Quality Account Yeovil District Hospital 2020/21

Yeovil Hospital Healthcare

Our year 2020/21

39,286
patients admitted

110,342
radiology tests

46,077
ED attendances

2,032
children admitted

1,411
babies born

1,519
patients treated for cancer

referral to treatment within 18 weeks
(Target 92%)
up to March 2021

408
stroke patients treated

ED patients seen within 4 hours
(Target 95%)

332
fractured hips mended

496
patients assessed by the frailty team

Diagnostic six week performance
(Target 99%)

2,559
admissions avoided through AEC

Cancer 2 Week Wait
(Target 93%)

Cancer 31 Day First
(Target 96%)

Cancer 62 Day Standard
(Target 85%)

43
new doctors

41
new nurses inc. unregistered & students

692
Patients treated for COVID-19

Contents

Part 1: Statement on quality from the chief executive of Yeovil District Hospital

1.1 Our commitment to quality, Statement from the Chief Executive

The last year has been like no other for Yeovil District Hospital NHS FT and the NHS in general with the pandemic putting unprecedented pressure upon our services, and requiring our staff to respond in the most extraordinary way.

Our Trust has been required to think strategically and innovatively about keeping staff, patients and visitors safe, without compromising care. This has included the physical reconfiguration of our site and new processes which together minimise infection risks and provide safe pathways for those attending the hospital for work or care.

As part of the efforts to maintain essential services and keep patients safe, the oncology and haematology services were moved to a new home at St Margaret's Hospice, Yeovil. This prevented patients having to attend the hospital and meant that they could maintain their care within a dedicated space, remote from the hospital's other clinical services, staff and patients.

In April, with numbers of COVID-19 positive patients in our hospital and in the local community having significantly decreased, we were pleased to introduce a new scheme for safe and responsible visiting. This allows people to book their visits online, allowing wards to control the number of additional people in an area to ensure their safety and that of patients and staff.

The Trust embraced new digital systems alongside the rest of the world, by delivering appointments digitally through the introduction of the Attend Anywhere system, allowing patients to attend virtual appointments by telephone and video. Between March 2020 and March 2021, there were nearly 73,000 appointments carried out in this way.

In 2020/21, Yeovil District Hospital NHS FT treated 692 patients with COVID-19. Nearly 40,000 patients were admitted during the year, and there were over 46,000 attendances to the Emergency Department. Despite the significant operational pressures and the reconfiguration of hospital services, the hospital has maintained positive feedback from patients about their care.

During the year Yeovil District Hospital NHS FT became one of the first 50 locations in the world to start providing the COVID-19 vaccine, establishing and operationalising a hospital clinic in an exceptionally short timeframe.

The Trust was extremely proud to be part of one of the biggest immunisation campaigns in history and at the time of writing the vaccination programme has delivered more than half a million vaccinations within Somerset. This has been completed in conjunction with partners within the Somerset health and care system, including Somerset NHS Foundation Trust (the lead organisation for the programme), primary care, Somerset Clinical Commissioning Group (CCG), Somerset County Council and the voluntary sector.

As we look to the future, we need to recognise our colleagues' physical and emotional wellbeing whilst being aware of the needs of our patients and service users who have had to wait longer as a direct consequence of the pandemic.

While we embed these new ways of working into everyday practice, we have also started to shift our focus towards the recovery of those elective services that we were unable to safely maintain during the height of the pandemic.

This has been a year in which much has been achieved at Yeovil District Hospital NHS FT and the hospital has enjoyed fantastic support from the local community, examples of which are too numerous to mention. This has been a year in which the skills and commitment of our staff have been thoroughly tested, and in which we have been called upon to demonstrate ingenuity to maintain access to life-changing, often life-saving care for people when they needed us most. The support from local communities has been unwavering and has helped us maintain the energy to continue rising to the challenges of the pandemic.

Jonathan Higman
Chief Executive

1.2 Our vision, values and corporate objectives

Yeovil District Hospital NHS FT's vision and strategy are shown below with the four strategic objectives supported by a clear set of organisational priorities. The Trust vision and strategy helps to guide the way the organisation develops. Both the vision and strategy have been developed in collaboration with staff from across the organisation. As well as guiding decision-making, our strategy is also intended to provide staff with opportunities to identify and implement improvements in their own areas of work. Our vision is shown below in figure 1:

Figure 1: Our Vision

To underpin our vision, Yeovil District Hospital NHS FT has a clear set of values that are based on our principles of iCARE. These principles were initially developed in 2006 by nursing staff and underpin all activities within the hospital; whether it is providing life-saving treatment, how staff relate to one another or our ambition of providing a warm and caring welcome to our hospital. ICARE stands for:

I	treating our patients and staff as **I**ndividuals
C	effective **C**ommunication
A	positive **A**ttitude
R	**R**espect for patients, carers and staff
E	**E**nvironment conducive to care and recovery

All staff are introduced to iCARE at the Trust Induction Day, where the expectations and standards outlined by iCARE are shared. In addition, the iCARE principles are included in staff appraisals, in job descriptions and are reiterated in policies, procedures and training programmes. The main focus, however, is to ensure that these values are evidenced in our daily work and in our care of patients, their visitors and our staff. This is underpinned by a set of strategic priorities, shown over the page in figure 2.

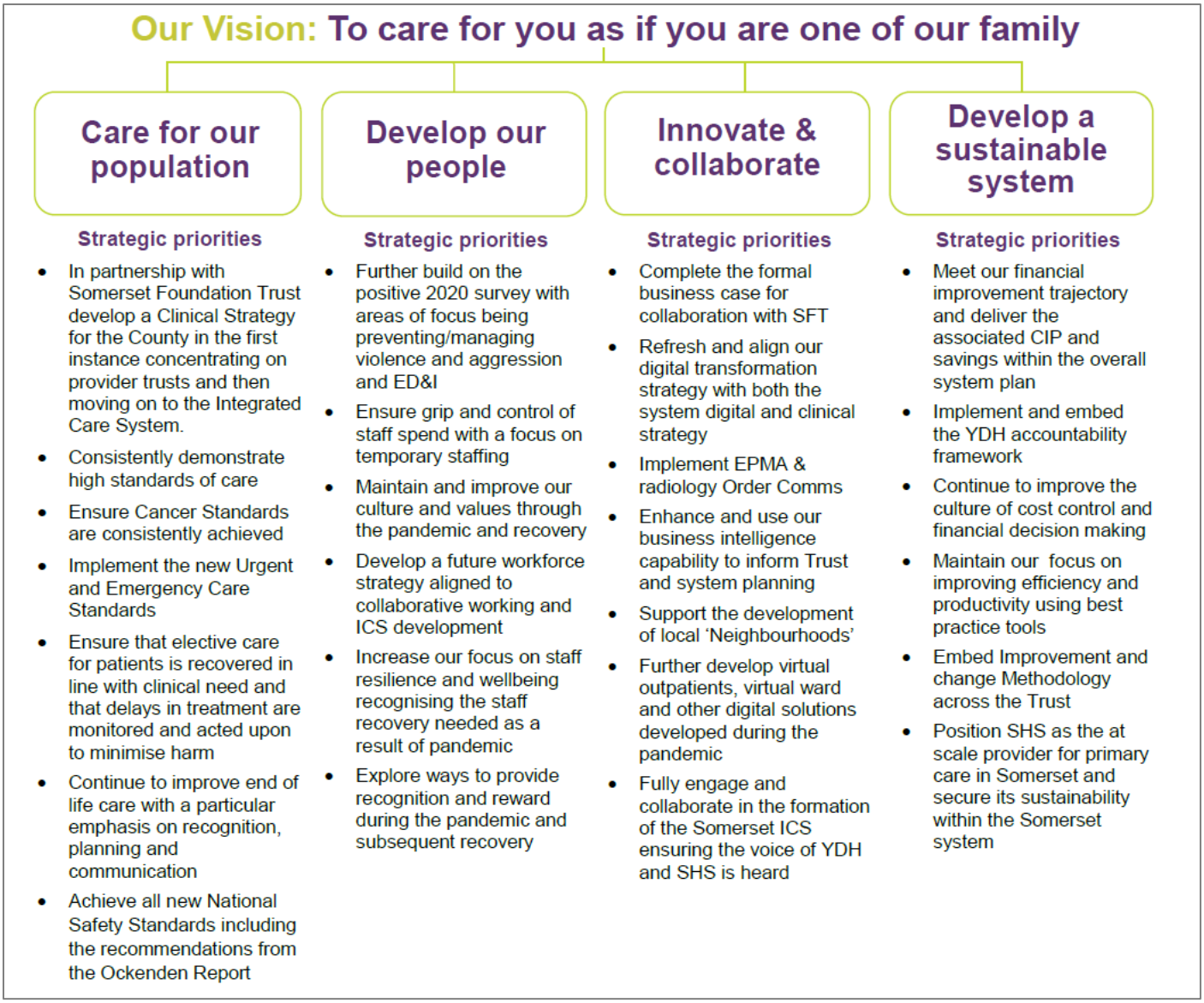

Figure 2 Strategic Priorities

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Quality improvement priorities

The quality priorities for 20/21 were presented to the Council of Governors in March 2020 where it was agreed that the intention at this time was to focus on 20/21 Commissioning for Quality and Innovation (CQUIN) programme, outlined below in table 1, however work on these areas has been impacted by the COVID-19 global pandemic. Whilst we have endeavoured to consider these key areas of quality improvement, quality and patient safety priorities have focused on preparing and managing the organisational response to this pandemic.

Prevention of ill health	Mental health	Patient safety	Best practice pathways
Appropriate antibiotic prescribing for UTI in adults aged 16+	Staff retention and wellbeing	Recording of NEWS2 score, escalation time and response time for critical care admissions	Treatment of community acquired pneumonia in line with BTS care bundle
Cirrhosis and fibrosis tests for alcohol dependent patients	Increase staff capability and respond to those with mental health needs	Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery	Adherence to evidence based interventions clinical criteria
Prevention strategy – personalised care planning		Safer care: falls, medication and pressure damage, never events	Rapid rule out protocol for ED patients with suspected acute myocardial infraction (excluding STEMI)
Staff flu vaccinations			

Table 1

Summary of performance

> The Trust's improvement and transformation agenda was impacted by the pandemic, with many projects paused or delayed. However a number of transformation projects have been implemented, including an electronic discharge letter for inpatients to replace paper, and electronic ordering of diagnostic tests for outpatient appointments which have supported the streamlining of patient care. Looking ahead, the Trust's improvement priorities will be focussed on supporting teams with elective recovery – examples include improving the pre-operative assessment pathway to help make sure patients are ready and fit for surgery. The improvement initiatives in the year ahead will focus on ensuring our activities are focused on adding value for patients and staff.

> In-house QI training has been challenging over the past year with the COVID- 19 measures that have been in place. However, with a mix of virtual and small groups of face to face training the Trust was able to provide bronze level, and 'An introduction to QI' training for those who were able to attend.

> The Trust has full representation on county wide committees, including Transformation Boards and Operational Groups. Senior Staff are nominated Senior Responsible Officers for a number of county-wide work-streams including workforce and urgent care.

> Within the past 12 months the Ambulatory Emergency Care (AEC) service has introduced the use of portable pumps to delivery intravenous therapies that would have previously have been delivered on an inpatient basis. Initial data from the pilot of seven patients demonstrated 113 bed days saved. This project will be a priority over the next year. A patient story has been presented to the Trust Board which provided excellent feedback.

> The Trust worked with the AHSN to implement the COVID-19 virtual ward at YDH. The COVID- 19 virtual ward model is a secondary care led initiative to support early and safe discharge (step down) for COVID-19 patients. The COVID-19 Virtual Ward is designed for enhanced remote monitoring with daily

calls and the possibility of hospital treatments for patients. These patients are at significantly higher risk of deterioration and this enhanced monitoring and treatment gives confidence to discharging clinicians and patients that they will be safely cared for virtually during the 'step down' process. The YDH COVID-19 Virtual Ward is based within the Ambulatory Emergency Care Unit (AEC) and the day-to-day running of the ward is the responsibility of the lead practitioner. Currently the COVID- 19 Virtual Ward is not required due to reduced numbers of COVID-19 patients within the locality, however its reinstallation is possible whenever the need arises.

> The concept of virtual wards is being explored further with AEC. A key element of this is to build on the existing framework of AEC. The use of the YDH App is currently being investigated which will allow patients to be monitored remotely.

Priorities for 2021/2022

Quality and patient safety priorities will continue to focus on preparing and managing the infection prevention and control response to the COVID-19 pandemic and the restoration of services including the recovery of all elective activity.

> As part of the intended merger between Somerset Foundation Trust and Yeovil District Hospital NHS Foundation Trust, there will be a focus on establishing a roadmap and framework for the bringing together of the respective improvement teams from the two Trusts, the focus will be on planning on how a merged improvement function can deliver value and benefits moving forward.

> The Trust was previously instrumental in securing £50,000 of funding from Health Education England to deliver QI Training to approximately 250 staff across the health and care system in Somerset. The funding was used to develop a Silver level programme by the AHSN and the Somerset Quality Improvement Faculty (SQIF). The 3rd cohort of Silver training is starting in June with 12 candidates from YDH. Following this cohort it is anticipated future deliveries will be completely delivered by SQIF. The next Silver Cohort is planned for September

2.2 Statements of assurance from the board

Service income

In response to the COVID-19 Pandemic, NHSI suspended all contractual arrangement for 2020/21. As part of this response, Somerset CCG and Yeovil District Hospital NHS FT were instructed to agree a Block Contract which guaranteed the Trust a minimum level of income reflecting the cost base at that time. Additional costs could be claimed in year, where incurred costs were higher than those reflected in the guaranteed minimum income.

Information on participation in clinical audits and national confidential enquiries

During 20/21 39 national clinical audits and one national confidential enquiry covered relevant health services that the Trust provides. During that period the Trust participated in 95% of the national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate during 20/21 are shown in table 2.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during the 19/20, are listed in table 3 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the teams of that audit or enquiry.

Data collection for a number of the national audits was suspended and / or limited due to COVID-19, these are denoted with a * within the table 2.

The reports of 50 national clinical audits were reviewed by the Trust in 20/21. The actions that the Trust intends to take to improve the quality of health provided are detailed in Part 3.

The reports of 38 local clinical audits were reviewed by the Trust in 20/21. The actions that the Trust intends to take to improve the quality of health provided are detailed in Part 3.

