<td>Stroke National Audit Programme</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
</tbody>
</table>
### National Audit of Dementia

<table>
<thead>
<tr>
<th>Service</th>
<th>Title of National Clinical Audit</th>
<th>Mandatory</th>
<th>Participated</th>
<th>% cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Womens &amp; Children's</td>
<td>Epilepsy 12 (Childhood Epilepsy)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Fever in Children</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Neonatal Intensive and Special Care</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Paediatric asthma</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Paediatric pneumonia</td>
<td>No</td>
<td>Yes</td>
<td>Ongoing *</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>Diabetes (Adult)</td>
<td>Yes</td>
<td>No*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult Bronchiectasis</td>
<td>No</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Diabetes (Paediatric)</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Inflammatory bowel disease</td>
<td>Yes</td>
<td>Yes</td>
<td>Ongoing *</td>
</tr>
<tr>
<td></td>
<td>Pain Database</td>
<td>Yes</td>
<td>Yes</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Notes
*Please note – where there are a small number of 2012/13 audits on-going where we are actively submitting cases during March- May 2013 – it is anticipated that we will submit 100% of the required cases for these audits.

1. **National Adult Diabetes Audit** – The Trust remains unable to participate in the National Diabetes Audit (Adults outpatients) as it does not have an electronic medical record for the extraction of required diabetes data which the service have been working to resolve for since last year. The Trust has however participated in some of the National Diabetes audit work such as the national diabetes in-patient audit 2012 and the Paediatric Diabetes audits 2012.

### National Confidential Enquiries

<table>
<thead>
<tr>
<th>National Confidential Enquiries 2012/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study title</strong></td>
</tr>
<tr>
<td>Asthma Deaths</td>
</tr>
<tr>
<td>Alcohol Related Liver Disease</td>
</tr>
<tr>
<td>Subarachnoid haemorrhage</td>
</tr>
<tr>
<td>Tracheostomy Care</td>
</tr>
<tr>
<td>Child Health</td>
</tr>
<tr>
<td>Maternal infant and perinatal</td>
</tr>
</tbody>
</table>

### Clinical Audit Activity

The completed reports and action plans of 2 national clinical audits and 13 local clinical audits were reviewed by various committees / clinical governance forums within Sherwood Forest Hospitals NHS Foundation Trust during 2012/13. The Trust has taken the following actions to improve the quality of healthcare provided:

- Community acquired pneumonia teaching/education sessions for junior doctors have been improved.
- There has been an increase in senior doctor involvement and junior doctor and nurse training to effectively manage patients receiving Non-Invasive Ventilation.
- We have reviewed how the Bereavement Centre works with new processes implemented.
- Using a standardised template we have improved how operative notes are recorded within the Breast service.
- New training has been initiated for community midwives to ensure they are aware of developments in routine enquiry for domestic abuse.
- A Trust wide review of nursing documentation has begun to improve and streamline the paperwork that nurses complete, thereby improving the quality of nursing notes.
The paediatric service have reviewed admissions against Royal College standards and are making changes to the rota to ensure children are seen in a timely manner, avoiding unnecessary delays and admissions.

We are planning to laminate new paediatric referral criteria for all Emergency department staff

We have written new Trust guidelines for the use of antibiotics in paediatric appendectomy patients.

### 2.3.4 Participation in Clinical Research

2012/13 has seen Sherwood Forest Hospitals NHS Foundation Trust participating in 187 studies, which are being actively recruited to. This is a combination of National Institute of Health Research portfolio adopted and non-adopted studies (these predominantly being towards educational awards.)

Our aim is to increase the number of studies we are actively recruiting to by 10% with a focus on attracting the commercial sector. We currently have 7 commercial studies with a target of opening a further two within the next year.

There are changes within the wider national research arena so we need to streamline our governance processes in line with the Health Research Authority’s plans.

Senior members of the research team attend meetings across the wider Trent region to ensure the Trust is engaged in the change process.

We have designated clinical leads for research and innovation and a strong central research team which comprises of 16 whole time equivalent staff, five of whom are employed on Honorary contracts: four with contracts with Mid Trent Cancer Research Network and one with a contract with the Stroke Research Network.

The Trust is actively involved in clinical research. This provides access to new treatments for local people but also supports advances in clinical care. The number of patients receiving relevant health services provided or sub-contracted by Sherwood Forest Hospitals NHS Foundation Trust in 2012/13 recruited to participate in research approved by the Research and Ethics Committee, was 1146. This is higher than last year when the recruitment total was 932. The Research & Innovation department target for 2013/14 is to increase on this figure.

The team proactively seek patients from all clinical areas including in and outpatient departments. They actively seek to involve clinical staff to ensure they are fully aware of the studies and the activity that is undertaken in their area. There are a number of different research networks including the Medicines for Children Research Network, Stroke Research Network, Mid-Trent Cancer Research Network, and the Comprehensive Clinical Research Network.

During 2013/14 the Research & Innovation Department will be working collaboratively with colleagues and clinicians across the Trust to maximise innovation. The aim is to benefit patients, improve care and capitalise on potential commercial opportunities. We have engaged with an external service provider to develop the required policies and procedures to achieve maximise potential in this area.

### 2.3.5. Use of the CQUIN Payment Framework

In 2012/13 a proportion of our income (£2.7m), was conditional upon us achieving Commissioning for Quality and Innovation (CQUIN) goals agreed between commissioners (NHS Nottinghamshire County Primary Care Trust) and ourselves. We received payment for 100% of this.

A proportion of Sherwood Forest Hospitals NHS Foundation Trust’s income in 2012/13 (£4.5m), was conditional upon achieving Commissioning for Quality and Innovation (CQUIN) goals agreed between commissioners (NHS Nottinghamshire County Primary Care Trust) and ourselves through the Commissioning for Quality and Innovation payment framework.
During 2012/13 the goals included:

- Improvements in risk assessment and prophylaxis treatment for blood clots (venous thromboembolism or VTE)
- Improvements in patient experience against 5 specific questions relating to privacy, medication and communication.
- Improvements in the care of patients with dementia
- Increase in the number of staff trained in dementia
- Collection and submission of the Safety Thermometer data which captures how the Trust is performing in relation to patient harms (pressure ulcers, falls, catheter associated urinary tract infection and VTE)
- Collection of feedback on whether patients would recommend the Trust to family and friends (also known as the net promoter score).
- An improvement in care for in-patients with diabetes through implementation of the 'Think Glucose' initiative
- Reduction in avoidable cardiac arrest rates
- Improved pathways of care for patients with learning disabilities
- Implementation of patient streaming targets within the Emergency Department and the establishment of a Clinical Decisions Unit
- Improving 'end of life' care by ensuring we are informing GP’s of patients on the end of life pathway

The Trust also had a number of specialised CQUIN targets, which included:

- Establishment of clinical dashboards to enable data to be submitted from specific specialties
- Improvements in communication with GPs for HIV patients
- Improvements in catheter-related infection rates for neonates

Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at [http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

### 2.3.6 Statements from the Care Quality Commission (CQC)

Sherwood Forest Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is showing a moderate impact in relation to Outcome 16 - Assessing and monitoring the quality of service provision. The Trust is compliant in all other standards.

Sherwood Forest Hospitals NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Sherwood Forest Hospitals NHS Foundation Trust during 2012/13.

In July 2012, Sherwood Forest Hospitals NHS Foundation Trust participated in a Special Review by the Care Quality Commission relating to termination of pregnancy. These were national inspections and for Sherwood Forest Hospitals NHS Foundation Trust we are pleased to report there were no compliance issues identified.

Sherwood Forest Hospitals NHS Foundation Trust participated in one responsive unannounced visit. This followed the discovery and announcement of issues relating to oestrogen receptor testing. It took place in October 2012 and was jointly conducted by the CQC and the Royal College of Pathologists. The visit conducted by the Royal College of Pathologists (RCP) concentrated on the Histopathology Department. The CQC visit was broader and reviewed the quality of care with regards to:
The CQC report for the Trust was published in April 2013 and shows the Trust to be compliant in Outcome 4; however the Trust needs to strengthen Governance structures and processes within the hospital. The CQC rated this to be of a moderate impact to patients (Outcome 16). The Trust is implementing actions to address these findings.

The visit to histopathology, identified problems with the organisation and quality governance within the department. In addition, issues related to national quality control and standardisation of oestrogen receptor testing was identified and will be addressed.

A responsive announced visit took place in March 2013. This visit was undertaken by ionising radiation (medical exposure) regulations, IR (ME) R, inspectors on behalf of the CQC.

The CQC visit reviewed the radiology services at King’s Mill Hospital site. Initial feedback from the visit requested a further audit review of the service in relation to radiation exposure, which has been subsequently produced. At the time of writing the Annual Quality Report the audit has been prepared for Board approval.

Internal assurance visits and the 15 steps

We commenced the Guardians of Care and Internal Assurance Team visits in 2012. This is an internal framework for monitoring the Trust and involves surveying the wards to identify areas of concern or good practice and feed back to ward sisters/charge nurses on the same day. This facilitates responsive actions to be taken and, importantly it also acknowledges good practice so that this is shared. The visits are done by teams of staff comprising executive directors, non executive directors, managers, clinical staff and governors. In 2013 we will be including patient representatives in the visits. The teams undertake walkabouts to look at specific quality outcomes and they also use the ‘15 steps’ developed by the NHS Institute for Innovation & Improvement. This tool enables us to look at areas through the patient’s eyes to assess things like how welcoming the ward is, how clean it appears, how friendly the wards are. We have seen many benefits since introducing these visits including an increased staff awareness of patient quality, improved visibility of senior staff and the opportunity for clinical teams to discuss their clinical area and any concerns.

2.3.7. NHS Number and General Medical Practice Code Validity

Sherwood Forest Hospitals NHS Foundation Trust submitted records during 2012/13 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:

<table>
<thead>
<tr>
<th>% of records in 2012/13 including the Patient’s NHS Number &amp; GP Code</th>
<th>Valid NHS number</th>
<th>Valid general Medical Practice Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>For admitted patients care</td>
<td>99.29%</td>
<td>99.75%</td>
</tr>
<tr>
<td>For out-patients care</td>
<td>99.85%</td>
<td>99.84%</td>
</tr>
<tr>
<td>For emergency care (A&amp;E)</td>
<td>97.82%</td>
<td>98.63%</td>
</tr>
</tbody>
</table>

Note - The validity is 100% of records submitted, the % above indicates some are "missing / unknown".
2.3.8 Information Governance (IG) Toolkit Performance

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

Sherwood Forest Hospitals NHS Foundation Trust’s Information Governance (IG) assessment report overall score for 2012/13 was 72%. This was graded as ‘Green’ – ‘Satisfactory’. There is a requirement for all IG Toolkit standards to achieve Level 2 or above for the Trust to be graded as green. We intend to maintain this standard for 2013/14 by undertaking the following actions:

- Ensure IG remains a mandatory annual training requirement for all staff
- Building on the establishment of Information Asset Owners and Administrators to ensure that there are responsible officers in each Division to support the embedding of IG principles within the Trust
- Developing a formalised programme of information asset risk assessment, providing assurance from each Division that information assets are actively reviewed
- Development of the Outcome Guardian role in relation to ‘Outcome 21 – Records’ to support the current CQC initiative. This involves carrying out ‘spot checks’ of staff knowledge and regular audits of wards/service areas.

Data Quality

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 to 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 year
- 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 Patient Administration System
- Any new member of staff or existing staff receives data quality awareness
- There are monthly data quality meetings which will discuss forthcoming information standards notices, data recording, secondary users’ dashboard and training documentation.

2.3.9 Clinical Coding Error Rate

Sherwood Forest Hospitals NHS Foundation Trust was subject to the Payment by Results Clinical Coding Audit, during the period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment were 4%. The Trust’s commissioners requested that both admitted patient and outpatient coding was audited.

This audit was focused on stroke patients for admitted patient care and ear, nose and throat patients for outpatient attendances. A random sample of these patients was provided from activity in Quarter 1 2012. A total of 54 spells of admitted patient care and 150 outpatient attendances were audited.

In the sample of admitted patient care spells audited, there were no errors affecting payments and the pre audit and post audit price remained unchanged. The performance of the Trust, measured against the number of spells with an incorrect payment, would place the Trust in the best performing 25% of Trusts compared to last year’s national performance. However, it should be noted that this is a targeted sample for stroke activity only.
In the sample of outpatient attendances audited, the Trust had 4% of attendances with an error that affected the price. The performance of the Trust, measured against the number of attendances changing payment due to errors in attendance details, would place the Trust in better than average, but not in the top 25% of Trusts compared to the last time the Audit Commission undertook a national audit of outpatient data (2008-2010).

2.4 Additional indicators required for the quality account for 2012/13

This year, Trusts have been asked by the Department of Health to report on additional indicators showing information for 2011 and 2012.

2.4.1 Summary Hospital Mortality Indicator (SHMI) and palliative care

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:

- We have made changes to palliative care provisions within the Trust to ensure the correct coding is recorded.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:

- Our rate of palliative care coding is just below the national average and in an acceptable position. The table below shows an increase in the % of deaths coded as palliative care. This reflects some of the work we have done this year to improve our coding.

| Patients Deaths Coded as Palliative Care (data from the Health & Social Care Information Centre) |
| Year | % of deaths | National Average % | Lowest National % | Highest National % |
| July 10 to June 11 | 7.6 | 16.1 | 0.1 | 40.1 |
| July 11 to June 12 | 15.4 | 18.2 | 0.3 | 46.3 |
| July 12 to Sept 12 | 15.7 | 19.0 | 0.2 | 43.3 |

Note: Data from the Health & Social Care Information Centre is only up to September 2012 as SHMI data beyond this date is not available to report on at the present time

The table below shows how we are banded for SHMI. A SHMI value is calculated for each Trust. The baseline SHMI value is 1. A Trust would only get a SHMI value of 1 if the number of patients who die following hospitalisation was exactly the same as the number of patients expected to die based on the SHMI methodology. Trusts are categorised into one of the following three bandings:

1 – Where the Trust’s mortality rate is ‘higher than expected’
2 – Where the Trust’s mortality rate is ‘as expected’
3 – Where the Trust’s mortality rate is ‘lower than expected.

The table shows that we have a score of 2 which is rated ‘as expected’:

| SHMI Banding (data from the Health & Social Care Information Centre) |
| Year | Value | Banding |
| July 10 to June 11 | 1.0206 | 2 |
| July 11 to June 12 | 1.053 | 2 |
| July 12 to Sept 12 | 1.07 | 2 |
Note: Data from the Health & Social Care Information Centre is only up to September 2012 as SHMI data beyond this date is not available to report on at the present time.

2.4.2 Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from their perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre and post-operative surveys.

PROMs have been collected by all providers of NHS-funded care since April 2009. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires.

The table below shows how Sherwood Forest Hospitals NHS Foundation Trust is performing. We consider that this data is as described for the following reason:

- PROMs data is always collated retrospectively and therefore the last complete year is 2012/13. Monthly performance updates are received from the national PROMs team.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:

- Continuing to encourage and collate PROMs related data for submissions to Hospital Episode Statistics (HES)
- Promoting the completion of PROMs returns during the pre-operative episode of care
- Interrogating the national database at provider and consultant level to determine variance in participation rates and then agree actions to improve returns
- Introduce new questionnaire forms
- Review the vein patient pathways and PROMs communication
- Review the hip replacement pathway to identify why we performed below the average in this area during 2012/13.

National data is not yet available for 2012/13 and the table below indicates data for 2012/13. We will seek the latest figures over the coming months to inform the work we are doing to improve these patient pathways.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin Hernia Surgery</td>
<td>0.84</td>
<td>0.88</td>
</tr>
<tr>
<td>Varicose vein surgery</td>
<td>0.83</td>
<td>0.84</td>
</tr>
<tr>
<td>Hip replacement surgery</td>
<td>0.56</td>
<td>0.78</td>
</tr>
<tr>
<td>Knee replacement surgery</td>
<td>0.73</td>
<td>0.71</td>
</tr>
</tbody>
</table>

2.4.3 Patients readmitted to a hospital within 28 days of being discharged

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:

- This data includes all readmissions within 28 days regardless of reason and is lower than the national average. The Trust is working towards reducing avoidable emergency re-admissions to hospital within 28 days of discharge to 1.75%. Avoidable emergency re-admissions are measured using clinician to clinician audit of case notes.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:
• Implementing GP telephone access to senior clinical opinion scheme
• Introduction of a clinical decision unit to enable patients to be seen, treated and discharged without being admitted to a general ward
• Strengthening the surgical admissions unit to enable direct access to surgical specialist, timely decisions and where appropriate discharge home
• Introducing an increased range of ambulatory care services at the front door (geriatrics, cardiology, diabetes and respiratory medicine.

Uploaded data to the national database tells us the percentage of patients re-admitted. This is broken down by age. This allows a comparison of the national average along with the lowest and highest percentage achieved within Trusts - see table below. This data is only available for 2012/13.

<table>
<thead>
<tr>
<th>% of Patients Readmitted to Hospital within 28 Days of being Discharged (data from the Health &amp; Social Care Information Centre)</th>
<th>Year</th>
<th>%</th>
<th>National Average</th>
<th>Lowest % NHS FT</th>
<th>Highest % NHS FT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged 0-14 readmitted to hospital within 28 days of being discharged</td>
<td>2012/13</td>
<td>8.92%</td>
<td>10.15%</td>
<td>3.19%</td>
<td>14.62%</td>
</tr>
<tr>
<td>Patients aged 15 or over readmitted to hospital within 28 days of being discharged</td>
<td>2012/13</td>
<td>11.10%</td>
<td>11.42%</td>
<td>7.37%</td>
<td>14.09%</td>
</tr>
</tbody>
</table>

As we only have data for 2012/13 from the national database we have supplied the Trust main information for 2011-13 to show comparative data of the total percentage of re-admissions (within 30 days). As a Trust we typically measure readmissions within 30 days.

<table>
<thead>
<tr>
<th>% of Patients Readmitted to Hospital within 30 Days of being Discharged</th>
<th>Year</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Total % Re-admissions</td>
<td>11/12</td>
<td>8.33%</td>
<td>8.81%</td>
<td>7.86%</td>
<td>7.54%</td>
<td>8.58%</td>
<td>8.31%</td>
<td>8.66%</td>
<td>7.94%</td>
<td>8.67%</td>
<td>8.76%</td>
<td>9.12%</td>
</tr>
<tr>
<td>12/13</td>
<td>9.73%</td>
<td>8.89%</td>
<td>9.52%</td>
<td>9.07%</td>
<td>9.32%</td>
<td>9.89%</td>
<td>9.48%</td>
<td>8.87%</td>
<td>9.37%</td>
<td>9.27%</td>
<td>9.12%</td>
<td></td>
</tr>
</tbody>
</table>

2.4.4 Responsiveness to the personal needs of patients

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:

• The data has been consistent and within the Strategic Health Authority average percentage.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:

• Continuing to strive to maintain this level of positive feedback.

Table to show average scores in relation to the 5 patient experience questions (2003-2012)
2.4.5 Staff who would recommend family/friend to receive treatment at our Trust

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:
- In our most recent staff survey for 2012/13, 70% of staff said they would recommend our Trust for family or friends to receive treatment. This is a deterioration on our 2012/13 result in which we recorded 73% in this question. This therefore remains a key priority for 2013/14.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:
- Implementing a communications strategy – ‘reminding staff of all the good things they have achieved and what they should be proud of’
- Developing an organisational development plan to secure improvements in staff engagement, development and job design
- Introducing quarterly staff surveys to assess views of staff in relation to key issues
- Enhancing communication and engagement with staff as referenced in the communications strategy.

The table below shows the reduction in our score in 2012. This is an on-going priority for 2013/14 and we describe how we are going to do this within Section 3.

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
<th>Average % Acute Trusts</th>
<th>Lowest % Acute Trusts</th>
<th>Highest % Acute Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff survey 2011</td>
<td>73%</td>
<td>62%</td>
<td>33%</td>
<td>89%</td>
</tr>
<tr>
<td>Staff survey 2012</td>
<td>70%</td>
<td>63%</td>
<td>54%</td>
<td>72%</td>
</tr>
</tbody>
</table>

2.4.6 Venous thromboembolism (VTE)

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:
- We have a robust monitoring process for uploading the data into the Health & Social Care Information Centre. We also collect data to support the VTE CQUIN. We are able to use both of these data sets to cross check for consistency and accuracy.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:
- Exploring electronic systems for VTE risk assessment that increase compliance and provide more accurate monitoring processes than at present. The introduction of VitalPAC (described earlier) will enable this action to be implemented.
25%

Percentage of Patients Risk Assessed for VTE in 2011-2013, Against National Average (data from the Health & Social Care Information Centre)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of Patients Risk Assessed</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/2012 (Oct 11 to Mar 12)</td>
<td>91.8%</td>
<td>92.1%</td>
</tr>
<tr>
<td>2012/2013 (Apr 12 to Dec 12)</td>
<td>94.0%</td>
<td>94.0%</td>
</tr>
</tbody>
</table>

For 2012/13 our average compliance for VTE assessment was 94%. During quarter 3 and 4 it was 95%.