National audit YDH eligible to participate in	YDH participation 20/21	Percentage of required number of cases submitted
Antenatal and Newborn national audit protocol 2019 to 2022	Yes	Continuous audit of all eligible patients
BAUS Urology Audits:		
> Cystectomy	N/A	--
> Nephrectomy & Nephroureterectomy	N/A	--
> Percutaneous Nephrolithotomy (PCNL)	N/A	--
> Radical Prostatectomy	N/A	--
> Surgery for Stress Urinary Incontinence (SUI) –registry	Yes	Continuous audit of all eligible patients
> Urethroplasty	N/A	--
British Spine Registry – Amplitude Clinical Services Ltd	N/A	--
Case Mix Programme (CMP) - Intensive Care National Audit Research Centre (ICNARC)	Yes	Continuous audit of all eligible patients
National Confidential Enquiry into Patient Outcome and Death Programme (NCEPOD):		
> Medical and Surgical Clinical Outcome Review Programme	Yes	
> Organisational Study - Alcohol related Liver Disease *(this is not part of the usual programme and was the only survey to run during the period)*	Yes	
> Child Health Clinical Outcome Review Programme – Royal College of Paediatrics and Child Health	No*	--
> Mental Health Clinical Outcome Review Programme – University of Manchester, NCISH	N/A	--
Elective Surgery (National PROMs Programme)	Yes	Continuous audit of all eligible patients
Cleft Registry and Audit Network (CRANE) – Royal College of Surgeons	N/A	--
Emergency Medicine quality improvement programmes		
> Fractured Neck of Femur	No*	--
> Pain in Children	No*	--
> Infection Control	No*	--
Falls and Fragility Fracture Audit Programme (FFFAP):		
> The National Hip Fracture Database - Royal College of Physicians (RCP)	Yes	Continuous audit of all eligible patients
> The National Audit of Inpatient Falls - Royal College of Physicians (RCP)	Yes	Continuous audit of all eligible patients
> The Fracture Liaison Service Audit - Royal College of Physicians (RCP)	Yes	Unable to collect all eligible patients due to COVID-19
Inflammatory Bowel Disease (IBD) Audit	Yes	Continuous audit of all eligible patients
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Continuous audit of all eligible patients
Mandatory Surveillance of HCAI	Yes	Continuous audit of all eligible patients

National audit YDH eligible to participate in	YDH participation 20/21	Percentage of required number of cases submitted
Maternal and Newborn Infant Clinical Outcome Review Programme - Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries (MBRACE-UK)	Yes	Continuous audit of all eligible patients
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)		
> Chronic Obstructive Pulmonary Disease Audit - Royal College of Physicians (RCP)	No*	--
> Adult Asthma Audit - Royal College of Physicians (RCP)	No*	--
> Children and Young People Asthma Audit - Royal College of Physicians (RCP)	No*	--
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Continuous audit of all eligible patients
National Audit of Cardiac Rehabilitation – University of York	No	
National Audit of Care at the End of Life (NACEL) – Postponed to next year due to COVID-19	No*	
National Audit of Dementia (NAD) – Postponed due to COVID-19	No*	
National Audit of Pulmonary Hypertension – NHS Digital	No*	N/A to our Trust
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	No	Unable to participate
National Bariatric Surgery Register – British Obesity and Metabolic Surgery Society	N/A	N/A to our Trust
National Cardiac Arrest Audit (NCAA)	Yes	Continuous audit of all eligible patients
National Cardiac Audit Programme (NCAP) – Barts Health Trust and National Institute for Cardiovascular Outcomes Research (NICOR)		
> Adult Cardiac Surgery*	N/A	N/A to the Trust
> Congenital Heart Disease*	N/A	N/A to the Trust
> Cardiac Rhythm Management	Yes	Continuous audit of all eligible patients
> Myocardinal Ischaemia National Project (MINAP)	Yes	Continuous audit of all eligible patients
> Heart Failure	Yes	Continuous audit of all eligible patients
> Percutaneous Coronary Intervention (PCI)*	N/A	--
National Comparative Audit of Blood Transfusion programme* - All audits were suspended due to COVID-19		
> Audit of the management of perioperative paediatric anaemia	No*	
> Survey of use of FFP, cryoprecipitate, PCC and fibrinogen concentrate	No*	
> Audit of NICE Quality Standards	No*	
> Audit of Blood Sample Collection & Labelling	No*	
National Diabetes Audit Adults - NHS Digital	Yes	Continuous audit of all eligible patients
National Pregnancy in Diabetes Audit - NHS Digital	Yes	Continuous audit of all eligible patients
National Paediatric Diabetes Audit (NPDA)	Yes	Continuous audit of all eligible patients

National audit YDH eligible to participate in	YDH participation 20/21	Percentage of required number of cases submitted
National Early Inflammatory Arthritis Audit (NEIAA)*	Yes	Continuous audit of all eligible patients
National Emergency Laparotomy Audit (NELA)	Yes	Continuous audit of all eligible patients
National Gastro-intestinal Cancer Programme	Yes	Continuous audit of all eligible patients
National Joint Registry	Yes	Continuous audit of all eligible patients
National Lung Cancer Audit (NLCA)	Yes	Continuous audit of all eligible patients
National Maternity and Perinatal Audit	Yes	Continuous audit of all eligible patients
National Neonatal Audit Programme (NNAP)	Yes	Continuous audit of all eligible patients
National Ophthalmology Database Audit -	Yes	Continuous audit of all eligible patients
National Prostate Cancer Audit (NPCA)	Yes	Continuous audit of all eligible patients
National Vascular Registry	N/A	N/A to our Trusts
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections.	Yes	Continuous audit of all eligible patients
Paediatric Intensive Care Audit (PICANet)	N/A	N/A to our Trust
Perioperative Quality Improvement Programme (PQIP)	Yes*	Continuous audit of all eligible patients
Prescribing Observatory for Mental Health UK (POMH-UK)	N/A	N/A to our Trust
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Continuous audit of all eligible patients
Serious Hazards of Transfusion Scheme (SHOT)	Yes	Continuous audit of all eligible patients
Society for Acute Medicine Benchmarking Audit* - Audit didn't run during this period	N/A	Audit did not run during reporting period
Surgical Site Infection Surveillance	Yes	Continuous audit of all eligible patients
The Trauma Audit & Research Network (TARN)	Yes	Continuous audit of all eligible patients
UK Cystic Fibrosis Registry	Yes	Continuous audit of all eligible patients
UK Registry of Endocrine and Thyroid Surgery	N/A	N/A to our Trust
UK Renal Registry National Acute Kidney Injury Programme	N/A	N/A to our Trust

Table 2

Information on participation in clinical research

The number of patients receiving relevant services provided or subcontracted by the Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 1780.

The Trust has a commitment to using research as a driver for improving the local quality of care and patient experience and also contributing to the evidence base both nationally and internationally.

The Trust is a partner organisation of the National Institute for Health Research (NIHR) South West Peninsula Clinical Research Network. For more information on research carried out by the Trust, and other highlights, please see the Clinical Research and Development page on the website (https://yeovilhospital.co.uk/about-us/research-anddevelopment/).

Information on the use of Commissioning for Quality and Innovation (CQUIN) payment framework

CQUIN payments with an assumed achievement of 100%, were included within the above guaranteed minimum level income.

No CQUIN goals were agreed for 2020/21 as a result of the COVID-19 Pandemic.

Information relating to registration with the Care Quality Commission (CQC) and special reviews / investigations

Yeovil District Hospital NHS FT is registered with the Care Quality Commission (CQC) and its current registration status is Requires Improvement, the Clinical Services review was graded Good overall. The Trust has no conditions on registrations.

Yeovil District Hospital NHS FT has not participated in any special reviews or investigations by the CQC during the reporting period. The Care Quality Commission has not taken enforcement action against the Trust during 20/21.

The hospital was rated as Requires Improvement under the safe domain. The Care Quality Commission published the Trust's Use of Resources report at the same time, which is based on an assessment undertaken by NHS Improvement. The Trust was rated as Inadequate for using its resources productively.

The combined rating for the Trust, taking into account the Care Quality Commission's inspection for the quality of services and NHS Improvement's assessment for Use of Resources, is Requires Improvement.

It is important to clarify the reasons behind the ratings given against the safe domain, which relate to technical aspects of the service and did not, in themselves, suggest clinical risk to patients. The Care Quality Commission noted certain areas where it would like to have seen greater clarification, evidence or improvement, including the need for greater consistency in record keeping and changes to the support provided for children and young people with mental health issues.

All 'must do' actions identified by the Care Quality Commission have been completed with ongoing monitoring as to their effectiveness.

This rating comprised of 35 'good' or 'outstanding' ratings in a total of 39 inspection themes.

Patients attending our hospital to receive care or treatment from any of these services can therefore do so confident that we are meeting or exceeding national benchmarks for hospital services.

The matrix of core service results is shown in figure 3.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Outstanding ↑↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Medical care (including older people's care)	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Surgery	Requires improvement Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Critical care	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Maternity	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Services for children and young people	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
End of life care	Requires improvement ↓ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Outpatients	Good Jul 2016	N/A	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Overall*	Requires improvement →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019

Figure 3

In February 2021, the Care Quality Commission commenced an unannounced, but routine, inspection at Yeovil District Hospital NHS FT, focussed specifically on infection prevention and control. The Care Quality Commission is conducting these inspections in care settings across the country and they are specifically to see that:

- Adequate PPE is available for staff and residents to control infection safely;
- Staff are properly trained to deal with outbreaks and the proper procedures are in place;
- Shielding and social distancing is being complied with;
- Layout of premises, use of space and hygiene practice promote safety.

The findings from the report were wholly positive with the Care Quality Commission recognising that the Trust has a clear vision and strategy for continuously improving practices relating to infection prevention and control, and that these practices were aligned with other departments and the wider healthcare system.

The report outlined that staff felt respected, supported and valued, and the service had an open culture where staff could raise concerns without fear. An assurance system was recognised to be in place for infection prevention and control, which enabled performance issues and risks to be reviewed.

The Care Quality Commission identified outstanding practice with Yeovil Hospital in relation to Infection Prevention and Control, including the Trust recognising the importance of, and benefiting from, bringing the bed management team and infection prevention and control team together to work as one team during the pandemic.

Another area of outstanding practice was recognising the value and importance of a high degree of support for staff and, in the recent staff survey, the Trust was rated among the best in the country for staff engagement.

A small number of 'should-do' actions were identified, including the review of processes to update and review policies and standard operating procedures, identify and document actions to improve compliance following audits, include a review of any eye protection when auditing Infection Prevention and Control compliance, and to consider systems and processes to easily gain assurance about cleaning regime completed.

This Infection Prevention and Control inspection does not influence the Care Quality Commission ratings for the Trust. The Trust's rating remains in place from the full inspection conducted in 2019/20 of which an overview is provided below.

This report outlined there had been clear progress in a number of areas since the previous inspection and in two domains the highest Outstanding rating was achieved. The hospital's core services were rated as Good for caring and for being effective, responsive and well led.

Information on the quality of data

Secondary Uses Service data

The Secondary Uses Services (SUS) is the single comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services. SUS is a secure data warehouse that stores this patient level information in line with national standards.

Yeovil District Hospital NHS FT submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data, see table 3.

The percentage of records in the published data which included the patient's valid NHS number was:
> 99.9% for admitted patient care;
> 99.9% for outpatient care; and
> 99.6% for accident and emergency care.
The percentage of records in the published data which included a valid General Medical Practice code was:
> 100% for admitted patient care;
> 100% for outpatient care; and
> 100% for accident and emergency care.

Table 3

Information Governance Assessment Report / Data Security & Protection (DSP) Toolkit

The 2021 DSP Toolkit introduced a number of new elements, with an increased focus on Cyber Security. This combined with many previous evidence items having expired, meant the Trust had a great deal of outstanding items to complete the DSP Toolkit to a satisfactory level. The Trust will complete all 42 of 42 assertions, and while all 110 mandatory items will be provided, some of these will be in the form of improvement plans (specifically in areas such a regular Information Governance audits, Business Continuity and emergency response testing, as well as Information Governance training levels in the Trust).

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS DSP Toolkit. This contains 10 standards of good practice, as outlined below.

1. Personal Confidential Data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Reviews
6. Responding to Incidents
7. Continuity Planning
8. Unsupported Systems
9. IT Protection
10. Accountable Suppliers.

In response to the COVID-19 outbreak, the submission of the DSP Toolkit was nationally postponed until 30 September 2020 which the Trust duly published. The Trust recognises data security and information governance as a high priority and continues to ensure that high standards are met throughout the organisation with data security and information governance breaches reported and monitored through the Information Governance & Information Technology Oversight Group, which, in turn, reports to the Audit Committee.

While the Information Governance group meetings were suspended during the pandemic, they were restarted under the title Information Governance & Information Technology Oversight Group (IGITOG) in May 2021. In order to provide clinical oversight to digital transformation the Clinical Design Authority was put in place and has met monthly from November 2020 onwards. A number of risks were resolved through system improvements in TrakCare and updates as well as other clinical and other systems, this resulted in risks being successfully removed from the Trust risk register.

In line with the DSP Toolkit eight incidents were submitted via the portal, of which three met the Information Commissioner's Office (ICO) reporting criteria and investigated. The ICO decided in all three of the incidents that no further action was necessary but made recommendations for the Trust. The ICO advised the Trust that for remaining five incidents, they did not feel met the criteria for a reportable data breach under Article 33 of the GDPR. Four of these incidents related to information being disclosed in error. One incident related to suspected theft of information by a recent employee. One incident related to phishing emails sent to a member of staff.

The Senior Information Risk Owner position for 2020/21 was held by the Chief Finance Officer.

Payment by Results clinical coding audit

Yeovil District Hospital NHS FT was not subject to a Payment by Results clinical coding audit during by NHS Improvement in 20/21.

Actions to improve data quality

A series of Clinical Coding audits were undertaken by an NHS Digital Approved Clinical Coding Auditor on behalf of YDH, which examined the Clinical Coding accuracy of 200 spells Finished Consultant Episodes (FCEs) for activity between 1 April 2020 and 28 February 2021, see table 4.

Spells tested	%of HRG changes	Pre-audit value	Post-audit value	Net change	Net change %
200	7.5%	£419,820	£428,239	£8,419	2%

Table 4

The areas reviewed were a random sample covering the following core specialities: general medicine, general surgery, trauma and orthopaedics, paediatrics, obstetrics, gynaecology and day theatre activity.

The coding accuracy (see table 4) achieved the advisory Data Security and Protection Toolkit attainment level overall with all four coding fields reaching the higher advisory levels. Compared to the 2019/20 audit this has highlighted the Trust has maintained the highest DSPT Advisory accuracy level. Of note, the auditor identified that all errors were coder errors indicating that source material, both full paper case notes and electronic patient records, are of good quality and fit for purpose.

Acute Trust	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Advisory	>=95%	>=90%	>=95%	>=90%
Mandatory	>=90%	>=80%	>=90%	>=80%
Yeovil	**97%**	**96%**	**95%**	**93%**

Table 5

The greatest sources of error from audit stemmed from the Secondary Diagnosis Omitted error key and the Secondary Diagnosis Not Required error key accounting for 29 and 27 errors respectively. Despite the trust achieving the highest advisory attainment level these error keys can be indicative of a difficulty in extracting the salient information without straying over into "over coding" incidental or irrelevant conditions.

The error rate resulted in a potential net financial undercharge of £8,419 (2%) to the commissioners for the sample audited. This was the result of 15 Healthcare Resource Group (HRG) changes (7.5%) with the largest single HRG change was an increase from £4,364 to £11,054 in an orthopaedic trauma admission.

The gross change totalled £14,311 (3.4%). However, this financial analysis is not a true representation of the financial impact on the trust as the majority of activity is billed as per local agreements rather than National Tariff and the results should not be extrapolated further than the actual sample audited.