### 2.4.7 Clostridium difficile

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:
- It is part of the mandatory surveillance within the Department of Health guidance
- It is a Key Performance Indicator for the Trust and the data is checked by the Infection Prevention and Control team prior to submission.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:
- Implementing weekly *C. difficile* multi-disciplinary team meetings including consultant gastroenterologist, microbiologist and infection prevention and control nurse attendance
- Encouraging accountability and ownership of the *C. difficile* strategy across the Trust
- Improving our use of the Root Cause Analysis (RCA) tool as a learning tool
- Continuing with the two step algorithm for testing stool samples which was implemented in April 2012 in accordance with Health Protection Agency (HPA) guidance, to improve the diagnosis and patient outcome
- Ensuring on-going Hospital Antibiotic Prudent Prescribing Indicator (HAPPI) audits to monitor and manage prudent antimicrobial stewardship
- Raising awareness at ward level to support early recognition of possible *C. difficile* cases.

<table>
<thead>
<tr>
<th>C. difficile Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>2011/2012 (Apr 11 to March 12)</td>
</tr>
<tr>
<td>2012/2013 (Apr 12 to March 13)</td>
</tr>
</tbody>
</table>

### 2.4.8 Patient safety incidents reported resulting in severe harm or death

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason:
- The Trust promotes the reporting of incidents and has seen an increase in the number of incidents reported as staff are actively encouraged to report all levels of incidents and near miss events
- Incidents are reported electronically and can be submitted anonymously in line with the Trust’s Whistleblowing Policy; this allows staff the facility to raise concerns without the need to identify themselves.
Levels of incident reporting at Sherwood Forest Hospitals NHS Foundation Trust for 2011-2013 (data from the Health & Social Care Information Centre)

<table>
<thead>
<tr>
<th>Year</th>
<th>Sherwood Forest Hospitals NHS Foundation Trust</th>
<th>Comparison with other Medium Acute Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Incidents</td>
<td>Rate per 100 Admissions</td>
</tr>
<tr>
<td>2011/2012</td>
<td>2,573</td>
<td>6.42</td>
</tr>
<tr>
<td>2012/2013</td>
<td>2,941</td>
<td>7.43</td>
</tr>
</tbody>
</table>

This data reflects figures uploaded to the Health and social Care Information Centre. Three serious incidents were reported locally and not captured within national data. Work is being done to reconcile this. Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:

- The Trust is investing in governance structures and processes to improve risk and safety management. We will be actively training staff in risk management, reporting of incidents and investigation management as part of the new governance support unit
- The Trust is working to embrace the necessity for us to learn from incidents, complaints and patient stories
- Undertaking a concentrated piece of work to address our governance structures from ward to Board to improve the analysis and learning from incidents.

Were there any whistleblowing incidents?

During this reporting period no whistleblowing incidents have been reported. The Trust has revised the Whistleblowing Policy; ensuring staff have the opportunity to review this current version. The Policy has been communicated through senior managers and importantly to individuals in the Trust through e-communications, bulletins and the staff intranet

The Trust is considering the use of external whistle blowing support to provide an alternative medium for staff to raise concerns.

3.0 Looking back at 2012/13: Quality Review

This section includes a range of information relating to the Trust’s quality performance in 2012/13. Whilst this is not an exhaustive list it gives an overview of the Trust’s performance in both hospital-wide and service specific indicators. It will focus particularly on the goals that were set in last year’s Quality Account, which were:

**Patient Safety:**

- To reduce hospital acquired infection rates for *C. difficile*
- To meet the 2013/14 pressure ulcer targets
- To reduce patient safety incidents and those resulting in severe harm or death
- To deliver safe, harm-free use of medicines.
Clinical Effectiveness:

- Mortality - to reduce our Summary Hospital Mortality Indicator to 97
- To reduce avoidable emergency readmissions to hospital within 28 days of discharge
- To meet the 95% target that patients are risk assessed for venous thromboembolism
- To improve the inpatient diabetes service and implement ‘Think Glucose’.

Patient Experience:

- To meet the friends and family test (net promoter score) requirements
- To improve the quality of care for patients living with dementia
- Increase the number of staff who would recommend our hospital to family and friends.

3.1 Patient safety indicators

3.1.1 Harm free care – reducing hospital acquired infection rates (principally *C. difficile*)

**What did we set out to achieve:** To reduce hospital acquired *C. difficile* year on year. For 2012/13 we aimed to reduce the number of cases to below 36.

**Progress:** Target achieved

**Outcome:** 29 patients experienced an episode of Trust acquired *C. difficile*

**In order to achieve this we set out to:**

- Continue the delivery and monitoring of our *C. difficile* action plan
- Improve antimicrobial prescribing through the introduction of our antimicrobial policy and undertaking specific audits
- Implement new antibiotic guidance
- Implement external peer review recommendations
- Implement a continual programme of education, to maintain a sustained improvement
- Continue delivery of rapid actions following identification of *C. difficile* cases
- Undertake root cause analysis (RCA) and the interrogation of individual cases, ensuring we embed the lessons learnt from individual cases.

The graph below gives a comparison of how we performed in 2012/13 and 2012/13:

*C. difficile* infections reported April 2011 to March 2013
Improvements achieved:

- The infection control team have continued to train our staff to recognise and promote sustained prevention of infection
- They have developed guidance and support to staff so that clear standards are maintained
- The 2012 inpatient survey recently showed an improvement in the availability of hand gel across our Trust
- We have further developed the investigation process by retrospectively reviewing the *C. difficile* cases from 2012/13. Consequently this has improved infection control measures for 2012/13
- Investment in the early identification of patients who are admitted to hospital has been enhanced with responsive action taken to maximise prevention of infection control.

Monitoring and reporting for sustained improvement

- All progress is reported to the Infection Control Committee. The infection control profile is maintained through an infrastructure of link nurses; their role being to maintain standards at ward level alongside ward sisters
- Our commitment to recognising the challenges that prevention of infection presents, is discussed at a bi-weekly meeting. Attendance includes matrons, ward sisters/charge nurses, microbiologists, infection control specialists and clinicians. This multi-disciplinary forum reviews results from audits and investigations and agrees actions. It is instrumental in establishing subsequent learning
- The Clinical Governance Committee receives the Trust’s Infection Control Annual Report which provides additional assurance regarding the Trust’s infection control performance, detailing outputs from 2012/13.

Further improvements identified

Our target for 2013/14 is 25 hospital acquired *C. difficile* cases or less. This will be an extremely challenging target but one that we will tackle proactively. To prepare for this reduced trajectory we are currently:

- Undertaking an independent review of all 29 case reports – identifying themes and trends which may not have been identified within individual cases
- Continuing to strengthen the management of antibiotic prescribing
- Obtaining an external assessment of the Trust’s best practice recommendations from the newly appointed microbiologist.

3.1.2 Performance against other infection prevention and control initiatives:
MRSA performance

What did we set out to achieve: To have zero cases of hospital acquired MRSA bacteraemia

Progress: Target achieved

Outcome: Three years since the Trust experienced a hospital acquired MRSA bacteraemia.
Urethral catheter associated infections

What did we set out to achieve: To reduce the incidence rate of Trust apportioned urethral catheter associated bacteraemias (blood borne infections) to less than 40 cases per year.

Progress: This target has been achieved

Outcome: The number of Trust apportioned urethral catheter associated bacteraemias has reduced from 40 in 2010/11 to three in 2012/13. The graph below shows the breakdown.

These improvements along with many others have resulted in significant results in relation to infection prevention and control for the last three years. The Trust is proud of this achievement and will work hard to sustain and improve upon this good work during 2013/14.

3.1.3 Pressure ulcer reduction

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.

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.

A Description of Pressure Ulcer Categories

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>Reddening of the skin</td>
</tr>
<tr>
<td>Grade 2</td>
<td>Blister or superficial break in the skin</td>
</tr>
</tbody>
</table>
What did we set out to achieve: To deliver harm free care by eliminating avoidable Grade 2, 3, and 4 pressure ulcers

In order to achieve this we set out to:
- Implement the safety thermometer for scoring/assessment (The NHS Safety Thermometer provides a quick and simple method for ward staff to survey patient harm on a monthly basis)
- Develop and implement a pressure ulcer reduction strategy
- Implement the Safe SKIN prevention bundle (this is a comprehensive care assessment and assists the nursing staff to formulate a specific care plan that meets the individual needs of patients)
- Strengthen the pressure ulcer steering group
- Ensure attendance at local and regional engagement events
- Work alongside Strategic Health Authority experts and intensive support teams to build capabilities within the project team and learn from other Trusts on how they approach this agenda.

Progress: We failed to meet this target

Outcome: We made progress to reduce pressure ulcers during 2012/13 (refer to table below) but we have seen an increase during Quarter 4 (January to March 2013), hence why we have identified this as a key priority for 2013/14. We recorded two grade 4 pressure ulcers in this reporting period. Grade 4 pressure ulcers are unacceptable.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
<th>Number of Hospital Acquired Pressure Ulcers recorded in 2012/13</th>
<th>Number of Hospital Acquired Pressure Ulcers recorded in 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1 (requirement to record this grade from May 2012)</td>
<td>Reddening of the skin</td>
<td>Not recorded</td>
<td>47</td>
</tr>
<tr>
<td>Grade 2</td>
<td>Blister or superficial break in the skin</td>
<td>219</td>
<td>207</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Full thickness of skin</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Grade 4</td>
<td>Involving muscle or bones</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Improvements achieved:

The graph below shows the number of pressure ulcers recorded for patients at the time of admission and 72 hours after admission:
Overall we have seen a slight increase in the level of reporting (as shown in the graph below). This could illustrate that staff awareness is improving and it could also be indicative that actual numbers of pressure ulcers are increasing (Quarter 4). We now record all grade one pressure ulcers to enable learning in relation to prevention.

Number of Pressure Ulcers reported April 2011 To March 2013

We monitor the number of inpatients who have undergone the pressure ulcer risk assessment and we consistently achieve > 95% compliance with this measure. This ensures we instigate the necessary prevention goals. We will work to continue this level of compliance next year.

Throughout the Trust all clinical areas now contribute to monthly pressure ulcer data collection. Wards and departments display information in their areas that shows how they are doing. The pressure ulcer steering group meets monthly and has developed a pressure ulcer strategy and a work programme which has been implemented throughout the Trust. The group has adopted and implemented the national SKINS tool which assesses and measures the individual patient requirements in regards to pressure ulcer avoidance.

The Trust has supported a pressure ulcer champion who has been an active member of a peer review team that has provided specialty advice and shared good practice both regionally and nationally. The Trust has actively contributed to the SHA pressure ulcer collaborative programme.
Further improvements introduced in 2012/13

- Introduction of a regional shared learning system where all Grade 3 and 4 pressure ulcers occurring prior to hospital admission are reported back to each organisation
- Achievement of 93% in the Essence of Care Pressure Ulcer Benchmark
- The tissue viability team have developed a more focused approach to care delivery providing bedside education and specialist advice to patients and the ward staff
- Introduction of photography of all grades 2 pressure ulcers and above
- Nottingham University Hospitals NHS Trust team invited into the Trust to peer review standards of pressure ulcer delivery and documentation in light of the work they have done at their Trust.
  - All pressure ulcer prevention and care documentation has been reviewed
  - Recruitment of a tissue viability nurse consultant

Monitoring and reporting for sustained improvement

The pressure ulcer steering group meets monthly and reviews all grades of pressure ulcers with the associated Root Cause Analysis (RCA). Key themes and learning from this forum are disseminated throughout the Trust to develop standards and the quality of care to minimise and avoid the risk of pressure ulcers.

The monitoring of these targets requires a consistent sustained commitment and the utilisation of quality metric tools used within the Trust, such as Essence of Care, safety thermometer, specific audits alongside prevalence surveys and quality nursing metrics. These audits support us to initiate improvements in this challenging and fundamental area of care.

Further improvements identified

Our ambition is for no patient to experience avoidable pressure ulcers - this will remain a key priority for 2013/14. We have discussed the key elements of our pressure ulcer reduction strategy in section 2 above.

3.1.4 Improve the care of deteriorating patients and reduce the rate of patient safety incidents that result in severe harm or death

The Trust has a rapid response system in place that ensures an escalation of care for patients who become acutely ill. We identified this as a key priority last year and have undertaken further work to enhance the care of deteriorating patients.

What did we set out to achieve?
- To improve the reporting of serious incidents as a high reporting Trust (which denotes a healthy organisation)
- To reduce the percentage of patient safety incidents resulting in severe harm or death

Progress: We met this ambition but further work is required

Outcome: Between April and September 2012 there were no incidents resulting in severe harm or death.

Total Number of Incidents (including those resulting in severe harm or death) 2011-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Incidents</th>
<th>Number Resulting in Severe Harm or Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/2012 (April to Sept 2011)</td>
<td>2,573</td>
<td>1</td>
</tr>
<tr>
<td>2012/2013 (April to Sept 2012)</td>
<td>2,941</td>
<td>0</td>
</tr>
</tbody>
</table>
In order to achieve this we set out to:

- Use the established Datix incident reporting system and the global trigger tool (GTT) methodology. (Trigger tools are a means of conducting rapid structured case note review to measure the rate of harm in healthcare)
- Implement quality and safety walk-rounds
- Continue to work on patient safety projects
- Implement new patient safety improvement projects in the priority areas identified from case reviews.

Improvements achieved

- We retrospectively review case notes as a learning opportunity, using the global trigger tool methodology. We are conducting a monitoring process for unexpected admissions to the intensive care unit between the periods of May 2012 – April 2013
- We have adopted the global trigger tool methodology to inform us of the areas we need to concentrate on within the patient safety programme.
- The Trust’s continual investment in the safety of patients is reflected in its proposed expansion of the critical care outreach team resources. The team supports hospital staff to recognise and appropriately manage the treatment of deteriorating patients and importantly prevent further harm
- National Early Warning Score (NEWS) was introduced in February 2013. This early warning tool replaced the previous local physiological track and trigger score to facilitate earlier identification of patients at risk
- Health care support workers are now trained to carry out all patient observations and National Early Warning Score (NEWS) scoring to improve compliance with monitoring the acutely ill adult.
- The introduction of the acute response team has become fully operational to respond to our deteriorating patients on the wards
- Acute illness management courses for health care support workers piloted and continue to be well attended
- Acute illness management courses for multi-disciplinary teams well established and on-going
- Acute kidney injury alerts sent to teams of doctors and the critical care outreach team from the pathology department to ensure early review and treatment of these types of patients, when staffing allows
- Trust wide sepsis training has commenced. Sepsis is a life threatening condition that arises when the body’s response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly. Research shows that early recognition and intervention saves lives – and may save as many as 15,000 lives annually in the UK per year. To achieve this improvement requires a partnership between patients, the public, and the healthcare professions. This partnership must start with heightened awareness and understanding of the condition.
- Appointment of a part-time specialist sepsis nurse
- Sepsis boxes implemented on all wards to facilitate early implementation of the care bundle approach. This is a box containing all the important equipment that the medical and nursing team need to look after a patient who has a serious infection.
Patient group directive (PGD) to facilitate registered nurse administration of fluid bolus in hypovolaemia. The condition hypovolaemia is extremely low blood plasma volume typically caused by dehydration or blood loss through haemorrhage. This results in a state of shock to the body as tissues lose their supply of oxygen (*hypovolaemic shock*).

Raising staff awareness across the Trust with regards to the importance of high flow of oxygen therapy in an emergency situation.

During mortality reviews the acute kidney injury risk was noted and work streams proposed to reduce risk.

We have introduced ward safety visits as part of our CQC assurance system and programme of internal assurance team visits.

All ward pharmacists review the patients that are flagged on our computer system as acute kidney injury levels 1-3, on a daily basis. Each patient’s current medication is reviewed and recommendations made to the medical team regarding which to stop and where doses need alteration. The aim is to prevent medication aggravating the condition and reduce the number of patients deteriorating further.

**Monitoring and reporting for sustained improvement**

The Trust’s focus on promoting and sustaining harm free care requires close monitoring. It is necessary that the standards of quality we promote are measured in performance outcomes and in the patient’s experience.

This monitoring framework will include:

- The on-going observation and National Early Warning System compliance audit which will occur on a six monthly and monthly basis respectively.
- The surveillance of unexpected admissions to the intensive care unit will continue on a monthly basis to act as a constant clinical indicator.
- Critical care outreach team monitoring of all trigger calls and responses that are made daily and reported monthly.
- Cardiac arrest monitoring and retrospective case note review
- Global trigger tool audit will continue on a monthly basis
- Sepsis audits will be undertaken. This will support the work being done to achieve the specific goals identified within the sepsis bundle CQUIN initiative.
- The Association of UK University Hospitals (AUKUH) audit is predominantly an audit of patient acuity and dependency across the Trust. This data is used to calculate appropriate staffing levels on our wards. Other nurse sensitive indicators, such as pressure ulcers and infection rates, can then be analysed in relation to changes in acuity and dependency.
- We have also developed an early warning dashboard with key indicators to show whether quality and safety are deteriorating. This is monitored at the patient safety steering group and the Clinical Governance Committee.

We will be continuing this work during 2013/14 as a strand of our mortality reduction programme. The introduction of ‘VitalPAC’ will be a key component in further improving the care of deteriorating patients during 2013/14.
3.1.5 High quality, harm-free, safe use of medicines

What did we set out to achieve: To deliver harm-free care, by promoting the safe use of medicines by reducing missed or delayed doses by 50% and improving medicines reconciliation. The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission.

In order to achieve this we planned to:

- Support the safe use and treatment of patients with the introduction of weekend clinical ward pharmacy services
- Reduce the number of delayed and missed doses of critical medicines by 95% by April 2015.
- Improve the quality and safety of prescribing to minimise risk and improve patient outcomes
- Maximise safety gains achieved with the introduction of e-prescribing (an electronic prescribing system)
- Achieve 95% reconciliation of medicines within 24 hours by April 2013
- Minimise risk to patients by ensuring medicines are stored securely throughout the Trust
- Minimise number of patients sent home without discharge medicines.

Progress: This target was not achieved. We made some progress however, notably the introduction of e-prescribing and improved performance in relation to medicines reconciliation.

Outcome: Missed or delayed doses were not measured
Medicine reconciliation improved to 96% in total

Medicines Safety Performance 2012/13 & 2012/13

<table>
<thead>
<tr>
<th></th>
<th>Year 2012/13</th>
<th>Year 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed or delayed doses</td>
<td>Not measured</td>
<td>Not measured</td>
</tr>
<tr>
<td>Medicines reconciliation</td>
<td>35% within 24 hours</td>
<td>68% within 24 hours</td>
</tr>
<tr>
<td></td>
<td>43% total</td>
<td>96% total</td>
</tr>
</tbody>
</table>

Note:
The medicine reconciliation figures look different because data collection was changed during the year. Our original system did not give an accurate reflection so we have changed this to make current data more reliable.
In regards to missed or delayed doses the intention to develop a robust strategy of measurement is a focus of the overall pharmacy department and is seen to be an essential quality indicator.

Improvements achieved:

- We have a system of tracking prescribing quality/errors on discharge prescriptions to determine issues and help us plan to minimise their occurrence. One of the Trust wide implementations to prevent medication errors is the introduction of e-prescribing. By using this approach we aim to reduce prescribing errors. Although roll out of e-prescribing has taken longer than anticipated, due to refinements being made around processes and equipment, the Trust has continued its commitment to the implementation of the system as it will bring significant benefits in terms of patient care and management of risk. In pilot areas, improvements have already been noted and once the pilot ends in summer 2013, the full roll-out will begin.

- The Trust has implemented a framework of Guardians, one of these being designated to monitor medicines management in the Trust.
• The Outcome Guardian and the team for medicines safety conduct Outcome Guardian ward and department visits (this process is an internal monitoring of quality and compliance against Care Quality Commission 16 essential standards) which have shown evidence of improved compliance in clinical and department areas. The Medicines Management Guardian indicates areas where improvements are needed and these are actioned by senior staff.

• Progress is limited at present in the area of improving the incidence of prescribing errors; these have increased from September 2012 and we are currently undertaking a diagnostic review to ascertain the reasons for this and identify what actions need to be taken.