Yeovil District Hospital FT will be taking the following actions to improve data quality:

> Clinical Coding Audit findings will be fed back to the Clinical Coders both on an individual basis as well as a group session highlighting all sources of coder error with all required post audit training implemented/scheduled in a timely manner as per each audit's action plan.

> Particular focus will be given to secondary diagnosis assignment training.

> In line with the YDH Data Quality policy we have identified the roles and responsibilities across the hospital to achieve good data quality. To assist in this the YDH Data Quality Steering Group is responsible for monitoring and compliance of coding standards with a particular focus on reporting. It also monitors the Trust Risk Register and reports on the standards of Data Quality, and monitors the implementation of any recommendations from both internal and external authorities in the Trust to the Information Governance Steering Group, now known as the Information Governance and Information Technology Oversight Group (IGITOG).

> Utilise healthcare intelligence from Dr Foster and Summary Hospital – Level Mortality Indicator (SHMI) in addition to key external performance frameworks such as the model hospital and more specifically the Data Quality Maturity Index (DQMI) to help both monitor and improve data quality at source.

> The Trust's DQMI score for 2020/21 was 89.7%, the National Average score for the same time period was 82.0%

Learning from deaths

1 During 20/21 774* YDH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
   > 167 in the first quarter
   > 141 in the second quarter
   > 229 in the third quarter
   > 237 in the fourth quarter

   *This includes those who died in the Emergency Department

2 By 31 March 2021, 467 case record reviews and 32 more detailed investigations have been carried out in relation to 499 of the deaths included above. There were no cases where death was subjected to both a full case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
   > 28 in the first quarter
   > 131 in the second quarter
   > 169 in the third quarter
   > 171 in the fourth quarter

   These figures include those cases reviewed by the Medical Examiner whose appointment in July 2020 is reflected in the increased number of cases subject to a review in the latter 3 quarters of the review period.

3 Two cases representing 0.25% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:
   > 1 representing 0.59% for the first quarter
   > 0 representing 0% for the second quarter
   > 0 representing 0% for the third quarter
   > 1 representing 0.42% for the fourth quarter

   These numbers include all cases rated 1-3 according to the scale contained within the Structured Judgement Review (SJR) tool developed by the Royal College of Physicians. This tool has been adopted throughout the Trust with formal mortality reviews recorded on a central database to enable learning to take place.

4 Summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above.

- The Medical Examiner role has increased communication with HM Coroner and enabled an initial assessment of the majority of deaths. This has also enhanced the review process, allowing the inclusion of questions raised by family members and enabling learning to be identified at an earlier stage.
- Timely and appropriate Do Not Attempt Resuscitation (DNAR) discussions and decisions were made on admission, but Community DNAR and Treatment Escalation Plans do not always inform the decision to admit or in-hospital management plans.
- Clear Treatment Escalation Plans should be provided when patients are transferred for ongoing care which should include clear directions about readmission to the acute unit and under what circumstances this would be appropriate.
- The process by which a patient can provide an Advance Directive and the way their expectations are managed was in need of review.
- Transfer of patients (due to COVID-19 measures) can detract from the completion of formal documented assessments, leading to less knowledge about the individuals' limitations and risks at a time when they may be unsettled from the transfer.
- There was a need to provide effective formal review of patients who have died as a result of a COVID-19 infection, particularly if this was a hospital-acquired infection.
- Delays in patient admission and diagnosis have been seen as a direct result of COVID-19.
- Early consultation with the Palliative Care Team in some cases can reduce unnecessary investigations and inappropriate invasive procedures.
- Ongoing work to detect Acute Kidney Injury and education about the importance of adequate fluid replacement needs to continue.
- Lack of oversight and liaison between the Mental Health Team and the Acute Trust can lead to inappropriate management and discharge.

5 Actions taken, or proposed in the reporting period, as a consequence of what the provider has learnt during the reporting period.

Actions are varied and may include changes to, or introductions of, policies and guidelines, changes to systems or changing patient pathways. Similarly, the outcomes of every case record review are monitored and ongoing themes and trends are reported and escalated as required to ensure any and all required changes are made.

- Analysis of case reviews at local Governance Meetings to inform decision making and learning.
- Review of changes to the Countywide Do Not Attempt Resuscitation (DNAR) Acute Kidney Injury (AKI) and escalation documentation.
- Review of the provision of Advance Directives at the Clinical Ethics Committee. Further work planned to look at the processes in place to manage a patient expectations in respect of an Advance Directive and ensure a formal process to store and flag the documents provided.
- Post-Infection Reviews incorporating Mortality elements have been developed to capture information about any patient with a hospital acquired COVID-19 infection.
- Reviews are being undertaken to identify and act on any delays caused by the pandemic including patient reluctance to attend and delayed investigation and diagnosis.
- Continued monitoring of patients for and management of Acute Kidney Injury AKI. Audits of compliance with appropriate hydration measures and early identification and treatment for deteriorating renal function.
- Education and discussions between clinical teams stressing the importance of completing a full assessment of patients who present with a mental health issue, including their physical needs and formal assessment of capacity.
- Discharge information and check list developed for use when the discharge of vulnerable adults takes place.
- As a consequence of the challenges and changing guidance relating to the COVID-19 pandemic there has been increased cleaning regimes, continued access to personal protective equipment (PPE) for all staff as required, continual review of patient pathways and substantial environmental improvements.

6	An assessment of the impact of the actions described above which were taken by the provider during the reporting period. > Individual learning has been evidenced within the junior doctors when reviewing the quality and content of medical records. > The quality of documentation within patient records has improved over the reporting period. > The Treatment escalation Plans TEP/DNAR documentation is updated when transfer of a patient occurs to ensure the receiving hospital has knowledge of the circumstances where a return/readmission to the acute unit would be deemed appropriate. > Discussions are ongoing in relation to the formal process for receiving and acting on a patient's Advance Directive. These documents are flagged on the electronic patient record system and can form a valuable record helping to confirm a patient's wishes. > The Trust is using a Post infection Review tool incorporating mortality details and an avoidability score for those patients who have suffered a hospital acquired COVID-19 infection and subsequently died. This process includes compliance with the national requirement for Duty of Candour. > Measures are already in place to facilitate continued non COVID-19 activity and encourage patients to report symptoms and attend the hospital for investigation and diagnosis. > The discharge process for Vulnerable Adults is subject to enhanced checks in relation to, the appropriateness of the discharge, the destination and the planned transport arrangements as well as ensuring that appropriate communication has occurred. > The Trust has maintained compliance with the changing National Guidance relating to COVID-19 measures with increased cleaning regimes, PPE, review of patient pathways and substantial environmental improvements.
7	No case record reviews or investigations were completed after 31 March 2020 which related to deaths which took place before the start of the reporting period.
8	None, representing 0% of the patient deaths occurring before the reporting period, but reviewed after the previous report are judged to be more likely than not to have been due to problems in the care provided to the patient.
9	None representing 0% of the patient deaths during 19/20 and reviewed following that reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Performance against national core set of quality indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital.

The Trust's performance against these indicators is shown below. For each indicator, the Trust is also required to make an assurance statement. There has not been an audit of the mandated indicators for the reporting period due to the national COVID-19 pandemic.

Organisational health indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
Overall patient experience of hospital care	NHS Digital	Aug 19 to Jan 20	77.0	77.5	89.0	69.2	76.0	78.1
Responsiveness to patients' needs	NHS Digital	Aug 19 to Jan 20	65.9	67.6	84.2	59.5	67.1	69.
Staff sickness	NHS Digital	Apr 20 to Mar 21	3.4%	2.9%	2.2%	7.9%	5.7%	3.8%
Staff turnover	Trust	Apr 20 to Mar 21	15.6%	16.4%	9.2%	22.1%	13.8%	15%
NHS staff survey response rate	NHS Digital	Apr 20 to Mar 21	65%	72%	79.8%	28.1%	49.1%	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website and where necessary our internal data intelligence. The increase in staff sickness is a likely outcome of the COVID-19 pandemic. Whilst the Trust's response rate for the national staff survey has decreased, it remained the highest in the country for an acute trust.

Effective indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
Palliative care coding	NHS Digital	Oct 19 to Sep 20	55.0%	58.0%	60.0%	9.0%	36.0%	-
SHMI	NHS Digital	Oct 19 to Sep 20	88.07	91.55	68	117	100	100
PROMS: Hip replacement EQ VAS	NHS Digital	Apr 19 to Mar 20	66.7%	50.0%	-	-	69.5%	-
PROMS: Hip replacement EQ 5D index	NHS Digital	Apr 19 to Mar 20	100.0%	100.0%	-	-	89.8%	-
PROMS: Hip replacement Oxford Hip Score	NHS Digital	Apr 19 to Mar 20	100.0%	100.0%	-	-	97.1%	-
PROMS: Knee replacement EQ VAS	NHS Digital	Apr 19 to Mar 20	85.7%	30.0%	-	-	59.8%	-
PROMS: Knee replacement EQ 5D index	NHS Digital	Apr 19 to Mar 20	71.4%	100.0%	-	-	82.9%	-
PROMS: Knee replacement Oxford Knee Score	NHS Digital	Apr 19 to Mar 20	100.0%	No Data	-	-	94.7%	-
Readmissions in 30 days: 0-15yrs	NHS Digital	Apr 19 to Mar 20	14.10%	12.50%	4.4%	18.5%	12.5%	-
Readmissions in 30 days: 16+years	NHS Digital	Apr 19 to Mar 20	13.90%	13.90%	7.0%	17.5%	14.7%	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website. The previously reported issues with the data interface for the PROMS provider has been resolved and the Trust is now able to report accurately against this requirement.

Caring indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
MSA breaches	NHS Digital	Apr 20 to Mar 21	0	0	-	-	0.0	-
Complaints rate	Trust	Apr 20 to Mar 21	0.54	0.48	-	-	-	-
Staff: friends and family test	NHS Digital	2020	79.1%	76.5%	97.7%	49.7%	74.3%	-
Maternity: friends and family test	Trust	Mar-21	98.4%	98.2%	-	-		-
Inpatients and day cases: friends and family test	Trust	Mar-21	98.1%	98.2%	-	-		-
Emergency Department: friends and family test	Trust	Mar-21	100.0%	97.9%	-	-		-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website and where necessary our internal data intelligence. All caring indicators are in line with expectations.

Safe indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
VTE risk assessment	NHS Digital	Apr 20 to Mar 21	94.6%	95.8%	-	-	-	95.0%
Percentage of Patient Safety Alerts (PSA) completed within the required timeframe	NHS Digital	Apr 20 to Mar 21	0	0	-	-	-	-
Never events	NHS Digital	Apr 20 to Mar 21	0	2	-	-	-	-
Emergency C-section rates	Trust	Apr 20 to Mar 21	20.0%	18.8%	-	-	-	-

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
Rate of C.diff infection per 100,000 bed days	NHS Digital	Apr 20 to Mar 21	7	8	-	-	-	-
MRSA bacteraemias	NHS Digital	Apr 20 to Mar 21	0	0	-	-	-	-
Rate per 1000 bed days: patient safety incidents	Trust	Apr 20 to Mar 21	50.1	47.9	-	-	-	-
Percentage of patient safety incidents that resulted in severe harm or death	Trust	Apr 20 to Mar 21	0.586%	0.217%	-	-	-	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website and where necessary our internal data intelligence. The Trust intends to take the following actions to improve the following indicators, and so the quality of its services:

> Work has been undertaken to improve performance with VTE risk assessment, this will also be a mandatory field within ePMA going forward.

> The Trust's guideline for caesarean birth will be updated in line with new NICE guidance, published in March 21.

Risk assessment framework indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
C.diff meeting the C.diff objective (all)	NHS Digital	Apr 20 to Mar 21	7	9	-	-	-	-
Certification against compliance with requirements regarding access to health care for people with a learning disability	Trust Board Declaration	Apr 20 to Mar 21	Compliant	Compliant	-	-	-	-
62 day wait for first treatment from urgent GP referral: all cancers	CWT return	Apr 20 to Feb 21	84.7%	86.0%	100.0%	51.0%	77.0%	85.0%
62 day wait for first treatment from consultant screening service referral: all cancers	CWT return	Apr 20 to Feb 21	41.7%	61.0%	97.0%	31.5%	84.5%	90.0%
31 day wait from diagnosis to first treatment: all cancers	CWT return	Apr 20 to Feb 21	97.4%	95.5%	100.0%	71.0%	96.0%	96.0%
31 day wait for second or subsequent treatment: surgery	CWT return	Apr 20 to Feb 21	93.4%	92.2%	100.0%	61.0%	91.0%	94.0%
31 day wait for second or subsequent treatment: anti-cancer drug	CWT return	Apr 20 to Feb 21	99.1%	99.0%	100.0%	83.0%	99.0%	98.0%
Two week wait from referral to date first seen: all cancers	CWT return	Apr 20 to Feb 21	94.7%	85.9%	100.0%	74.0%	91.0%	93.0%
Two week wait from referrals to date first seen: breast symptoms	CWT return	Apr 20 to Feb 21	94.9%	93.7%	98.0%	24.0%	84.0%	93.0%
18 week maximum wait from point of referral to treatment (incomplete pathways)	NHSI return	Apr 20 to Mar 21	65.6%	89.4%	100.0%	0%	36.0%	92.0%
Maximum 6 week wait for diagnostic procedures	Weekly SitRep	Apr 20 to Mar 21	93.7%	97.9%	99.7%	31.4%	79.8%	99.0%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	Weekly SitRep	Apr 20 to Mar 21	95.1%	94.7%	97.7%	47.6%	76.1%	95.0%

Yeovil District Hospital NHS FT considers that this data is as described as this is the latest available. As previously noted within this report one of the Trust's strategic priorities is to ensure cancer standards are consistently achieved. A national clinical harm review programme continues in order to identify those patients where a change in prioritisation of surgery is identified. The Trust are also aware of the number of patients who are choosing to delay surgery due to the pandemic.

Part 3: Other information

3.1 Patient safety

Patient safety incidents

The Trust aims to promote a high level reporting, low level harm culture with regard to incident reporting with monitoring processes in place to identify incidents and risks. These are analysed for trends to prevent reoccurrence. Should an investigation be triggered, this is reviewed by the Clinical Governance Team and any identified learning is reported back through clinical teams. At all times, members of staff are encouraged to report incidents with support provided by managers and through training.

The Trust utilises the National Reporting and Learning System (NRLS) for the reporting of all patient safety incidents together with mechanism to ensure action on safety alerts, recommendations and guidelines made by all relevant central bodies such as NHS England, the Medical Healthcare Regulatory Authority (MHRA) and the National Institute for Health and Care Excellence (NICE).

There were 9,699 incidents reported in 2020/21, this is a 9.1% increase from the number of incidents reported in 2019/20 (8,892). Of these 5,499 (56.7%) were patient safety incidents. Using the NHSE definitions incidents are categorised by harm level, these are shown below.