• We have established a pilot whereby we establish our staff on emergency assessment unit (EAU) and the surgical assessment unit (SAU) at the start of each day to complete medication reconciliation. This will improve our medications reconciliation figures although this will need further development to counteract the issues at weekends.

• We are also utilising our pharmacist prescriber on EAU to amend medication discrepancies which will reduce the number of missed/delayed doses due to medicines not being prescribed.

**Monitoring and reporting for sustained improvement**

The pharmacy department has highlighted ‘reducing delayed/missed doses’ as one of their key objectives for 2013/14. Scoping has facilitated learning from other Trusts who do continual snapshot audits of missed doses. These examples from other Trusts have indicated a measure of how we will be looking at ways of introducing similar processes.
3.2 Clinical Effectiveness

3.2.1 Reducing our Summary Hospital Mortality Indicator (SHMI)

There are a number of different ways to measure mortality and last year the Trust agreed to use the Department of Health’s preferred indicator, the Summary Hospital Mortality Indicator as its main focus. SHMI data includes in-hospital deaths and deaths within 30 days of discharge. During 2013/14 we will be looking at various metrics including HSMR, SHMI and crude mortality and we have already highlighted in section 2 what we intend to do to reduce these.

What did we set out to achieve: To reduce our SHMI to 97.

In order to achieve this we set out to:

- Implement an acute physician rota
- Introduce weekend ward rounds by all consultants to all medical wards
- Rollout ortho-geriatric service to the orthopaedic wards
- Implement an upper gastrointestinal rota
- Increase the availability of emergency radiology test at weekends
- Improve the number of patients who access emergency surgery at weekends
- Increase the availability of planned emergency surgical lists at weekends to reduce waiting.

Progress: This target was not achieved within the year

Outcome: Our SHMI position for 2012/13 was 101, our current position stands at 107.

This represents deterioration on our previous position and is why we have embarked upon a focused mortality reduction programme which will continue to be our number one priority into 2013/14.

Summary Hospital Mortality Index data July 2010 to June 2012

![Graph showing SHMI by data period]

Improvements achieved:

- We have begun the implementation of the acute physician rota, which has proved to be instrumental in improving timely assessment of patients. Further work will be done on this during 2013/14
- For those specialties that have extended weekend ward rounds, it has consolidated clinician presence within the Trust which also facilitates safe and efficient discharge
• The successful implementation of ortho-geriatrician to the orthopaedic wards continues to create a positive impact on the patient’s experiences and outcomes
• Further work has been developed in the gastrointestinal specialty, which offers a clinician service to these specialised patients that is both responsive and committed to improving the patient’s journey, by promoting early diagnosis and intervention when required
• Diagnostic provision has been reviewed and access to radiology tests at weekends has increased. The need to extend this provision is currently being discussed
• The provision for emergency patients within the surgical specialty to access surgery at the weekends has improved and this has shown impact in minimising delays. However the availability of planned emergency provision has not yet showed a marked increase, and this remains an objective for the Trust going forward into 2013/14
• We recently received positive feedback from the General Medical Council regarding the training and supervision we offer the junior doctors within the emergency department.

Further improvements identified:

• The emergency assessment unit (EAU) has been under continual review to improve the overall experience of the patient and their clinical management. The introduction of daily specialists ward rounds within the EAU have increased our ability to provide early intervention and diagnosis. It is important to focus our attention on maintaining the support and advice afforded to our junior doctors as well as with our senior staff. Changes have therefore been made to acute medical rotas that will improve continuity and consolidate their learning. We have appointed several new senior clinicians this year to support the unit
• The implementation of the National Early Warning Score (NEWS) has provided a monitoring tool that serves both nursing and medical teams to identify where early intervention is required. The Trust has been reviewing the Trust-wide implementation of electronic hand held devises (VitalPac) that can be used at bedside by both nursing and medical teams to record and importantly escalate deterioration of patients to appropriate senior staff. This immediate response system will further assist to support the early detection of patient’s conditions and facilitate prompt and appropriate treatment.

We have described our plans to continue reducing mortality within section 2 of this report.

3.2.2 Avoidable re-admissions

What did we set out to achieve: To reduce avoidable emergency re-admissions to hospital within 28 days of discharge, from 2% in 2012/13 to 1.75% in 2012/13.

We planned to:
• Introduce increased range of ambulatory care services at the front door (geriatrics, cardiology, diabetes and respiratory medicine.
• Introduce clinical decision unit (CDU) to enable patients to be seen, treated and discharged without being admitted to a general ward
• Implement GP telephone access to senior clinical opinion scheme
• Strengthen our surgical admissions unit to enable direct access to surgical specialist, timely decisions and where appropriate discharge home

Progress: We failed to achieve this target

Outcome: Our Trust re-admission rates have increased from 8.37% to 10.05%
## Trust Readmissions Figures 2012/13 & 2012/13

<table>
<thead>
<tr>
<th>Year</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Readmission Following Elective Admission</td>
<td></td>
</tr>
<tr>
<td>11/12</td>
<td>10.46%</td>
</tr>
<tr>
<td>12/13</td>
<td>13.59%</td>
</tr>
<tr>
<td>% Readmission Following Non Elective Admission</td>
<td></td>
</tr>
<tr>
<td>11/12</td>
<td>7.92%</td>
</tr>
<tr>
<td>12/13</td>
<td>9.38%</td>
</tr>
<tr>
<td>Trust Total % Readmissions</td>
<td></td>
</tr>
<tr>
<td>11/12</td>
<td>8.37%</td>
</tr>
<tr>
<td>12/13</td>
<td>10.05%</td>
</tr>
</tbody>
</table>

**Improvements achieved:**

- Senior clinical opinion scheme for GPs is now in place in geriatrics; respiratory; ear nose and throat and urology
- The clinical decisions unit is in its infancy and requires further development but this unit does offer an area for patients to be seen, treated and discharged without unnecessary admission. However we have made notable progress here and 645 patients in total have been through the newly established unit since October 2012
- A number of significant reviews of re-admissions took place across all specialties within medicine which helped inform pathways for both 2012/2013 but also identifying further improvements in pathways
- The service directors in surgery have reviewed a sample of their re-admissions (those where they are over the target) and looked at each patient pathway in order to determine whether or not the readmissions could be avoided. This included general surgery, trauma & orthopaedics and paediatrics. All of the reviews reported that none of the re-admissions could have been avoided by improved initial discharge planning and as such were clinically necessary re-admissions
- Ambulatory services that reduce the need for patients to be admitted (and in some cases re-admitted) continue to be developed. Outpatient antibiotics treatments (OPAT), deep vein thrombosis (DVT) screening and a number of other ambulatory pathways will be in place for 2013/2014 to decrease the likelihood of avoidable re-admissions
- In 2013, a general surgical ambulatory clinic is being introduced which is designed to avoid either initial emergency admission/readmission by offering an urgent clinic appointment for patients to be reviewed and managed. We will collect data to evaluate the success of this from implementation against current performance levels.

**Monitoring and reporting for sustained improvement**

Readmission rates and specific audits will be reviewed by each specialty into 2013/14 as part of their on-going performance management.

The development of the clinical decisions unit and general surgical ambulatory clinic will be reported via the Hospital Management Board and to commissioners via the quality and performance meetings. As we have not met our objective for this we will continue to drive this target and work with our community colleagues to improve patient pathways to avoid unnecessary admission.

### 3.2.3 Venous Thromboembolism

**What we set out to achieve:** The specific goals that we set were:

- To eliminate unnecessary deaths due to venous thromboembolism (VTE) by increasing the number of patients receiving a VTE risk assessment within 24 hours of admission to hospital, from 92% to 95%
95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment.

**Progress:** Target achieved

**Outcome:** By December 2012 we achieved our goal of 95% of patients who were at risk of venous thromboembolism (VTE) receiving appropriate preventative treatment. This was an improvement from the 2012/13 position of 92%.

% of Patients Receiving VTE Risk Assessment & Intervention

<table>
<thead>
<tr>
<th></th>
<th>Q1.</th>
<th>Q2.</th>
<th>Q3.</th>
<th>Q4. (indicative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patients receiving a risk assessment</td>
<td>93.9%</td>
<td>93.3%</td>
<td>95.0%</td>
<td>95.01%</td>
</tr>
<tr>
<td>B. Patients identified at risk and receiving appropriate intervention</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The introduction of VitalPac will help to resolve the challenges in achieving the required patient monitoring targets, VTE being one of these essential fields. While this electronic system becomes embedded the current paper data collection process is being redesigned.

**Further improvements identified**

To ensure compliance with future NICE and CQUIN targets, a protocol will be implemented for the mandatory investigation of all hospital associated thrombosis (HAT) events. Hospital associated thrombosis is defined as VTE occurring during a hospital admission or within 90 days of discharge. We will be undertaking detailed investigation of hospital associated thrombosis to identify the lessons that can be learned and ways to further improve the care we provide to patients with investigations and reporting at departmental clinical governance meetings.

**Monitoring and reporting to sustain improvement**

This priority will continue to be monitored through the Trust's internal processes and through national benchmarks (CQUIN and safety thermometer). Improvement work will continue to be undertaken until the national performance is achieved.

**3.2.4 Inpatient diabetes management and implementation of ‘Think Glucose’**

**What did we set out to achieve**

Last year we set ourselves the challenge of improving inpatient diabetes management by non-specialist teams and improving access to diabetes care by the full implementation of the national Think Glucose programme.

We set this priority as the number of people with diabetes is steadily increasing, but the provision of consistent, effective and proactive inpatient care for people with diabetes as a secondary condition can be inadequate. Think Glucose is a national programme that has been devised by the NHS Institute of Innovation and Improvement and supports hospital Trusts to deliver a clinical pathway that improves the management of patients with diabetes as a secondary diagnosis.

We specifically planned to:

- Implement and strengthen the inpatient diabetes service across the Trust by increasing referrals and availability of specialists
- Introduce a phased roll out for patients to be seen and assessed using Think Glucose across the Trust
- Ensure all staff refer appropriate patients using the electronic referral system
- Implement a daily review of emergency admissions by the diabetes team
To meet our CQUIN requirements to reduce length of stay for adults with a diagnosis of diabetes.

**Progress:** On plan

**Outcome:**
- We have increased referrals to the diabetes team.

The chart below demonstrates an increase in referrals to the diabetes team with the introduction of Think Glucose. The Trust’s objective is that specialist diabetes management is provided to all patients irrespective of their admission diagnosis.

**Number of referrals to the diabetes team during 2012**

- We piloted Think Glucose on four wards, the initiative then widened throughout 2012/13 to include wards and departments outside of the initial pilot areas
- We have implemented a system to review emergency admissions by the diabetes team
- We have reduced the length of stay for patients with a diagnosis of diabetes (as demonstrated in the graph below) and thereby met the CQUIN requirements.

**Average Length of Stay for Patients with Diabetes – April 2012 to March 2013.**
In order to achieve this we set out to:

- Strengthen the inpatient diabetes service
- Introduce a phased roll out for patients to be seen and assessed using Think Glucose across the Trust
- Ensure all staff refer appropriate patients using the electronic referral system
- Implement daily review of emergency admissions by the diabetes team.

Improvements achieved

- We have actively recruited to essential clinical posts and are in a position to provide specialist inpatient monitoring. A consultant and a diabetes nurse cover wards, including our emergency assessment unit (EAU)
- The EAU consultant ward rounds and responses to ward based referrals are coded as red on the Think Glucose criteria assessment forms. This ensures these referrals are acted upon within 24 hours, between 0900-1700, Monday to Friday
- Training sessions have taken place with medical and nursing teams to instil the key principles of Think Glucose and timely referral to the inpatient diabetes service. Over 500 registered nurses have received patient stories to communicate the benefits of maintaining diabetic patients’ independence and autonomy when they are admitted to our hospitals.

Monitoring and reporting for sustained improvement.

- The diabetes service undertakes the national diabetes inpatient audit to assess compliance against a number of standards and this will continue in 2013
- There is quarterly review of length of stay for diabetic patients so progress can be tracked and reported to the commissioners, divisional governance forums and Clinical Governance Committee
- Quarterly audits of insulin errors are also part of the on-going CQUIN initiative. This information is fed back to clinical teams to inform their practice
- Monitoring of the percentage of patients who are coded red for Think Glucose.

3.3 Patient Experience

3.3.1 ‘Friends and Family Test’

The Department of Health (DOH) emphasises the importance of enabling patients within target groups to relate feedback on their experiences. It stresses the importance of ensuring that the Friends and Family Test provides a vehicle to identify patient experience and quality issues and encourage staff to make improvements in response to this specific feedback.

From April 2012 organisations across NHS Midlands and East were set a regional CQUIN target. It is referred to as the net promoter score or the family and friends test. The question asks patients ‘How likely is it that you would recommend this service to friends and family’.

What did set out to achieve: Achieve and sustain a top quartile national performance.

Progress: Target achieved

Outcome: The Trust has topped the regional league table in NHS Midlands and East, recording a score of 96.6 in quarter 4, compared to an average of 71 across the 46 Trusts involved in the regional pilot.

The weekly results for the Trust are shown below and show a consistently high level.
In order to achieve this we set out to:

- Survey 10% of inpatients at discharge face to face or within 48 hours. This equates to approximately 60 patients per month
- Collate the results into a dashboard which reports from ward to Board
- Interrogate qualitative and quantitative results to provide greater understanding of patient concerns/issues
- Triangulate the results with other quality metrics
- Formulate action plans to address specific themes/concerns.

Improvements achieved:

- The results from the net promoter score have been reviewed and wards have made changes that have led to an improvement in their scores
- Triangulation against complaints and compliments has been undertaken to assist wards to formulate specific action plans
- The results have been disseminated to ward sisters/charge nurses and matrons to enable them to discuss results and implications at ward meetings. The net promoter score has been established with staff as an important mechanism to enable patients to comment if they are likely to recommend our services.

Monitoring and reporting for sustained improvements

We will report the net promoter score to the Clinical Governance and Quality Committee monthly and to the Trust Board through the integrated performance report. We will assess and triangulate the results (with other customer care metrics) through the quarterly quality report which will be presented to both the Clinical Governance and Quality Committee and Trust Board.

The net promoter score will be a national CQUIN 2013/14. In 2012/13 we surveyed 10% of inpatients at discharge, face to face or within 48 hours. This equates to approximately 60 patients per month. As from April 1st 2013, we must give all inpatients an opportunity to respond and cannot utilise a face to face methodology. An external company has been commissioned to collate and present the Trust data and this method has been trialled during February 2013. The reports will show not only Trust-wide results but also ward level results and trends, which will be reviewed alongside other care metrics so we can monitor standards and patient experience.
3.3.2 Improvement in the patient experience of their hospital stay

What did we set out to achieve: To achieve an 80% composite score in five indicators on discharge

Five questions are asked at discharge to determine patients’ experience during their hospital stay. They are as follows:

1. Were you as involved as you wanted to be in decisions about your care and treatment?
2. Did you find someone to talk to about worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Were you told about medication side effects to watch for went you went home?
5. Were you told who to contact if you were worried about your condition after you left hospital?

Progress: Target achieved

Outcome: Results have reflected a consistent standard. The Trust’s last quarter has reached the highest score over the year.

Percentage achieved for patient experience questions – April 2012 to March 2013.

![Overall Results per Quarter 2012/13](chart)

In order to achieve this we set out to:

- Survey 60 inpatients at discharge face to face each month
- Collate the results into a dashboard which reports from ward to board
- Review the results and formulate action plans to address specific themes/concerns
- Triangulate the results with additional quality metrics and qualitative information, including complaints, incidents, litigation, Patient Advice and Liaison Service (PALs) information
- Increase patient counselling on medication side-effects by pharmacy and other healthcare professionals.

Improvements achieved

- Week on week we were able to survey 60 patients
- The results are presented via ward, service line and Trust
- Evidence of implemented action plans and improvements
- The specific results relating to question 4 have been shared with pharmacy as these relate to medications. Subsequently an information card for every patient has been introduced. Pharmacy and ward staff will continue to distribute these to improve patients' experience.
Monitoring and reporting for sustained improvements

Results are shared on a monthly basis with staff and they are asked for their improvement ideas. Monthly reports are provided to the Board of Directors alongside other quality, safety and patient experience metrics.

3.3.3 Staff recommendations to family or friends to our hospitals

What did we set out to achieve: To increase the percentage of staff who would recommend our hospitals to a family or friends. To implement organisational development (OD) activities to secure the required improvements.

The Trust organisational development plan sets out required improvements that are needed.

Progress: This target was not achieved

Outcome: In 2011 73% of our staff would recommend the Trust to family and friends
In 2012 70% of our staff would recommend the Trust to family and friends

Percentage of staff who would recommend the Trust to friends & family in 2011 & 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
<th>Average % Acute Trusts</th>
<th>Lowest % Acute Trusts</th>
<th>Highest % Acute Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff survey 2011</td>
<td>73%</td>
<td>62%</td>
<td>33%</td>
<td>89%</td>
</tr>
<tr>
<td>Staff survey 2012</td>
<td>70%</td>
<td>63%</td>
<td>54%</td>
<td>72%</td>
</tr>
</tbody>
</table>

In order to achieve this we set out to:

- Engage with existing Trust groups, Hospital Management Board and Workforce Committee to share 2011 staff survey results and understand the links with the patient survey results
- Share staff survey outcomes to identify 3 top improvements for 2012/13 for each division
- Develop and agree the organisational development plan
- Ensure organisational structures support delivery of strategic direction
- 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
- Share progress with Board and staff regularly.

Improvements achieved

- Staff Survey results have been shared widely with staff. There were a number of areas where we could improve and as such corporate and divisional action plans were developed based on the survey results
- The Trust appraisal process has been revised. The appraisal process is an opportunity for staff and their managers to review personal objectives and the contribution of individuals to the overall Trust objectives. Appraisal documentation made clearer and monthly monitoring of appraisal rates commenced, however completion rates remain poor
- Progress has been made in various areas of training including: increased numbers of staff attending equality and diversity training, a focus on leadership attributes and management skills development
- A training programme has been put in place to support staff in conflict resolution, the gaining of skills in clinical holding techniques and the support of effective occupational health referral/reporting training
• During a period of significant workforce transformation and media attention regular communications have kept staff up to date. The communication cascade to staff, which includes the Team Brief, was revamped and staff were encouraged to contribute to improvements at work
• A model of clinical leadership has been implemented within operational divisions, executive director portfolios have been reviewed and responsibilities clarified.

Further improvements identified

• Quarterly staff surveys on key issues will be undertaken and reported to the Trust Board within the HR quarterly report
• Central support will be provided to managers to improve data collection around appraisals and ensure the number of appraisals completed is increased
• Engagement with staff will continue to be a priority as outlined within the communications plan/strategy.

Organisation development plan to be presented and agreed with the Trust Board.

Monitoring and reporting for sustained improvement

In applying some of the lessons learnt, it is imperative during 2013/14 that the information is relayed back to the wards and divisional teams in a more co-ordinated way, in order to inform practice and service delivery. This process will be refined during 2013 to ensure that all staff groups can usefully view the results and make any changes necessary to improve patient care.

3.3.4 Dementia

Last year, we set a goal to improve the quality of care and outcomes for patients with dementia. Improving dementia care requires a sustained improvement in finding, assessing, investigating and referring patients and during 2012/13 this was a focus for us. We also wanted to ensure more staff had received dementia training, which will in turn lead to improved patient care, delivered by competent and compassionate staff.

What did we set out to achieve

• By the end of 2012/13 that 95% of all emergency patients (exclusion criteria in CQUIN) above the age of 75 will be screened for dementia
• 95% of those who have been screened as at risk of dementia, have had a dementia risk assessment prior to discharge
• 90% of all relevant staff are trained in dementia care and the mental capacity act every 2 years

Progress and Outcome

• We did not meet our target to screen 95% patients over the age of 75 for dementia. We increased the number of patients screened to over 40%, which fell significantly short of our 95% CQUIN target
• Of those patients screened for dementia, 100% of them had a risk assessment prior to discharge
• By Quarter 4 2012/13, 90% of relevant staff had received training in dementia care.
Improvements Achieved

- A Practice Development Nurse focusing on improving Dementia care pathways has been employed. They are working with the Clinical Lead for dementia to embed the dementia screening tool and increase compliance across the Trust.
- The introduction of a dementia screening tool has been developed and is in place. Dementia awareness training has been integrated into orientation and mandatory days.
- Further development of staff at Level 2 is underway. These modules are being piloted and will enhance the staffs’ knowledge of dementia patient’s requirements to support their care management.
- A mental capacity training programme has been implemented, to raise awareness of this fundamental patient assessment.
- The Trust Dementia Strategy Group (DSG) has been re-invigorated, with clear reporting lines and representation from carers.
- Improved discharge information
- More teaching for medical staff
- Successful bid for funds from Hardwick Care Commissioning Group (CCG) for dementia information provision and activity equipment
- Pilot of dementia befriending volunteer programme
- Trust sign-up and representation on regional Dementia Action Alliance
- Engagement with Alzheimer’s Society and Age UK, with representation on our DSG
- Agreed increased staffing establishment on Ward 52, Dementia/Delirium ward

Reporting and Monitoring for Sustained Improvement

Results for the dementia CQUIN targets are reported to Trust Board on a quarterly basis. Weekly compliance of dementia screening is monitored within the safeguarding team. The impetus for compliance improvement is to address the individual assessment needs of patients. The Trust dementia pathway and strategy is available for internal/external scrutiny.