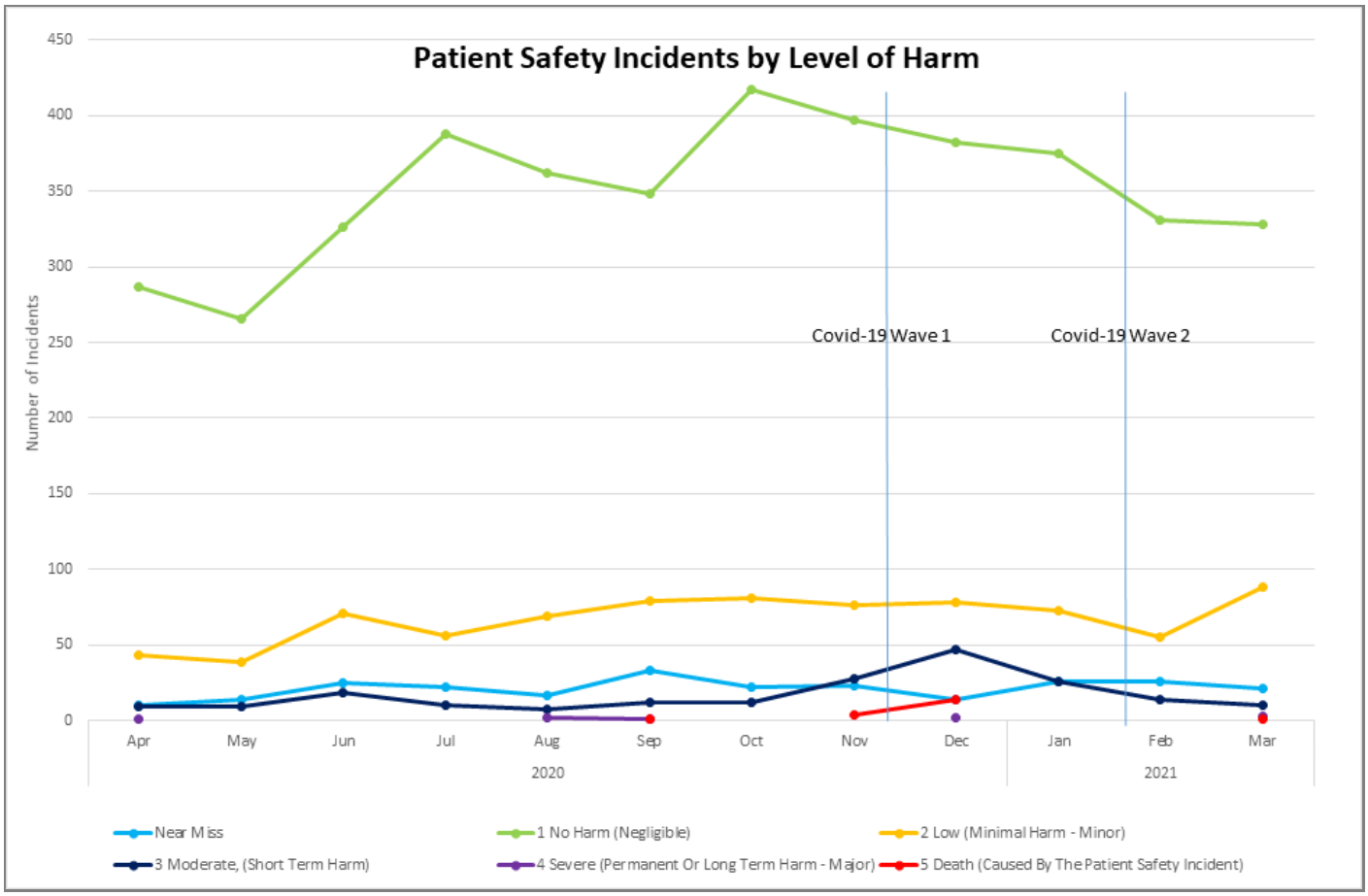

Figure 4

Serious incidents

A total of 68 investigations were commissioned in 2020/2021. Of these, four required a comprehensive root cause analysis (level 2 investigation) as they met the definitions of a serious incident requiring investigation, in accordance with national guidance, and were reported to Somerset Clinical Commissioning Group (CCG).

In addition, 21 incidents were reported to the CCG as they met the definition outlined in guidance issued by NHS England and NHS Improvement in October 2020 as a probable, or definite, hospital-onset healthcare-associated COVID-19 infection death. Following discussion with the CCG it was agreed that rather than identify all COVID-19 infection deaths as a serious incident, a review of each case would be undertaken in order to ascertain any care and service delivery problems that contributed to the outcome. This process is ongoing and post infection reviews (PIR) and case reviews will be shared with patients and families as per our Duty of Candour requirements.

Never events

NHS Improvement describes Never Events as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

There were no Never Events during the reporting period.

Duty of candour

When a patient safety incident occurs that results in a patient suffering moderate, or significant harm, the Trust, our staff:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that an incident has occurred, and provide support to them in relation to the incident;
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts known about the incident;
- Advise the relevant person what further enquiries we believe are appropriate;
- Offer an apology;
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries;
- Keep a written record of all communication with the relevant person.

The incident reporting system has a section for recording compliance with the Duty of Candour and for including the detail of who has been spoken with (the patient, or where the patient lacks capacity, their next of kin). Patients and/or their family are written to setting out an apology and the process of investigation. Formal investigations include patient involvement and a full copy of the report is shared with them accordingly. Performance with Duty of Candour during the reporting period is shown in Table 7.

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Total
Number of incidents requiring 1st DoC	3	2	1	4	1	6	2	2	7	3	2	2	35
% compliance with first DoC	100%	100%	100%	75%*	100%	100%	100%	100%	100%	100%	100%	100%	98%
Number of investigations quality assured / signed off	6	4	4	0	3	3	1	3	5	2	3	3	43
Number of incidents requiring 2nd DoC	6	4	4	0	3	3	1	3	1	2	3	2	35
% compliance with 2nd DoC	100%	100%	100%	-	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 6

*There was a three day delay of the first Duty of Candour letter being sent out, this related to a falls review.

Pressure ulcer prevention

At the end of the year 2020/21, a total of 56 hospital acquired pressure ulcers (Grade 2 and above) were reported compared to 56 for 2019/20. The rate per 1,000 bed days for 2020/21 was 0.57 which compares to 0.49 for 2019/20.

Pressure ulcer prevention challenging with the COVID-19 global pandemic. There are many factors that have been identified that contributed to the susceptibility of the patients to develop pressure damage identified as hospital acquired. The Tissue Viability Team have noted that the acuity of the patients reviewed has deteriorated significantly and this has been identified on admission. Nationally this has also been recognised and been associated with self-isolation, limited / no contact with personal support, poor self-care and anxiety in terms of seeking medical help.

In response to this the Team has significantly enhanced the Trust's stock of pressure relieving equipment facilitating off-loading pressure to the heels, seating cushions and replacement alternating air mattresses. This is supported with daily clinical ward reviews to support and educate staff to ensure the patients are appropriately risk assessed and appropriate measures are in place.

The Team have worked with the Clinical Governance Team to implement a photograph attachment facility to incident forms with a view to improving the accuracy of reporting and assist with the validation process.

Healthcare associated infections (HCAI)

Since 2008 there has been a legal requirement on the NHS and other health and social care organisations to implement the Health and Social Care Act 2008, and to meet the standards The Trust continued to sustain focus and energy on the infection prevention and control agenda, sharing key learning and best practice against the need for compliance with the HCAI national targets.

The implementation and maintenance of robust infection prevention and control practice remains a key action for the Trust in reducing avoidable health care associated infections. Ensuring infection prevention control policies and guidance are in place and implemented, is essential for confidence of all those that use the service and their families. The Infection Prevention and Control dashboard for 20/21, can be seen on page 28.

NHSEI identified a rise in Gram-negative blood stream infections across the healthcare community. This instigated a national ambition to reduce these infections by 50% by March 2021. The Somerset wide multidisciplinary working group has continued to address this and a robust action plan has been followed. Unnecessary catheterisation of patients remained a focus and reduction was seen across the county.

The process for reviewing HCAI involves a Post Infection Review (PIR) to identify learning and any focused improvement work required. Care and services delivery concerns are identified on the dashboard as lapses in care. During the year there were two lapses in care identified, these are outlined below:

- Clostridium Difficile infections (August 20). The index case was an admission from another acute trust who on admission was negative, testing positive following a second test. Another patient in the bay proved positive and typing confirmed the same strain. Therefore lapse of care from healthcare workers (HCW) between the two cases.
- MRSA blood stream infection (January 21). The patient was not decolonised when required due to a breakdown in communication between IPC, the Gastroenterology Team and the Ward. The review of the cannula documentation highlighted this as a possible contributing factor.

This data is reported locally to the Patient Safety Steering Group and Somerset Infection Prevention and Control Steering Group, chaired by Somerset NHS Clinical Commissioning Group. We are also required to report this nationally via HCAI Data Capture System Mandatory Surveillance facilitated by Public Health England.

A report was presented to the Governance Quality Assurance Committee in June 20 which detailed the outcome of a review into all of the hospital-onset healthcare-associated probable and definite COVID-19 infections.

Infection prevention and control dashboard 20/21

		19/20												
Quality objective	**Threshold**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
MRSA BSI	0	0	0	0	0	0	0	0	0	0	1	0	0	1
MRSA BSI Lapses in Care	0	0	0	0	0	0	0	0	0	0	1	0	0	1
MSSA BSI		0	0	0	1	0	0	1	1	1	2	0	0	6
MSSA BSI Lapses in Care		0	0	0	0	0	0	0	0	0	0	0	0	0
E Coli BSI		1	0	1	0	2	3	1	1	2	1	0	1	13
E Coli BSI Lapses in Care		0	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas BSI		0	0	0	0	0	0	0	0	0	0	1	0	1
Pseudomonas BSI Lapses in Care		0	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella BSI		1	0	0	0	0	2	0	0	2	0	2	0	7
Klebsiella BSI Lapses in care		0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Infections		1	2	0	0	2	0	0	3	0	0	1	1	10
Clostridium Difficile Infections Lapses in Care		0	0	0	0	1	0	0	0	0	0	0	0	1
Hand Hygiene - Trustwide average of scores submitted	90%	98%	98%	95%	98%	96%	95%	95%	96%	95%	97%	97%	94%	96%

Reducing patient falls

Some patients are at high risk of falling, either as a result of their rehabilitation or condition, and it is recognised that this causes anxiety, loss of confidence and in some cases serious injury to patients. The length of stay for patients who have fallen whilst in hospital is often increased as staff attempt to improve their mobility and confidence.

The Trust has a Falls Steering Group which is a multidisciplinary working group who meet bi-monthly to oversee quality improvement projects and respond to incidents as they occur. TagCare (a system of ensuring a group of patients who are deemed to be at high risk of falling are managed collectively by a ward based multidisciplinary team who have line of sight at all times in a bay) and Cohorting of patients continues to be used and has become embedded in ward practice, forming part of the daily ward risk assessment and plan of care for high risk patients.

During 2020 a new VitalPac module that includes the facility to record lying and standing blood pressure was implemented. VitalPac is the Trust's patient clinical monitoring system and will alert users if the patient's vital signs are outside acceptable limits. It is used in all inpatient clinical areas with the exception of maternity and paediatrics.

The ward trauma project continues to be embedded across the Trust; this is a ward-based trauma call system that has been implemented for patients aged 65 or over, in line with NICE guidance (Falls in older people: assessing risk and prevention CG161). A trauma call will be triggered for patients meeting the criteria below:

- Fall from standing height or greater than standing and at least one of the following:
- Systolic BP < 110mmHg or pulse > 90BPM
- Conscious level on AVPU scale = VPU
- Concerning injury (head, spine, pelvis, hip, chest)

The falls data detailed is extrapolated from the Trust incident reporting system (Ulysses) captures all reported incidents of slips, trips and falls; this data is reviewed monthly by the Patient Safety Committee.

Overall the number of falls has increased slightly over the year with the final number for 2020/21 reported as 858 compared with 797 reported the previous year. The rate per 1,000 bed days for 2020/21 was 8.80 which compares to 6.98 for 2019/20.

The Falls Steering Group was stood down for a period during the pandemic in order prioritise use of resource, and recommenced at the end of 2021. The key priorities for the next 12 months are:

- The implementation of a Frailty Roaming Service including Occupational Therapists and Social Workers. This multidisciplinary team review frailty patients within the Emergency Department, the Clinical Decisions Unit and the Rapid Assessment Zone with a primary focus on information gathering and liaison with family and care agencies etc. in order to determine the best course of action e.g. admission, discharge with a package of care.
- There has been an increase in falls noted on the Emergency Admissions Units (EAU), a member of the group has been working with these areas looking at prevention, documentation and incident reporting.
- The falls alarms purchased last year are being trialled on EAU following an increase in the number of falls resulting in harm that have occurred on the Unit.
- A rapid review template has been tested on a fall that resulted in a fracture, this was undertaken very quickly following the event with positive results. The findings of the review will be taken back to the Serious Incident Review Group. The aim of the rapid reviews is to ascertain the facts regarding the fall to reduce the burden of the full level 1 falls reviews, and allow more resource to focus on improvement. This will also include the completion of the dataset for the national audit of inpatient falls.
- Since March 20, and the start of the pandemic, there has been an increase in the level of patient dependency; anecdotally patients are presenting deconditioned and as a result are at greater risk of falling. There have also been a number of environmental changes implemented to mitigate the risk of

transmitting COVID-19 between patients and staff that may have had unintended consequences for these patients, further increasing their vulnerability to falling. These have included:

- All visiting was stopped on the 5 November 20.
- Changes in ward configurations and staff groups looking after different cohorts of patients
- Limiting footfall on to the wards from Pharmacy and Therapy Staff
- Doors on bays decreasing visibility.
- The requirement to don PPE before entering bays, increasing the time needed to answer patients' call bells and / or provide assistance if they are attempting to mobilise from their bed.
- Staffing issues.
- Wards have been unable to instigate tag care due to the requirement to keep the doors to bays closed, staffing issues and the donning and doffing of PPE.

Safer medicines

Pharmacy continue to provide an enhanced and extended seven day pharmacy service for patients and staff. 95.5% of all patients admitted to hospital during 2020/2021 were seen and reviewed by a clinical pharmacist within 24 hours of admission. The decentralised pharmacy discharge service continues to support patient flow across the Trust and improve patient experience at discharge. The average time taken for pharmacy to process discharge summaries at ward level was 37.5 minutes. 11442 changes to medication were made by pharmacists under the Trust's Enabling Policy ensuring the safe prescribing and administration of medicines to patients.

Pharmacy made a number of operational changes to their services during the COVID-19 pandemic to ensure medicines optimisation continued for every inpatient while minimising the risk of infection to patients and staff. Additional pharmacists were trained to provide a clinical pharmacy service to ICU, the Enabling Policy was expanded to allow pharmacists to provide additional support to prescribers, extra staff were trained to transcribe discharge medication and a pharmacy team worked alongside staff in the Discharge Lounge to ensure the safe and rapid discharge of patients. A team of pharmacy staff were also involved in the implementation and delivery of the Trust's COVID-19 vaccination programme.

The Medicines Committee, the Medicines Optimisation Programme and Audit Plan and the Medication Safety Assurance Audit continue to support improvements in medicines safety and assurance. Numerous Trust wide policies and procedures were developed, reviewed and approved by the Medicines Committee. Pharmacy conducted a number of medicines related audits including the annual pharmacy intervention audit which reported a total of 423 interventions made over a 5 day period in October 2020 (including 51 graded as major), equating to 22,000 pharmacy interventions per year.

Pharmacy delivered a total of £460,636 financial benefits for the Trust during 2020/2021 which is a combination of financial savings on medicine costs, increased commercial activity and additional income through NHSEI and Somerset CCG.

The pharmacy Aseptic Services Unit (ASU) manufactured 5366 injectable chemotherapy treatments with 83% of these being delivered on time. Vial sharing savings of £900 were made during 2020/2021.

The number of pharmacist independent prescribers increased to 9 allowing the team to provide regular prescribing support to rheumatology, diabetes and oncology. 2 specialist pharmacist posts were also created during 2020/2021 in Human Immunodeficiency Virus (HIV) medicines and anticoagulation with these pharmacists providing a highly specialist service to inpatients and outpatients.

There was an acceleration of digital transformation across the Trust as a result of the COVID-19 pandemic. A new Inpatient Discharge Letter (IDL) was launched as the end of the year in preparation for the implementation of electronic Prescribing and Medicines Administration (ePMA) during 2021/2022. Other developments included the development of Pharma Outcomes interfaces, Venus Thromboembolism (VTE) and COVID-19 vaccine data collection, tools for tracking creatinine clearance and Acute Kidney Injury (AKI) and support for e-charting in Intensive Care Unit (ICU).

Further improvements to the pharmacy service and the provision of medicines optimisation are planned for 2021/2022 and include the following:

- Implementation of ePMA across the Trust.
- Development of a new specialist pharmacist role in diabetes.
- Access to Pharma Outcomes, a web-based system to support the referral of patients to their community pharmacists for review following discharge from hospital.
- The roll out of self-administration of medicines across the Trust to give patients the opportunity to administer their own medication in hospital.
- Introduction of the electronic ordering of stock medication on the wards.
- The replacement of locks on all medicine cupboards across the Trust with a swipe card access system.
- To review the provision of medicines through the current outpatient pharmacy as the existing contract with Boots Ltd finishes in February 2022.

Medication related incidents continued to be well reported during 2020/2021, see figure 5, with a total of 628 reported via Ulysses (compared to 757 incidents for the previous financial year). There were two medication incidents graded as significant i.e. the error caused actual harm to a patient. All medication related incidents continue to be reviewed by the Medication Safety Officer and discussed by the Medicines Committee. Key prescribing errors or common themes are identified and the required learning from these incidents is established.

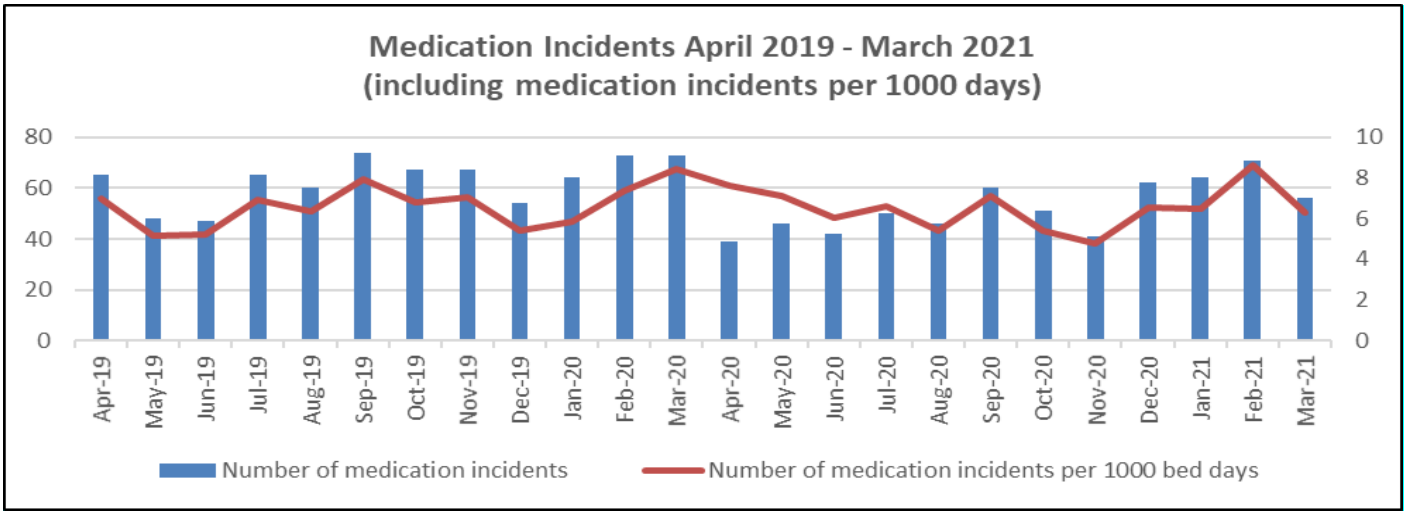

Figure 5

During 2020, a specialist pharmacist anticoagulation service was commenced within the Trust as a pilot study. The pharmacist in this role is responsible for reviewing inpatients with complex anticoagulation requirements and also working as an advanced practitioner in Ambulatory Emergency Care (AEC). Over a five month period, a total of 352 inpatients were reviewed by a specialist pharmacist and interventions were made for 41.5% (146) of these patients.

Deteriorating Patient

The Deteriorating Patient Steering Group was relaunched at the end of 2020/21 following a review of the membership and agenda.

The key areas to note are:

- It was agreed that the immediate priority will be to ensure regular and accurate audit of National Early Warning Score (NEWS) / Paediatric Early Warning Score (PEWS) and SEPSIS data from VitalPac, along with a review of three months of reported incidents of failure to recognise deterioration in order to identify themes and identify areas of focus going forward.
- The Trust will be registering a team to participate in the South West Academic Health Science Network's NEWS2 event series. This consists of four events focussed on building capacity to optimise the use of NEWS2 and is being delivered as part of the national patient safety improvement work on managing deterioration; and building upon the regional NEWS2 Champions Network which was formed as part of the response to the patient safety alert released in April 2018.

- The successful introduction of a new PEWS chart which is now comparable to our tertiary centre in Bristol. This was as a result of an incident where there was a delay in the transfer of a child. There was an issue identified and some work required to align the Modified Early Warning Score (MEWS) calculations within TrakCare, used within the Emergency Department, however steps have been taken to mitigate any risk while this work is completed.

Maternity safety

The year started as the impact of the COVID-19 pandemic began to take hold. The Maternity service had to swiftly implement new ways of working to maintain the service and the safety for both service users and staff.

This required amongst many other changes, finding a new hub to see women in the antenatal period, setting up telephone booking appointments with the midwifery team instead of face-to-face appointments and the use of social media to communicate changes with all service users in collaboration with the Maternity Voices Partnership.

Midwifery students were for the first time taken out of their practice placements by their respective Universities for their safety. The year was challenging with frequent national guideline changes due to the pandemic.

In the maternity service, a culture of high reporting low harm is promoted. Learning from incidents is recognised through case reviews by clinical leads and by presentations and discussion of cases at multidisciplinary departmental meetings. A weekly safety huddle takes place with the Risk Manager, Clinical Director, Head of Midwifery and Matron, to discuss incidents and recognise immediate learning.

Maternity mortality cases are reviewed to identify learning using the National Perinatal Mortality Review Tool (PMRT). The tool facilitates a comprehensive, robust and standardised review of all perinatal deaths from 22+0 gestations (excluding terminations) to 28 days after birth; as well as babies who die after 28 days following neonatal care. Review is undertaken by a multidisciplinary panel of clinicians, which has to include an external, to the unit, panel member. These reviews have taken place throughout the year in a timely manner.

The unit was introduced in 2019 to involvement with Health Service Investigation Branch (HSIB) a maternity investigation programme devised as part of a national action plan to make maternity care safer. Learning had been identified and actions taken for all cases reviewed from the reports early in 2020. There have been a further two cases referred in 2020/21. The Trust awaits these investigations and learning. The Professional Midwifery Advocate Team supports staff during their interviews with the investigators.

All Transformation work, national audits and surveys were paused for most of quarter one and two. Resuming in a limited capacity in quarters three and four due to the COVID-19 pandemic.

The Saving Babies Lives Care Bundle 2 has five elements:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth

These elements are being implemented. Elements one and two are embedded. One of the main impacts of the care bundle has been the increased demand on ultrasound capacity. An increasing number of women are now required to have serial growth scans as recommended by the Growth Assessment Programme (GAP) and due to being smokers. There are currently insufficient ultrasound scan slots during clinic sessions necessitating the overbooking of sessions. Discussions are currently taking place as to how both the maternity and ultrasound service can respond to this demand. The fifth element is focused on Reducing Preterm Births; work is ongoing with data collection.

In March 2019, NHS England undertook an Antenatal and Newborn Screening programme Quality Assurance visit. The action plan raised four high priority findings of which three have been completed and the fourth due to be completed shortly.

Due to changes in commissioning, the Newborn Hearing Screening service changed to a hospital model from March 2020. This has embedded over the year with screening carried out on the postnatal ward or at the postnatal drop in session in the hospital. The screeners are Band 4 trained support workers employed by Somerset FT with two based at YDH. The transition has been smooth and well evaluated by the service users at present.

The Somerset LMS is now established and the Head of Midwifery and Clinical Director for Obstetrics and Gynaecology both attend the LMS executive and safety programme boards. As a result of LMS activity, collaboration between the two Somerset maternity service providers continues to develop, ultimately to improve maternity services across Somerset.

Local Maternity System (LMS) has continued to support the ongoing fixed term roles of Maternity Transformation Lead midwife and Foetal Surveillance Lead midwife. These roles have enabled the progression of the MatNeo work programme and the quality improvement projects. The two quality improvement projects, reducing the occurrence of foetal hypoxia through measurement of the incidence of Apgar scores of <7 at 5 minutes and reducing the incidence of Postpartum Haemorrhage (PPH) >1500mls continue to be led by the foetal monitoring lead and safety champions. Two new LMS fixed term funded project lead midwives for Public Health and Bereavement commenced in February 2021 for twelve months.

Implementation of Continuity of Carer (CoC) to meet national targets continues, two teams have now embedded with the introduction of a third team in February 2021.

March saw the percentage of women booked on a CoC pathway at 42.9%, 67% of Black or Asian women, and 50% from a deprived area in March. Exceeding the target of 35% of all women, 35% of Black, Asian and minority ethnic women and women who live in the 10% deprived area being placed on a continuity pathway. Investment is required to carry on with the plans to achieve 51% of CoC by March 2022.

The use of a community hub as a setting to provide antenatal and postnatal care to women as recommended by Better Births is working extremely well, with a plan to source other venues for future teams.

On 10 December 2020, 'The Ockenden Report' was released, with the emerging findings and recommendations from the Independent Review of the Maternity services at The Shrewsbury and Telford Hospital NHS Trust.

The initial review of 250 cases led to the requirement of the implementation of seven urgent actions in The Shrewsbury and Telford Hospital NHS Trust maternity services. This learning was shared nationally through the report with recommendation that maternity services across England put into place 'Immediate and Essential Actions'. A response was required by 21 December 2020 to NHSEI.

A full review of the report and recommendations took place, by the multidisciplinary team and the Trust Safety Board Member. An action plan put in place and immediate actions taken. The response was signed off by the Chief Executive of the Trust and the Chair of the Local Maternity System (LMS) and submitted to the Regional Chief Midwife.

An assurance assessment tool was also completed and submitted on 15th February 2021. The report was shared with the LMS and shared with regional teams in order to complete a gap and thematic analysis that was reported to the regional and national Maternity Transformation Boards. At present we are waiting to submit the trusts evidence, this will take place when the regional portal is open.

The submission date for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme year three was extended nationally due to the ongoing pressures of the pandemic to services. The maternity service is working hard to demonstrate compliance in meeting the ten safety actions qualifying for a reduction in the clinical negligence scheme for trusts CNST premium. It is anticipated that this will be met by the submission date in July 2021.

The maternity dashboard is reviewed monthly at the Risk Management meeting. Birth numbers have remained consistent with the previous year. Bookings for antenatal care are slightly lower. There has been an increase in Induction of labour. This is due in part to the increased foetal surveillance now carried out, through the Growth Assessment Protocol (GAP). Home Birth is consistently about 5%.

Over the past 12-18 months we have implemented measures to reduce the number of women suffering third and fourth degree tears, and the rate is now decreasing. Maternity staff have attended training study

days focusing perineal care in normal deliveries. A new perineal care bundle, with four key elements to reduce to further reduce the risk of tears was launched in October 20. Success in embedding these practices will be assessed through audit. Please also refer to page 34 with the outcome of the national maternity and perinatal audit.

The Avoiding Term Admissions into Neonatal Unit (ATAIN) quality improvement programme reviews term admissions. The national target is for less than 5% of term births to result in an admission to a neonatal unit. The Trust rate is 4.7% the teams are working hard to reduce the rate but working with small numbers each admission holds a greater percentage increase. On reviewing the admissions there does not appear to be any clear themes.

On the 31 March 2021, NICE published new guidance on Caesarean Birth (NG192); the Trust's guideline will require review and a baseline assessment completed prior to being updated. This will be carried out in Q1 of 2021/22.

3.2 Clinical effectiveness

Clinical audit

Clinical audit is a quality improvement and assurance tool, when carried out in accordance with best practice it:

- improves the quality of care and patient outcomes;
- provides assurance of compliance with standards; and
- identifies and minimises risk, waste and inefficiencies.

All clinical audit activity in YDH must be carried out with an explicit intention to improve, or assure, quality of care delivery. The Clinical Governance Team support all local and national clinical audit activity. Clinical audit activity is overseen by the Clinical Outcomes Committee. The tables below outline the recommendations and any action taken as a result of a selection of the local clinical audits undertaken during the reporting period.

National clinical audit

The following details the learning and outcomes from a selection of the national clinical audits during the reporting period.

NHS Benchmarking - NHSEI Learning Disability Improvement Standards 2019/20

Audit Aim:

The national learning disability improvement standards for NHS Trusts apply to all services funded by the NHS with an aim to promote greater consistency and to ensure Trusts deliver outcomes that people with a learning disability and/or autism expect and deserve. These were designed by people with a learning disability, autism or both, carers, family members and healthcare professionals to drive rapid improvement of patient experience and equity of care. The data collection aims to give a holistic view of services provided to people with learning disabilities and/or autism, as well as to measure how Trusts perform against the four standards that NHS England and NHS Improvement expect Trusts to meet. There have been a number of areas of focus for services provided to people with learning disabilities and/or autism over the last couple of years. These include the ability to flag people with learning disabilities and/or autism on patient systems, demonstration of reasonable adjustments to care pathways, promotion of anti-discriminatory measures and ensuring people with learning disabilities and/or autism are empowered to exercise their rights. The Survey consists of three parts Organisational, Staff and Patient feedback.

Report findings:

The report is split between, organisation, staff and patient.

Organisation:

- The Trust's organisational report shows very similar outcomes to other trusts around the country. The Trust performed very favourably in areas such as Reasonable Adjustments to meet the needs of this cohort of patients.