The dementia strategy and work plan is reviewed and monitored at the Dementia Strategy group and any deviations from plan are reported to Clinical Governance and Quality Committee. In 2013 the results from individual service lines will be discussed at divisional governance meetings.

Further work planned for 2013/14

- Involvement in an innovative training project in conjunction with neighbouring Trust’s and Nottingham University. The study day is called ‘Inside Out of Mind’ and will help non registered staff to understand the needs of dementia patients.
- The Dementia Strategy group plans to develop a carer feedback questionnaire and information provision services. A planned implementation of ‘This is me’, which identifies patient’s individual preferences, is to be introduced.
- Introduction of dementia training on orientation and mandatory training events to ensure maximum coverage of all disciplines
- Collaboration work with regional teams to develop University based academic level 5 course
- Individualised documentation for patients so that their lifestyle is mapped
- Greater involvement in carer contribution to patient management

The Trust will continue to work towards the CQUIN requirements for 2013/14 which involves on-going compliance with dementia screening, improved carer involvement and clinical leadership.
Carer Group Story

Meet Joan, Assistant to the Secretary for the Forget-Me-Not Dementia Support Group. Based in Kirkby-in-Ashfield, Forget-Me-Not has been established for just over a year. This independent group provides monthly meetings to anyone suffering with memory problems, their carers, families and friends. They always offer a warm welcome, a friendly and relaxed atmosphere and experienced volunteers for support and advice.

Following a visit from Sherwood Forest Hospitals NHS Foundation Trust’s Practice Development Nurse for Dementia, an invitation was extended for a representative to join the Trust Dementia Strategy Group; set up to shape and implement real and practical improvements in the care of people with dementia across the Trust.

Joan regularly attends the Trust Dementia Strategy Group and helps to shape the direction and work undertaken within the Trust.

“I’ve had a long career in social care and have looked after close family members with dementia. I was not happy with the services offered to local people with dementia and jumped at the chance to be involved with the hospital. I’m proud to be a valued part of this group and can see real change for the good already. I’m excited about what the future holds. It’s hugely important that carers are listened to in the planning process for hospitals and groups like this are key to giving people with dementia and their carers an influential voice.“ - Joan Cannan.2013
3.4 Progress on other Initiatives & Services

3.4.1 Measuring our Nursing Care

The nursing metrics have been developed to provide information relating to the contribution of nursing to the quality and delivery of healthcare

The nursing metrics are used to monitor nursing standards across the inpatient wards. Nurses outside of the ward teams are used to assist independent assessment, however, the ward nurses are actively encouraged to participate. The metrics highlight best practice, as well as areas where systems and processes require support.

The metrics work at various levels:

- Patients receive safe, clean and personal care
- Ward Teams – ownership
- Divisions and Service Lines – can assess nursing care in their areas and use this as part of their governance assessment
- Trust executive – demonstrate quality of nursing care across the whole of the organisation.

The metrics are carried out on the wards every month. The metrics are currently under review to further establish a robust measurement of aspects of care that have been identified as important to patients. These newly devised quality metrics will include the speciality areas within the Trust to capture specifics that relate to them.

Summary of the Trust Wide Nursing Metrics Scores 2012/2013

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</thead>
<tbody>
<tr>
<td>Medication Storage And Custody</td>
<td>93%</td>
<td>97%</td>
<td>92%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
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<tr>
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<td>88%</td>
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<tr>
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<td>87%</td>
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<td>83%</td>
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<td>Tissue Viability</td>
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3.4.2 Patient Environment Action Teams (PEAT) scores

Last year the Trust participated in the national self-assessment of Patient Environment using the PEAT assessment tool. This annual audit measured the standards of cleanliness, environment, patient meal service and privacy and dignity afforded to patients. The audit team consisted of
representatives from Infection Prevention and Control, Facilities Services, Head of Nursing and also included a patient representative. The validated scores for the Trust were confirmed and are included in the table below. Excellent scores for environment, cleanliness and food service were recorded at all three sites. Patient feedback was also very positive.

**Summary of PEAT Scores 2010-2012**

<table>
<thead>
<tr>
<th>Site and Year</th>
<th>Environment</th>
<th>Food</th>
<th>Privacy and Dignity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010: King’s Mill</td>
<td>4 (Good)</td>
<td>5 (Good)</td>
<td>4 (Good)</td>
</tr>
<tr>
<td>2010: Newark</td>
<td>4 (Good)</td>
<td>5 (Excellent)</td>
<td>5 (Excellent)</td>
</tr>
<tr>
<td>2011: King’s Mill</td>
<td>4 (Good)</td>
<td>5 (Excellent)</td>
<td>4 (Good)</td>
</tr>
<tr>
<td>2011: Newark</td>
<td>4 (Good)</td>
<td>4 (Good)</td>
<td>5 (Excellent)</td>
</tr>
<tr>
<td>2012: King’s Mill</td>
<td>5 (Excellent)</td>
<td>5 (Excellent)</td>
<td>4 (Good)</td>
</tr>
<tr>
<td>2012: Newark</td>
<td>5 (Excellent)</td>
<td>5 (Excellent)</td>
<td>5 (Excellent)</td>
</tr>
<tr>
<td>2012: Mansfield</td>
<td>5 (Excellent)</td>
<td>5 (Excellent)</td>
<td>5 (Excellent)</td>
</tr>
</tbody>
</table>

For 2013 the annual PEAT audits are being replaced by the PLACE audits (Patient Led Assessment of the Care Environment). The new audit process sees significant changes to the audit process with the key change being the increased involvement of patient representatives on the audit teams.

The Trust has always had enthusiastic support from a dedicated team of patient representatives in previous years and has never undertaken an audit without patient involvement. It is the number of representatives which are now required that will make a difference to the composition of the team for 2013.

As with PEAT the PLACE audit findings will be publically published in the form of league tables, and each Trust will be required to publish an action plan to deal with any issues identified.

As with PEAT the audit is split into 4 categories:

- Cleanliness
- Food
- Privacy and Dignity
- General Maintenance and Décor

Trusts are being given 6 weeks’ notice of the week they must undertake the audits (as of the date of the writing of this paper the Trust has received notification of the audit dates for Newark and Mansfield sites only. The date for Kings Mill audit is still awaited. No audits have taken place yet). The audits will be completed nationally by 21st June 2013, with preliminary results published in July and final results in September 2013.

There will be no weighting associated with the scoring but other information from other audits will be considered in awarding the final score – CQC Inpatient Survey for example.

Scoring has been simplified to Pass (P), Qualified Pass (QP) AND Fail (F). The scores achieved should be scored by observation and discussion and whilst there is no margin or mitigation where an item can fail but still achieve a pass, a QP allows the team to ask themselves “what would a reasonable person think”

### 3.4.3 Cleanliness

Cleaning of Trust property is the responsibility of Medirest contracted by Central Nottinghamshire Hospitals PLC (CNH) as part of the PFI agreement. The monitoring of clinical areas are undertaken on a weekly/monthly basis following the National Specifications of Cleanliness guidelines, with audits
undertaken by Medirest and independent audits undertaken by Trust staff, including Heads of Nursing, Infection Prevention and Control Team and the PFI Contract Management leads. Further joint audits are undertaken in conjunction with Central Nottinghamshire Hospitals throughout the year.

Cleanliness remains high on the Trust agenda and regular meetings continue to be held with Medirest and CNH and all levels of the organisation, to raise concerns and address issues that have arisen in the PFI partnership arrangement. The Facilities Liaison Group is an established forum for members of the organisation to meet the service providers face to face to discuss and resolve operational issues.

Hydrogen peroxide vapour decontamination (fogging) continues for the decontamination of areas that have been occupied by patients with CDI. Hydrogen peroxide vapour has also been in use following cases of norovirus, with full wards fogged when capacity allows. Medirest are involved in the Infection Control meetings organised around any potential outbreak situations, and work with the ward teams to enable the area’s to be brought back in to use in a timely fashion.

Medirest, the soft services provider, has undertaken patient satisfaction surveys for cleanliness and catering across King’s Mill, Mansfield Community and Newark Hospital. The results of these surveys are showing patients being very happy with the standards of cleanliness within their area and the hospital generally as well as quality of the food presented and choices available.

All areas now have disposable curtaining and the introduction of the Steamplicity catering system has further improved the perception of cleanliness at ward level on the three Trust sites with the clear separation of cleanliness and catering. In addition, this change to the service delivery methodology has resulted in an increase in the number of dedicated cleaning hours per day.

As part of our partnership working with Medirest, the Domestic Supervisors have adopted the Institute of Innovation and Improvement 15 steps initiative as an audit tool. This parallels the use of this tool with the nursing staff on the assurance visits. The 15 steps is a measurement of the environment which includes how individuals are welcomed onto the ward and if the ward feels safe. It also measures the initial impressions of caring and involving patients and how well organised and calm the ward/department environment is. We are choosing to use the same tools measured by different staff to maintain objectivity when we are monitoring.

### 3.4.4 Paediatric Services

Paediatric services across the Trust continue to develop and expand, with recent additions of a paediatric ambulatory clinic at Newark Hospital, which facilitates GP’s in ensuring their patients are seen quickly by a paediatrician. This means that children are seen close to home rather than having to travel to King’s Mill Hospital.

The Paediatric Diabetes Service welcomes the appointment of two nurse specialists to support children and young people with diabetes and their families.

Our superb, purpose built facilities ensure our staff are able to provide high quality in-patient and day case care to patients from across Nottinghamshire and beyond.