Staff:

- Nationally, the mean number of staff who received up-to-date training covering learning disabilities / autism awareness in 2018/19 was 58% with the Median = 77% and YDH = 33%. Whilst the Trust are currently below national average, there are plans nationally for compulsory LD/autism training for Doctors and Nurses. The release of the guidelines for the training were delayed due to COVID-19.
- 6,132 staff surveys were completed by 205 participating organisations, which resulted in a 60% completion rate, with an average of 30 staff surveys completed per Trust. Our Trust had a return rate of 22 (out of 50) which was below the national average response rate from staff.

Patient:

- The Trust's patient feedback was on par with the national responses and exceeding in some areas, for example 95% of patients felt staff cared about them (Figure 131), compared with 88% nationally. However, the Trust is slightly below the national average.

Areas for improvement:

- Trusts are expected to demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers. Nationally 98% of Trusts providing universal services have onsite facilities to accommodate family carers overnight; 53% of Trusts providing universal services and 40% Trusts providing specialist services have changing places toilet facilities (45% universal, 36% specialist in 2018). The Trust intends to address this as part of the ongoing estates planning.

The Sentinel Stroke National Audit Programme 2019/20

Audit Aim:

The Sentinel Stroke National Audit Programme (SSNAP) is a national healthcare quality improvement programme based in the School of Population Health and Environmental Studies at King's College London. SSNAP is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of the NHS in England and Wales as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). SSNAP measures the processes of care (clinical audit) against particular standards referring to the interventions that any patient may expect to receive. It is also the single source of stroke data nationally.

Report findings:

- The Trust has seen an improvement in the median time for when a patient is first assessed by a Stroke Nurse following their onset of stroke systems. During Jul-Sep 20 the average tie was 6 hours and 19 minutes, however in Oct-Dec 29 this has reduced to 2 hours 43 minutes, although still outside of the national average of 52 minutes.
- The national target for the use of thrombolysis treatment for ischaemic stroke patients is 10%. In July-Sep 20 the Trust administered thrombolysis to 14.7%, and in Oct-Dec 20 to 13.3% of patients.
- The Trust has participated in the regional implementation of an Artificial Intelligence software called 'Brainomix', this programme reviews brain scans to predict the longer term damage caused by stroke. It is hoped that this programme will assist the process of identifying patients who require thrombectomy.

Areas of improvement

- The national average percentage compliance against the Therapy Target of 45 minutes of Occupational Therapy on 5 days a week is 92.4%. During Jul-Sep 20 the Trust was 96.3% compliance, however between Oct-Dec 20 this has reduced to 75.9%.
- The national average against the Therapy Target of 45 minutes of Physiotherapy on 5 days a week is 88.9%. During Jul–Sep 20 the Trust were 88.5%, however this also dropped to 69.0% during Oct-Dec 20.
- The Trust has recently commenced a stroke service enhancement programme, which will focus on a set of work streams framed around the SSNAP data, and the Stroke Team are undertaking Quality Improvement training to support this.

National Maternity and Perinatal Audit (Data period 2016/17)

Audit Aim:

The National Maternity and Perinatal Audit (NMPA) is led by the Royal College of Obstetricians and Gynaecologists (RCOG) in partnership with the Royal College of Midwives (RCM), the Royal College of Paediatrics and Child Health (RCPCH) and the London School of Hygiene and Tropical Medicine (LSHTM), and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Following national maternity and neonatal reviews and other improvement initiatives, changes are being implemented in the delivery of care to mothers and their babies in England, Scotland and Wales. Use of electronic records for maternity care is constantly developing, and provides a rich source of data to understand and evaluate these changes. The National Maternity and Perinatal Audit (NMPA) uses these data to produce information that can usefully support the improvement of maternity and perinatal care.

Report findings:

- The Trust had a rate of 4.2% of third and fourth degree tears, compared to the national mean of 3.5%.
- The Trust had a rate of 36.2% of women experiencing an obstetric haemorrhage of 500mls or more, compared to the national mean of 34.1%.
- YDH had a rate of 11.2% vaginal births after primary caesarean section (VBAC) compared to the national mean of 24%.
- The Trust's overall caesarean birth rate was 22.7%, compared to the national mean of 26.7%, Elective caesarean birth was also lower than the national mean at 9.2% (11.7% nationally). This is demonstrating that women in labour received good intrapartum care.

Areas for improvement:

- The Trust is currently undertaking local audits of third and fourth degree perineal tears to inform a quality improvement project with the aim to reduce the occurrence of tears. This includes a focus on protection of perineum during labour and the performance of an episiotomy if indicated.
- The Trust is currently trying to reinforce the VBAC service by reviewing the care provided and decision making regarding mode of delivery.
- A quality improvement project continues within the maternity service with the aim of reducing the rate of women experiencing an obstetric haemorrhage of 500mls or more.

Local clinical audits

The following details the learning and outcomes from a selection of the local clinical audits during the reporting period.

Compliance with NICE Guidance of Reporting and Treating Cancer Patients with Pulmonary Embolism, 2020

Aim:

- To assess the compliance of clinicians treating PE at Yeovil District Hospital NHS FT (YDH) regarding choice of anti-coagulation agent, treatment duration, documentation of PESI or sPESI scores at the time of diagnosis and standard of radiology reporting of CTPA.

Conclusion:

- All patients with PE had CTPA/CT scan to establish the diagnosis of PE appropriate.
- 100% of patients received appropriate management for PE and received their anticoagulation therapy according to NICE and other guidelines.
- All CT scans reported site of PE in 100% patients
- 30.7% of CT scans commented for RHS, and 38.4% mentioned clot size.
- Recording for PESI score was 11.1%.

Recommendations:

- Need to meet and implement PESI scoring for all patients diagnosed with PE in A&E and on all wards
- Need to meet implement standard reporting criteria for CT PA as per European Society for Radiology standards.

Fourth Re-Audit: Head CT-Lens Exclusion, 2020

The exclusion of the lens from the standard brain CT examination will reduce the radiation dose to the eye and reduce the likelihood of lens damage and cataract formation. All brain scans should be performed with the baseline set as to exclude the lends of the eye (100%)

Aim:

> To complete a fourth re-audit for exclusion of the lens of the eye in routine head CT examinations

Conclusion:

> The re-audit shows that the percentage of lens exclusion has not improved but stayed the same as compared with the previous audit (3rd re-audit)
> The data for 60 years and less age group shows a further drop in lens exclusion

Recommendations:

> Discuss with PACS teams to add an extra column in the post-completion data/questionnaire for CT Head studies. This could make all those who scan CT Head studies a bit more conscientious than otherwise
> Re-audit after 3-6 months
> Ensure new radiographers are aware of the importance of lens exclusion and the results of this audit cycle.

Fluid Balance on ICU Re Audit, 2020

Fluid therapy constitutes an essential step in the overall management of severely ill patients, however, fluid overload remains a common finding in critical care admissions.

Setting a daily fluid balance target based on the assessment of patients' fluid status improves the overall management of patient's condition, and helps avoid positive balance and fluid overload in the replacement and redistribution phase on intravenous fluid therapy.

Aim:

> To re-audit fluid balance on ICU
> To assess whether the quality improvement project after the initial audit has made a difference

Conclusion:

> Increase in the percentage of fluid balances set and achieved from the initial audit to the-audit. The QI project seemed to have worked.

Recommendations:

> Set daily fluid target in all level 2 and 3 patients
> Need for further stickers

Fluid Balance on ICU Re Audit, 2020

There is a concern that patients coming in with COVID-19 related symptoms would remain on antibiotics when this would not be appropriate. This audit looks at the adherence to the antibiotic guidelines at Yeovil District Hospital NHS FT with regards to the COVID-19 and pneumonia guidelines.

Aim:

> To see if the current prescribing of the COVID-19 and respiratory guidelines is in line with the current antimicrobial prescribing and NICE rapid guidelines

Conclusion:

> The majority of patients received antibiotics for longer than 5 days, 54% had them for 6-7 days and 11% had them for longer than 10 days.
> 93% of prescribing choice followed our current antimicrobial guidelines.

Recommendations:

> The report will be forwarded to the medicines committee to discuss the outcomes and to the regional antibiotic prescribing group and to all of the consultants involved in the care of respiratory patients.
> Antimicrobial pharmacist will continue to go to the wards to review patients (apart from restricted wards)
> The ward pharmacists will be encouraged to continue to write review and stop dates on the drug charts to prompt doctors to review and doctors will be reminded of the importance of writing stop dates on the drug chart in line with the current guidelines

Management and Implementation of National Best Practice Guidance.

During the reporting period the Trust has made significant progress with the review and assessment of compliance with NICE guidance. Compliance with guidance is monitored on monthly basis and reported through the Clinical Outcomes Committee.

Learning from deaths

Dr Foster

Throughout 2020/21 the Trust has sought external assurance through the Dr Foster Health Care Intelligence Portal. This system provides access to a wide range of key hospital quality and efficiency data providing an analysis of the patient's hospital journey from the Emergency Department to inpatients and outpatient activity. This tool provides multiple ways to analyse and assess hospital activity data which allows us to provide more effective and accurate decision making as we are able to better understand trends, emerging patterns and variations in patient outcomes.

Dr Foster analyses data, using the Trust's clinical coding information and looking at expected versus actual trends relating to mortality and readmissions data.

Dr Foster data has enabled us to identify and understand potential quality of care issues and inefficiencies across several areas of the Trust including:

- In-hospital mortality
- A&E attendances
- Inpatient and outpatient admissions
- Length of stay
- Excess bed days
- Readmissions

The monthly Dr Foster reports provide an overview of outcomes for the Trust highlighting areas or groups of patients where activity is not as anticipated given the mix of patients for that condition. This indicates that there could be a significantly higher than expected mortality, readmission or complication rate. The mortality data provided by Dr Foster provides Cumulative Sum (CUSUM) alerts allowing the Trust to interrogate the data and review patient records where an alert occurs.

CUSUM is short for cumulative sum and an alert occurs when the number of deaths, readmissions or activity within the Trust in a cohort of patients with the same coded condition, (taking account of their comorbidities) is higher than anticipated.

All alerts are reviewed to identify why the alert has occurred and to identify any actions that should be taken to address any issues with the management of this cohort of patients. A full review of the medical records for the group of patients allows us to ensure that there have been no underlying problems or lapses in care and also to check that the patients' diagnosis and condition have been accurately captured. The Clinical Outcomes Committee monitors the outlier reports and analyses the specialty level data triangulating this with our internal outcomes data.

Summary Hospital-level Mortality Indicator (SHMI)

The number of deaths in hospital is captured through the Summary Hospital-level Mortality Indicator (SHMI). This reports mortality at Trust level using a standard and transparent methodology which is published quarterly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. Data includes hospital deaths and those occurring 30 days after discharge. Our latest published SHMI covering 12 months February 2020 to January 2021 is 95.1, with 100 being the expected norm.

Hospital Standardised Mortality Rate (HSMR)

The Trust uses Dr Foster to support analytical review of outcomes data. This includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators to inform understanding of quality and improvements in clinical care.

The HSMR complements the SHMI by: Focussing on deaths while in the care of the hospital, using more sophisticated risk models for individual diagnoses and providing more timely information than the SHMI.

Taken together, the HSMR and SHMI provide a powerful insight into hospital mortality. HMSR data is based on summary indicators using strict definitions which encompass a basket of 56 diagnosis groups, (made up of high volume procedures and conditions) that account for around 85% of in-hospital deaths. The SHMI includes all diagnosis groups accounting for 100% of deaths.

Other key differences in methodology include: HSMR is adjusted for more factors than the SHMI, most significantly patients receiving palliative care being excluded from the HSMR calculations. A further difference is seen in the fact that SHMI data includes post-discharge deaths, up to 30 days after discharge while the HSMR focuses on in-hospital deaths. The SHMI attributes a death to the last spell within an acute non-specialist trust, whereas the HSMR attributes a death across a continuous in-patient spell.

Both the HSMR and SHMI are reported with a data time lag allowing for analysis. Due to the timing of this Annual Quality Account figures from both analytical tools have been updated to reflect the position at year end.

The Trust HSMR is reported at 95.1, rolling year as at January 2021, which is a positive outcome and statistically lower than anticipated. This favourable position has been ratified and monitored throughout the year and it is believed to be due to a combination of factors including the good practice of identification and management of patients at the end of life and efficient coding of existing patient comorbidities.

HSMR is calculated based on the relative risk, the ratio of the observed negative outcomes to the expected number of negative outcomes, multiplied by 100. The national average, benchmark figure is always 100, hence figures below 100 represent performance better than the benchmark.

Figure 6 shows the HSMR trend over the last 2 years.

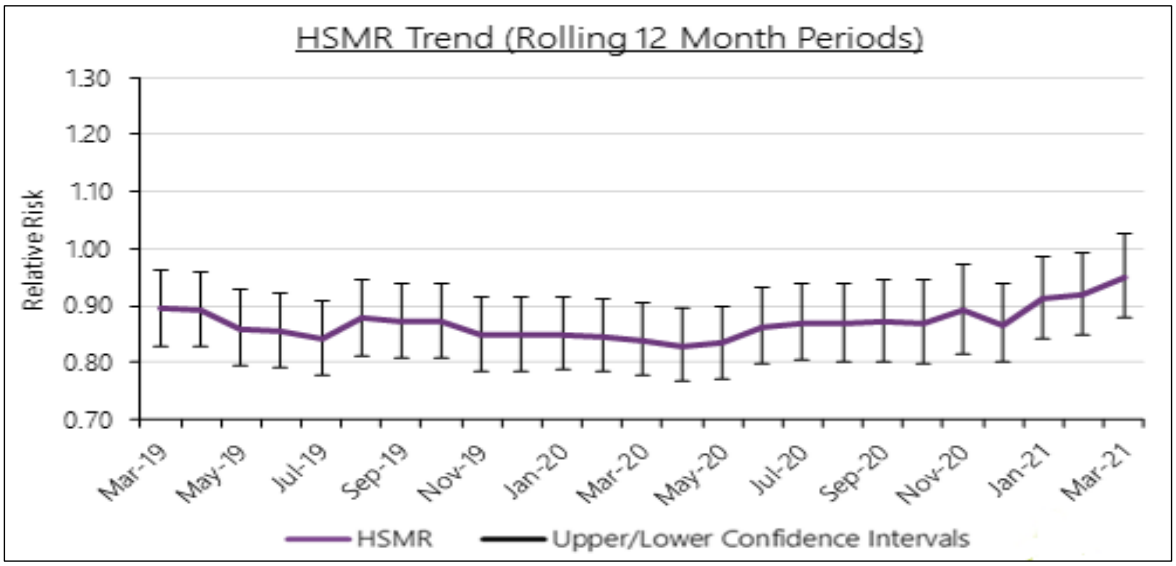

Figure 6

Standardised review of deaths

The National Quality Board 'Guidance on Learning from Deaths' published in March 2017, introduced enhanced reporting of case note mortality reviews. The National focus remains on standardising the review of deaths using a Structured Judgement Review (SJR) tool developed by the Royal College of Physicians. This tool has been adopted throughout the Trust, with formal mortality reviews recorded on a central data base to enable learning to take place across all areas of the Hospital. Links to the Trust's bereavement

data ensure that all in hospital deaths are captured with an initial records review highlighting where a full formal Mortality Review or other investigation should be completed.

Publication of the Notification of Deaths Regulations in October 2019 have resulted in arrangements for a new role of Medical Examiner (ME). The Trust appointed to this position in July 2020. The Medical Examiner provides greater scrutiny of all non-coronial deaths and provides a coordinated and knowledgeable better service for the bereaved.

The Medical Examiner is working in line with the National Medical Examiner's Good Practice Guidelines, published by NHS England and NHS Improvement, in January 2020. The ME ensures that all patients who die within the Trust are reviewed to ascertain the cause of death, liaising with HM Coroner where appropriate. The ME supports and educates junior staff through the process to enable timely and effective death certification. Their assessment of each patient's clinical management and care is recorded to ensure that any learning is captured. This may lead to a referral for a further investigation or full Mortality Review, using the Structured Judgement Tool.

Outcomes from formal Mortality Reviews are discussed at our Monthly Mortality Review Group. The group includes senior clinicians from all specialities who oversee the local reviews completed by the specialist teams and complete those reviews required for more complex patients. Outcomes data is also published quarterly highlighting the total number of deaths and the number of these patients who have been subject to an investigation as a result of a Serious Untoward Incident, a complaint, a bereavement concern, a Learning Disability death (LeDer) review or formal mortality review using the SJR tool.

Figure 7 shows the number of deaths by month and demonstrates national and seasonal trends over the last and this financial year.

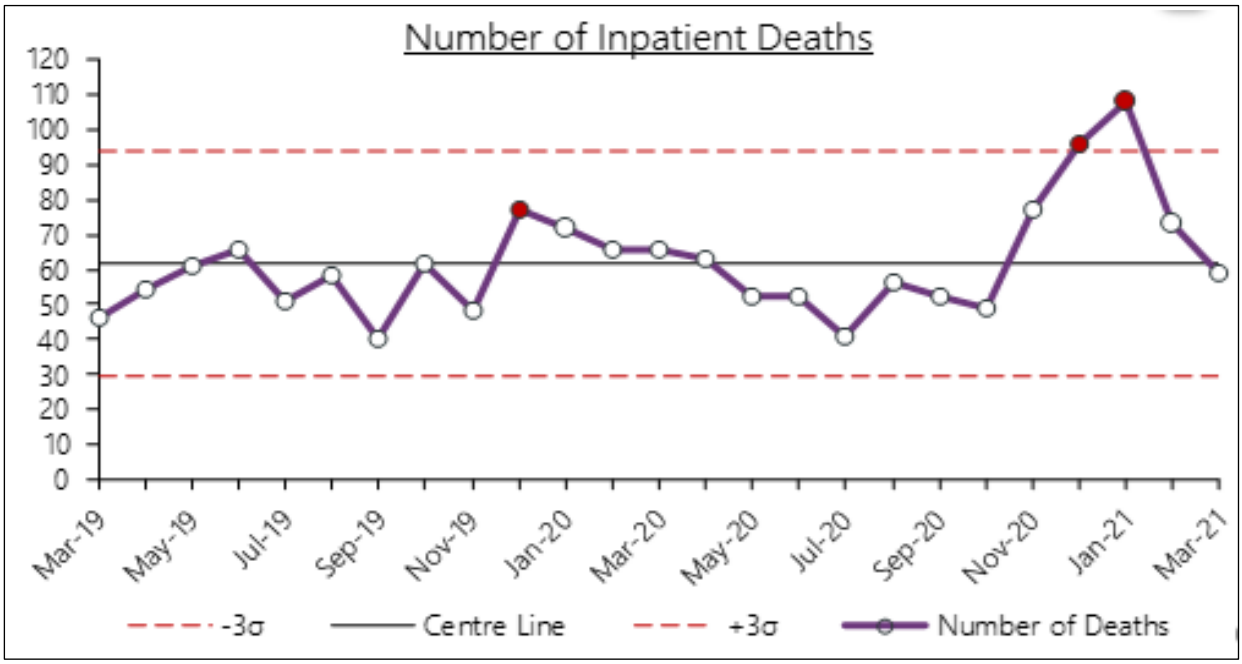

Figure 7

During the review period cases were reviewed using the SJR tool from the Royal College of Physicians, or via the Trust's Serious Untoward Incident process. The SJR enables clinicians to assess the management of each case and identify a level of potential avoidability based on the actions taken and the care provided for each individual case. This is a subjective judgement but is based on the clinical best practice for the given situation. The SJR has been adopted throughout the Trust to ensure that formal Mortality reviews are undertaken and that this data is available to inform improvements in care and reporting to the Board.

Perinatal maternity review tool (PMRT)

In January 2018 the PMRT was launched. The PMRT was commissioned by the Department of Health and the Stillbirth and Neonatal Death Charity to promote a comprehensive and robust review of all perinatal death from 22 weeks, with the exception of terminations of pregnancies to 28 days after birth. The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. The factual information is entered in advance of a multidisciplinary panel of internal and external peers (allowing for a 'Fresh eyes' perspective) review of cases. The tool is used to identify required learning with action plans generated, implemented and monitored. It is used as an alternative to the in house Trust Governance investigation process. However, if a case is a Serious Incident to the Strategic Executive Information System (StEIS), then a 72 hour report will be submitted to enable immediate learning and with actions to drive required improvement.

Learning from PMRT cases this year has centred on the main themes stated below with action devised to address issues of concern:

- A vast majority of cases indicate smoking as a risk factor, not only women who smoke themselves but also a significant risk are people who smoke in the household. Cessation is now being offered to all. Improvement is required to ensure there is a robust safety net, included in the process, so that all recognised smoking is acted upon. The unit's Public Health Midwife is currently addressing this.
- Documentation is consistently noted as requiring improvement. Education, audit in both community and unit areas, spot checks at ward level with real time support are ongoing.
- Highly relevant in PMRT cases is recording information onto the partogram, used when monitoring labour care; case review has found these to be incomplete and sometimes unused. The bereavement project led midwife is currently driving improvement through education regarding the importance of partogram use even if a baby is no longer alive and mother is in labour.
- PMRT case reviews have prompted discussion with regards to foetal monitoring at the earlier gestation of 26 weeks instead of 28 weeks, as per current guidance. The pros and cons have been considered as early monitoring can be difficult to interpret and can significantly impact management plans. To deliver a premature baby with all associated risk verses risk in continuation of a high risk pregnancy, is a balance consultant obstetricians have to consider when managing care.

3.3 Patient experience

Patient engagement

Our Patient Experience Team have continued to engage with partner organisations in the local community to gain insight and feedback from the local population throughout the COVID-19 pandemic. The Team ensures representation at the County wide Complaints Managers Meeting, Somerset Engagement and Advisory Group, and continues to develop an ever increasing network, although engagement opportunities have reduced due to the COVID-19 pandemic.

Patient surveys have been undertaken for Dermatology, Macmillan, Nutrition and Dietetics, Young Persons Survey and COVID-19. The COVID-19 survey aimed to gain feedback on our patient's experience throughout the pandemic. The feedback the Trust received informed us that patients' generally felt comfortable about being in hospital during the pandemic and most patients understood the need to stop visitors from coming into hospital. Most patients' also felt they had access to enough communication devices and that staff communicated well with their family and friends.

The Patient Experience & Engagement Lead has also helped coordinate and distribute the referral to treatment (RRT) Survey for Somerset.

A three year strategy for Patient Experience and Engagement has been drafted to ensure the Trust is involving patients and carers in the decisions and changes made.

The team have been working closely with the volunteer manager to strengthen the Patient Voice Group, and increase the number of volunteers who participate. The Patient Voice job descriptions have been amended, as the Trust plans to empower these volunteers to become part of ward teams and be able to assist on the ward where possible. Work is underway to plan their return and to recruit new members. Links

have been made with Health Watch Somerset to work closely to understand and review patient feedback to make any changes as a region.

Patient feedback

The Patient Experience and Engagement Lead manages the process for national surveys. Once the Trust receives the results, an action plan is developed with the department managers, to identify where improvements are required and make a plan for change. We also share positive results at relevant committees and governance meetings to celebrate our successes.

The national survey work has started for inpatients, maternity and Children and young adults. The emergency department survey results have been published and there are no significant areas of concern for 2020, but there are many areas of improvement regarding communication with patients.

Friends and Family Test

The Friends and Family Test (FFT) is captured using both paper and on-line surveys, which are managed by the Patient Experience team using digital survey software. This allows the Trust to capture feedback at ward and department level and the system has enabled staff to capture feedback at individual clinic level.

Nationally it was agreed that the Friends and Family test national reporting could be stood down during the pandemic. National reporting recommenced in December 2020. Since then, the Patient Experience & Engagement Lead has worked on other ways to promote the survey and has been working closely with department managers to help encourage staff members to ask patients to complete the survey. The Patient Experience & Engagement Lead has produced a QR code, so that patients can access the survey electronically, whether this be from their bed or at home. Work has been completed with the communication team to promote this and posters and business cards have been produced.

Health and Wellbeing Hub

The Health and Wellbeing Lead hub was relocated at the end of January 2021 due to COVID-19. By adhering to government guidelines and infection prevention control requirements the Trust will reopen the hub for face to face communication on Mondays and Fridays from April 2021.

A theme of mental health and wellbeing requirements has been identified and people have asked how they can improve their wellbeing. People newly diagnosed with cancer have also attended the hub asking for information on chemotherapy and fatigue. Staff who have attended the hub asking for wellbeing, have been directed to the staff health and wellbeing office or given contact details ensuring they are receiving the appropriate support.

Our Health and Wellbeing Lead has been also working alongside the cancer support workers to support them with their workload and also help by sorting out the information in St Margaret's hospice and hospital to stop duplication of ordering information. The hospice has up to date information and if they need to request any more information they are able to contact us to assist.

We are arranging a date with the Citizens Advice Bureau, for them to attend our hub area and meet people face to face and to use our private meeting room to see patients with cancer.

Complaints and PALs

The Complaints and PALS process has continued to be reviewed during the year as this provides opportunity to improve efficiency and enables us to be proactive in meeting the needs of service users.

Unfortunately, due to the global health pandemic complainants are not able to be offered face to face early intervention meetings, to discuss the concerns and to agree expected outcomes and timeframes for any investigations. However, the Complaints Lead has been telephoning the complainant ahead of them receiving the formal acknowledgement letter to introduce themselves and discuss the concerns, the complaints process and the timeframes involve.

All complaint responses continue to provide a decision about whether the complaint is upheld, partially upheld or not upheld. Where complaints are identified as upheld, actions are identified and where appropriate, an action plan is included with the complaint response. These actions are implemented by the department leads and their progress is monitored by the Patient Experience Team to ensure compliance. The actions and themes are also monitored at the Patient Experience and Engagement Committee.

All PALS communications are graded as either an enquiry (easily and quickly resolved) or a concern (which needs an investigation). The PALS service received 1027 concerns / enquiries during 2020/21:

- Quarter 1 = 249
- Quarter 2 = 356
- Quarter 3 = 407
- Quarter 4 = 422

Departmental Managers make initial contact with enquirers, where appropriate, and the PALS team provide verbal or email responses to enquiries. Concerns are addressed more formally via letter.

Over the course of the year, PALS dealt with more enquires than concerns, this was due to the introduction of the Patient Experience Matron and the skill set of new members of the Patient Experience Team, which has meant that PALS have been able to deal with issues raised within the team, therefore, being able to provide more timely responses to concerns raised.

There were 49 formal complaints received during 2020/21:

- Quarter 1 = 5
- Quarter 2 = 16
- Quarter 3 = 16
- Quarter 4 = 14

The mandatory KO41 health and social care data return was suspended by NHS digital in quarter 4 of 2019/20 due to the coronavirus pandemic, but was restarted in Quarter 3 of 2020/21. Therefore, there is no comparative data to report over the last two financial years.

The Deputy Director of Quality Governance and Patient Safety, and the Chief Medical Officer play a key role in conciliation and early intervention meetings, which has made them very effective and provides opportunities for shared learning across departments and at Trustwide level. Clinical input is also enormously beneficial and valued by complainants attending such meetings.

Learning and actions

The following outlines a selection of the key learning and actions from complaints during the reporting period:

- Undertake an audit of patient handovers between staff (at different times of day) to identify any improvements and implement any changes to the current standard operating procedures/ policies as a result.
- To ensure doctors & nursing staff receive palliative care training and monitor as part of their appraisals. Identify any staff who require refresher training and encourage staff to ask for guidance and advice from the Palliative Care Team as required on a daily basis.
- Ward staff to undertake teaching sessions/ training provided by the Learning Disability Liaison Practitioner. Review compliance and uptake as part of appraisals and offer further support to staff where required.
- As part of the Ward Sisters quality improvement day, undertake observations to review all specialist staff interacting with the patient (e.g. Physio, Occupational Therapist, Dementia Team, Dietician) to ensure that a family member is kept updated on the patient's progress, either directly or via the nursing staff. To review medical records to determine if regular contact has continued throughout the patient's admission, particularly to discuss a change in treatment plan before it has commenced. Families should also be advised of any proposed move within the hospital or ward.
- Ward staff to issue bereaved families specific information about how they should contact the bereavement team, who will advise about the change in the bereavement administration process during the Covid-19 pandemic.
- Review of nursing communication assessment in patient risk assessment admission booklet to ensure necessary actions are identified and completed.To be undertaken as part of the Ward Sister's quality improvement day whereby they review current inpatient paperwork, to inform staff of any learning at that time on the ward.
- Patients who are discharged home from an outbreak COVID-19 ward without knowing their last swab result, must be telephoned as soon as possible by the discharging ward if the results are returned as COVID-19 positive.

- Deputy Chief Nurse to share at the Senior Sisters meeting that the transferring ward should take the responsibility of informing the next of kin regarding patient movement and to update Patient Transfer Policy.
- Clinical Nurse Specialist to review the Palliative Care Assessments Policy to ensure inpatient's who are referred, receive a full assessment.
- A review to be carried out on the Patient Information Leaflet (pre-infusion documentation sheet) to include possible severity of symptoms relating to an extravasation injury.

National inpatients survey 2020

The Trust participates in the annual national adult inpatient survey, which is commissioned by Care Quality Commission. Other surveys in the NHS Patient Survey Programme include Maternity, Children and Young People's inpatient and day care services and Urgent and Emergency Care.

A total of 1,250 patients were sent the questionnaire. 1,183 were eligible for the survey, of which 532 returned a completed questionnaire, giving a response rate of 45%.

Yeovil District Hospital NHS FT were placed 39 out of 74 trusts for the Adult Inpatient Survey, with 5 key areas where the Trust was rated significantly better than the national average and better than our results for 2019:

- Waiting to get a bed on a ward
- Keeping in touch with family and friends through restrictions
- Cleanliness of the room or ward very or fairly clean
- Food was very good or fairly good
- Received enough support from health or social care professionals after discharge

There were a small number of areas where the scores decreased around discharge which included:

- Patients feeling involved in decisions about discharge from hospital
- Being given enough notice about when discharge would be
- Being given written/printed information about what they should or should not do after leaving hospital.

All of these areas are being reviewed with action taken to improve the scores within subsequent surveys.

Urgent and Emergency Care survey 2020

Yeovil District Hospital NHS FT participated in the Picker Urgent and Emergency Care Survey, which is commissioned by Care Quality Commission. A total of 1,250 patients were sent the questionnaire, 1213 were eligible for the survey, of which 474 returned a completed questionnaire, giving a response rate of 39%.