Our seamless links with partners in the community, and our own specialist nurses, ensure our children and young people with on-going needs are cared for by a dedicated team of professionals focussed around the child.
3.4.5 Maternity Services

Maternity services has continued to be a popular service during 2012/13 and we have given care to over 4000 women and their families across North Nottinghamshire and close border areas. We offer Community based services, obstetric ante natal and post natal services from the Kings Mill Hospital and Newark sites, and intra partum facilities at the Kings Mill site.

Our services are complimented by the work of colleagues in the early pregnancy unit, Sonographers, Physiotherapists and other medical colleagues in paediatrics and anaesthetics.

Our Birth outcomes are outlined in the table below and continue to place our birth outcomes as one of the best nationally:

Birth Outcomes

<table>
<thead>
<tr>
<th></th>
<th>12/13</th>
<th>11/12</th>
<th>10/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Numbers</td>
<td>3414</td>
<td>3499</td>
<td>3427</td>
</tr>
<tr>
<td>% from previous year</td>
<td>↓2.4%</td>
<td>2.1%</td>
<td>6%</td>
</tr>
<tr>
<td>MW to birth Ratio</td>
<td>1:32</td>
<td>1:33</td>
<td>1:32.3</td>
</tr>
<tr>
<td>Caesarean Section Rate</td>
<td>18.48%</td>
<td>17.96%</td>
<td>15.74%</td>
</tr>
<tr>
<td>Vaginal Birth Rate</td>
<td>81.52%</td>
<td>82.04%</td>
<td>84.26%</td>
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<tr>
<td>Home Birth Rate</td>
<td>4.7%</td>
<td>5.17%</td>
<td>6.76%</td>
</tr>
</tbody>
</table>

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 water for birth and aromatherapy. These compliment the traditional services available from midwives, obstetricians paediatricians, anaesthetists and neo natal services.

We also value the views of our services users. We collect comments that our 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 audit our women on a quarterly basis to elicit their views on their care in labour. It has been demonstrated that women who receive 1:1 care in labour and having a midwife available to them during their labour, when they chose improves birth outcomes.

Over the last year over 99% of our women reported positively on this.

Our challenges are regarding broader public health targets such as smoking cessation rates in pregnancy and breast feeding initiation rates which we are taking various strategies to address.

We have made some additional key achievements during 2012/13. They include:

- The Birthing Unit participated in a management audit undertaken by the Tobacco control Collaborating Centre in Aug /Sept 2012.
- From November 2012 New Leaf has provided a specialist smoking cessation worker who attends the Maternity Ward once a week. She attends between visiting times on a Wednesday afternoon, when women are with their partners. The worker accesses all known smokers both antenatal and postnatal that have been identified by the Midwife.
- Maternity Services have been asked to take part in a study being run from Nottingham University, whereby all women accessing a dating scan within the Trust are offered a carbon monoxide (CO) reading at the same appointment. Smokers and non-smokers, with a CO reading above 4, will have a discussion on the effects of their smoking, or passive smoking and electronic referral to Smoking Cessation services.
3.4.5.1. UNICEF UK Baby Friendly Initiative

The maternity service was awarded the prestigious Baby Friendly Award, achieving recognition from UNICEF (United Nations Children’s fund). The service achieved an outstanding 100% in all of the eight Criteria and has been accredited with a stage 2 award, which focuses on the commitment to provide high quality education for all staff in the care of mothers and babies especially in relation to breast feeding.

The baby friendly initiative established by UNICEF and the World Health Organisation is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. In the UK, the initiative works with Health professional to ensure that mothers and babies receive high quality support to facilitate successful breast feeding. The award is given to maternity services after an assessment by a UNICEF team.

The assessor reported that all the staff working on the maternity unit are welcoming and caring. It also highlighted that it was exceptionally unusual for a service to be given a mark of 100% and in ten years she had never marked a service so highly.

3.4.6 Accident and Emergency (A&E) indicators

In 2012/2013 the department continued to measure itself against the national set of care quality indicators, designed to monitor and support improvement of the quality of care given in emergency departments. It continues to adapt to an increasing demand on its services with innovative improvements such as combined psychiatric and medical reviews for patients that require them and near patient testing reducing the time patients have to wait for some diagnostic tests.

<table>
<thead>
<tr>
<th>A &amp; E Indicators</th>
<th>2012/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients spending 4 hours or less in A&amp;E</td>
<td>94.34%</td>
</tr>
<tr>
<td>95th percentile time for patients arriving by ambulance in A&amp;E to start of full initial assessment – aim 15 minutes</td>
<td>39 mins</td>
</tr>
<tr>
<td>Median waiting time (in minutes) spent for patients arriving at A&amp;E before start of definitive treatment (seeing a decision making clinician) – aim 60 minutes</td>
<td>56 mins</td>
</tr>
<tr>
<td>Left without being seen – aim less than 5%</td>
<td>2.08%</td>
</tr>
</tbody>
</table>

The key national standard is that patients should spend less than 4 hours in A&E. We have not achieved this standard, narrowly missing it by 0.6%. However, as the table shows, the A&E target indicators have been met. These require consistent monitoring but the dedicated A&E team are continually motivated to maintain the quality of care received in their department.
3.5 An overview of measures (to include data for 12/13 in the table) – data taken from the Trust’s dashboard, year to date – March data will be available end April.

Quality measures that are reported monthly to the Trust Board.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted</td>
<td>Monitor</td>
<td>18 weeks 90%</td>
<td>88.86%</td>
<td>94.94%</td>
<td>95.13%</td>
<td>94.64%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted</td>
<td>Monitor</td>
<td>18 weeks 95%</td>
<td>94.71%</td>
<td>97.76%</td>
<td>97.98%</td>
<td>98.53%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway</td>
<td>Monitor</td>
<td>18 weeks 92%</td>
<td>95.24%</td>
<td>94.45%</td>
<td>93.43%</td>
<td>95.84%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>A&amp;E Clinical Quality: Total Time in A&amp;E Dept (% &lt;4 hour wait)</td>
<td>SFHFT</td>
<td>Monitor 4 hours &gt; 95%</td>
<td>94.34%</td>
<td>96.21%</td>
<td>97.70%</td>
<td>98.70%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Cancer 2 week wait: All Cancers</td>
<td>Monitor</td>
<td>93%</td>
<td>95.82%</td>
<td>95.32%</td>
<td>94.20%</td>
<td>94.40%</td>
<td>99.80%</td>
<td>99.70%</td>
</tr>
<tr>
<td>Cancer 2 week wait: Breast Symptomatic</td>
<td>Monitor</td>
<td>93%</td>
<td>95.54%</td>
<td>96.39%</td>
<td>95.10%</td>
<td>92.80%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cancer 31 day wait: from diagnosis to first treatment</td>
<td>Monitor</td>
<td>96%</td>
<td>99.42%</td>
<td>99.60%</td>
<td>99.60%</td>
<td>98.80%</td>
<td>99.30%</td>
<td>99.80%</td>
</tr>
<tr>
<td>Cancer 31 day wait: for subsequent treatment - surgery</td>
<td>Monitor</td>
<td>94%</td>
<td>98.63%</td>
<td>98.98%</td>
<td>97.30%</td>
<td>94.30%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cancer 31 day wait: for subsequent treatment - drugs</td>
<td>Monitor</td>
<td>98%</td>
<td>100%</td>
<td>99.70%</td>
<td>99.20%</td>
<td>99.70%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cancer 62 day wait: urgent referral to treatment</td>
<td>Monitor</td>
<td>85%</td>
<td>90.73%</td>
<td>89.54%</td>
<td>89.70%</td>
<td>84.50%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cancer 62 day wait: for first treatment - screening</td>
<td>Monitor</td>
<td>90%</td>
<td>94.95%</td>
<td>96.35%</td>
<td>93.10%</td>
<td>90.50%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clostridium (C) difficile – meeting the C.difficile objective</td>
<td>Monitor</td>
<td>Local targets</td>
<td>29</td>
<td>45</td>
<td>54</td>
<td>96</td>
<td>177</td>
<td>324</td>
</tr>
<tr>
<td>Infection Prevention Control: MRSA Bacteraemia (No. of cases attributed to Trust)</td>
<td>Monitor</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td>Access to Healthcare for people with learning disabilities</td>
<td>Monitor</td>
<td>Compliant</td>
<td>Compliant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data completeness: Community Services: Referral to treatment information</td>
<td>Monitor</td>
<td>50%</td>
<td>74.35%</td>
<td>0.23%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Referral information</td>
<td>Monitor</td>
<td>50%</td>
<td>54.37%</td>
<td>54.78%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Treatment activity information</td>
<td>Monitor</td>
<td>50%</td>
<td>68.77%</td>
<td>70.17%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
3.6 What do other people say about this Quality Report?

**Comments from the Clinical Commissioning Group**

The CCGs have worked closely with the trust during 2012/13 to monitor and improve the quality of patient care. We noticed an increased board focus on patient safety and governance as the year progressed. The trust has experienced a number of high profile quality challenges during 2012/13. We support the continued prioritisation of improvements in mortality rates and quality governance. Sustaining and building on change will be essential to deliver 2013/14 objectives. Hospital doctors and GPs are working together to improve patient care across settings. We envisage that this will be further strengthened in 2013/14. We welcome comments about the need for cultural changes and we will be active partners in initiatives to improve patient care.

**Comments from the Healthwatch**

Healthwatch Nottinghamshire came into being on April 1st, 2013. We are grateful for the opportunity to be asked to comment on the Sherwood Forest Hospital Trust’s Quality Account, but after only four weeks of operation, we do not yet feel qualified to give a considered view of the content of the document. We would welcome the chance to work closely with the Trust over the next 12 months to identify how Healthwatch Nottinghamshire can contribute to the continuous improvement of services provided by Sherwood Forest Hospitals Foundation Trust.
3.7 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 to prepare Quality Accounts for each financial year.

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The Quality Report presents a balanced picture of the NHS foundation Trust’s performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (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

27 June 2013.....Date...................................................Chairman

27 June 2013.....Date..................................................Chief Executive
Independent Auditor's Report to the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of Sherwood Forest Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Sherwood Forest Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile - all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits - the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the NHS Foundation Trust Annual Reporting Manual; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

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

- Board minutes for the period April 2012 to June 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the Commissioners dated May 2013;
- Feedback from local Healthwatch organisations dated May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;
- The 2012/13 national patient survey.
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles 2012/13; and
- The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sherwood Forest Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sherwood Forest Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sherwood Forest Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sherwood Forest Hospitals NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

KPMG LLP

KPMG LLP, Statutory Auditor

Birmingham

Date 27 June 2013