Yeovil District Hospital NHS FT were placed 19 out of 66 trusts for the Adult Inpatient Survey, with 5 key areas where the Trust was rated significantly better than the national average and better than our results for 2018:

- Patient was informed about the side effects of medication
- Staff helped control pain
- Patient experience rated as 7/10 or more
- Patient was informed about how long they would have to wait

- Patient was told about what symptoms to look for

There were a small number of areas where the scores decreased from our 2018 results. These included:

- How the patient was told they would receive the results of tests
- Being able to get suitable food and drink
- Receiving test results before leaving A&E

The Trust is aware of the improvement needed from the results of the survey and will be working closely with the patient experience team, nursing staff, doctors and business managers to ensure improvements are made in these key areas. This will be monitored by the Patient Experience and Engagement Committee.

End of life service

During 2020/2021, 754 patients died at Yeovil District Hospital NHS FT (this does not include patients who died in the Emergency Department).

How we care for those who are dying is indicative of the culture of a hospital and wider society. In providing person-centred care to patients at the end of life, we will not only work towards achieving a 'good' death but also improve the bereavement experience of those that are left behind.

The pressures of the COVID-19 throughout 2020/21 pandemic have placed new challenges in the provision of end of life care throughout the Hospital. Despite the unprecedented time end of life care remained a key priority. New guidance was rapidly developed and shared around symptom control.

Despite the strict visiting restrictions, decisions were made to continue with visiting for those who were recognised to be in the final days or hours of life to allow families to be together at this time. Changes were made on two occasions to allow couples, both patients, to be together at the end of life. There was even a wedding conducted by the radiology manager having received instructions from the registrar for a patient dying from COVID-19.

The end of life steering group continued to provide oversight throughout the year, with only one meeting in April 2020 being cancelled due to COVID-19 pressures. The year has seen the development of an end of life risk register and ongoing monitoring of incidents to look at areas of risk around end of life care.

Complaints and PALS have also been monitored through this governance process.

Difficulties with communication have been seen as a theme throughout the year and remain a focus for improvement work going forward.

The difficulties with communication were clearly further impeded by the restrictions placed on visiting and adaptations were made in all areas, not just in end of life care, to facilitate visits wherever possible.

The national care of the dying audit was cancelled for the year but local audits continued to provide relevant data and immediate feedback about end of life care. Despite the pressures the year has seen ongoing improvement in the use of the end of life care plan, one indicator of good end of life care. As with concerns raised from incidents and complaints and PALS, communication continues to be an area where there is clearly some difficulty experienced by the teams involved.

An education plan had been in place, this had to be rapidly altered due to COVID-19 but limited the numbers that could be taught. The use of simulation training has expanded over the year and continued throughout the pandemic. This has seen various scenarios developed to allow staff to practise and rehearse practical difficulties but communication as well. The plan is to continue this for the future. To reach all staff remains a challenge to improve communication amongst other areas and will take time but remains a priority and a focus of ongoing work.

As a team the palliative care team has continued to see patients throughout the pandemic. The Dr Foster mortality data continues to show that the team see a large proportion of patients who are dying from illnesses other than cancer and continue to have a high referral rate when compared to other acute Trusts.

Work has continued to develop the service and in particular in the development of a seven day service. A business case was agreed to expand the palliative care team and provide a weekend and bank holiday on call service to allow the provision of specialist knowledge and skills throughout the weekend and any holiday periods. This has started in April 2021.

Through work with the chaplaincy team work has been done to provide an element of bereavement support. This has led to the development of a service where all families are called two to four weeks after the death of their loved one as a supportive call. This has seen in just six months 450 calls made.

Although not just about end of life care the palliative care team have been involved in the monitoring and use of the Somerset Treatment Escalation Plan (STEP) forms which include the DNACPR decision. This has recently shown some areas where improvement is required and the palliative care team are part of this improvement process.

Key Successes of 20/21:

- Continued high number of non-cancer patients seen: In comparison to other acute Trusts the Specialist Palliative Care Team at YDH see a larger proportion of non-cancer patients. This continues to reflect the work done across the trust.
- Simulation Training: The further use of simulation training throughout the year, despite COVID-19 restrictions.
- 7 Day Service: Agreement of business plan to expand the team to provide a 7 days service.
- COVID -19 Pandemic Response: The immediate and rapid response to the COVID-19 pandemic including continuing with visiting for patients in the final/days hours of life.

Key Priorities for 21/22

Priorities have been developed as part of the formulation of the strategy for the next three years. These are included within this strategy but are the key priorities for the next year:

- Establishment and review of a seven day on call end of life support service.
- Improved assessment of spiritual needs at the end of life
- To be part of the county wide improvement in use of the Somerset Treatment Escalation Plan
- Simulation training. Embedding simulation training within end of life education with a focus on communication.
- Enhanced support for families visiting patients in the last days of life
- To improve the recognition and management of symptoms.
- Improved identification of patients in the last year of life.

3.4 Recruitment and selection

Throughout 2020/2021, Yeovil District Hospital NHS FT has continued supporting the employment of International Nurses to 15 Trusts despite the various restrictions due to the pandemic.

The Trust is recognised by NHS England / Improvement as a Lead Recruiter and a case study on their innovative work has been published by NHS Employers. The team now work closely with NHSEI and Department of Health to support Trusts nationally to hit the government target of recruiting 50,000 international nurses within 5 years.

The Trust has also led on a programme of Radiographer recruitment initiated by NHSEI South to support Trusts fill their vacancies and increase staffing to enable delivery of their recovery plans.

The success of this programme has seen the Trust also support the South East region and partner with the Global Programme to support Trusts in the Northern regions. A programme of Mammographer recruitment is also underway.

The Trust is now launching their programme to recruit Mental Health nurses across the South West and South East, which is once again supported by NHSEI regional teams.

Staff survey 2020

The 2020 Staff Survey results built on the successes of the previous year, and were the best we have ever had. Our response rate was 65%, which was the highest in the country for an acute trust.

We maintained our position of having the highest rating in the country for health and wellbeing. We were also ranked amongst the top in the country for the quality of our senior managers, for our flexible working opportunities, and for equality and diversity. Overall, the Trust was in the top 20% of all trusts in the country for 61 of the 78 questions asked.

During the past year, more has been demanded of our staff than ever before, and there is not a single person, regardless of their role, who has not had to adapt and rise to new challenges as part of the hospital's response to the pandemic. As a Trust we have tried hard to ensure staff feel supported, cared for and listened to and, whilst we will not get this right all the time or for every individual, these results show we have been able to maintain this during an incredibly fast-paced and difficult 12 months.

We all know that providing good care for patients starts with providing good care for staff, so to know that those working within the Trust have, for the most part, felt supported, engaged, and respected is crucially important.

Our results also show how important good managers are to staff experience. With the pandemic putting a stop to many large meetings, we have relied more on managers to keep staff informed and engaged and teams to adapt in new working practices, respond to the needs of individuals, keep people safe and comfortable at work.

One area of continued focus for the Trust, and one of just two areas in which we are below the national average, is in relation to staff experiencing abuse or violence from patients – though fewer staff said they had experienced such incidents compared to the previous year.

Due to the nature of the care we provide and with many patients living with conditions such as dementia, it is unfortunately inevitable that some staff will experience abuse from those they care for at some point.

It is also true that some staff will have been subject to aggression from those who have full capacity and this can never be excused.

Regardless of its nature, any experience of abuse can be distressing and we continue to provide training and promote the importance of reporting any such incidents, whatever their nature, so we can respond appropriately to safeguard our staff and our patients. It is encouraging that levels of reporting such instances are higher in our Trust than the national average.

There is always more to be done and we will, as always, be using the results to make this an even better place to work or receive care.

3.5 Statement regarding junior doctor rota gaps

Following the past year, with the unprecedented effect that COVID-19 has had on our workforce it is more important now than ever that we are able to support our junior doctor workforce, ensuring that our junior doctors are not adversely affected by rota gaps is just one point that we can manage to ensure that our juniors enjoy a good work/life balance.

We have an appointed Guardian of Safe Working (GSW) in post, to ensure that our doctors have the support they require to raise issues relating to safe working. This is supported through our exception reporting process through the electronic system, Allocate.

Exception reporting is managed by our Guardian and supported by the medical workforce department, where there are clear patterns the Trust ensures that we review the rota / reason for exception and act on this to improve the working lives of our staff.

The Guardian also completes a quarterly Guardian of Safe Working report which includes data of our exception reports and actions to mitigate these. A final extended Annual Report is presented at the end of each academic year to the Trusts Board of Directors.

Actions which we take to address rota gaps include:

- Recruitment of locum staff and junior specialist doctors, we have had additional staff in during the pandemic and winter period.
- Review of skill mix within certain departments, for example the appointment of Advanced Clinical Practitioners (ACPs) and Physicians Associates who are able to undertake some of the junior doctors' work
- Consideration of recruiting innovative junior doctor Trust roles, for example roles which include a leadership/ quality improvement/ other non-clinical elements to the role.

The Medical Rota Team within the Trust also support the facilitation of safe staffing levels across the Trust with duties including but not limited to the following:

- Creating compliant Junior doctor rota templates
- Monitoring rosters / working patterns/ hours of work – Contractual and European Working Time Directive (EWTD)
- Ensuring safe staffing levels across our junior rotas, escalating detail as appropriate.
- Administering exception reporting process (e.g. if doctors experience differences in hours of work / rest breaks / the work pattern itself)
- Locum / Agency booking

Template rotas are set at a minimum level to reflect expected numbers of junior doctors each day, these are in line with the Royal College guidance on safe staffing and include the safe staffing numbers, however gaps are inevitable. Reasons can include:

- Posts not filled by HEE (Health Education England), or variation in speciality numbers
- Less than full time trainees occupying full time rota slots
- Unplanned leave, e.g. sickness, maternity, paternity, special leave
- Special occupational health reasons where some doctors are unable to undertake certain duties e.g. on-call, night working

Rotas' gaps are highlighted in quarterly Guardian of Safe Working Reports. When gaps do arise, out of hours duties are filled using locum staff to ensure that junior doctors are not mandated to work in excess of their contracted hours.

Table 9 shows the rota gaps for the reporting period.

	August 19	September 19	December 19	March 20
WTE vacant training post (rota gaps)	2	3	3	2

Table 7: rota gaps 20/21

3.6 Statement regarding encouraging staff to speak up

The National Guardian's Office and the role of the Freedom to Speak up Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015).

These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

Freedom to Speak up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.

Guardians also work proactively to support their organisation to tackle barriers to speaking up. Freedom to speak up Guardians are appointed by the organisation that they support and abide by the guidance issued by the National Guardian's Office (NGO), and follow a universal job description.

YDH has appointed four Freedom to Speak UP Guardians, they have a key role in helping to raise the profile of concerns within the Trust and provide confidential advice and support to staff in relation to concerns they have about, for example, patient safety and / or the way their concern has been handled.

Freedom to Speak up Guardians do not get involved with investigations or complaints, but help to facilitate the process of raising a concern where needed, ensuring policies are followed correctly. Feedback and outcomes are given directly to staff who make themselves known.

If a concern is raised anonymously, where possible, and when appropriate, the outcome and improvements made as a result are published in The Trust's news bulletin.

Staff can contact the Freedom to Speak up Guardians using a dedicated email address, via the Trust Intranet site or via a drop in session.

Staff can also raise concerns anonymously if preferred. All concerns raised are reviewed and presented quarterly to the Chief Executive and Trust Board of Directors. They discuss patterns, trends and look for solutions and remedies to increase staff support and influence a Culture of 'speaking up'.

Raised concerns are also reported quarterly to the CQC which helps to identify the national picture in terms of the source and types of concerns.

3.7 Statement on the implementation of the priority standards for seven day hospital services

As per the 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic' letters from NHS England and NHS Improvement the seven day services assurance requirement was suspended.

Annex A: Statement from Council of Governors

The Council of Governors receives regular reports on all aspects of the hospital's work. Governor observers attend the Financial Resilience and Commercial Committee, Governance and Quality Assurance Committee, the Risk Assurance Committee and Patient Experience and Engagement Group. Governors attend the full Board of Directors meeting on a rotational basis. At all these meetings, governors are encouraged to contribute their views, and to report back to the full Council of Governors. On this basis, the Governors are confident that the provision of high quality care is a core aim of Yeovil District Hospital and that appropriate measures are in place to monitor standards.

Once again, Yeovil District Hospital has achieved high performance of key standards, particularly with regard to four-hour waits and cancer performance, which has maintained the Trust's position amongst the best performing trusts in the country. This has been particularly impressive as this performance has been achieved throughout the Coronavirus pandemic.

The Governors continued to monitor the Local Indicator - the number of patients who attend the accident and emergency department and only receive advice and guidance, with no further treatment - recorded as 'unnecessary attendances'. The rate for these has fallen to about 12%, although Covid has had an impact on this.

The Governors received regular information on system working within Somerset, with Yeovil District Hospital working more closely with the Somerset Foundation Trust, Somerset Partnership and the County Council. Governors have been kept regularly informed of the work towards merger with Somerset Foundation Trust.

Yeovil District Hospital continues to participate in both national and regional research projects and audits and is keen for continued self-improvement.

The Council of Governors welcomes the very positive outcome from the Staff Survey, which again had a very high response. The results illustrate further improvements in the health and wellbeing of staff, diversity and inclusion, staff morale and staff engagement – all of which have been of vital importance during the pandemic in terms of keeping the staff well and positive and thus allowing them to maintain high standards of care for patients. Governors have been very impressed and grateful for the superb response of all staff to the immense pressures of the pandemic and would like to thank them all for their enormous efforts and resilience. Governors are also very conscious that, at a time when they could be expected to be flagging, staff are already making great strides in recovery of activity to pre-Covid levels.

Governors are pleased to note that the development of the site has continued despite the pandemic. This has allowed for improvements in ED to increase capacity and improve facilities, the move of oncology patients to the site of the local hospice for their safety, ward alterations and an increase in virtual appointments.

The Council of Governors continues to actively monitor and receive updates on the recruitment of staff, both for medical and nursing staffing groups. Governors have been very impressed by the success of the programme for overseas recruitment of nurses and radiographers, which has been nationally recognised and has again resulted in YDH having no nursing vacancies.

The Governors fully support the vision statement, the iCARE philosophy and the principles of good care which continue to underpin all that the hospital does.

Alison Whitman

Lead Governor

Annex B: Statement from the Somerset Clinical Commissioning Group

NHS Somerset Clinical Commissioning Group statement for inclusion in the Yeovil District Hospital NHS Foundation Trust Quality Account

NHS Somerset Clinical Commissioning Group is the lead commissioner of health services from the Trust. We welcome the opportunity to provide this statement and comment on their Quality Account 2020/21.

Current reporting arrangements are outlined in 'Reducing the Burden' which sets out the work that can be paused during the pandemic. Regardless of the pandemic and current reporting requirements, the CCG is well qualified to comment on the Quality Account 2020/21 based on the close working arrangement we have with the Trust.

The start of the financial year was like no other in the history of the NHS, seeing unprecedented challenges in how the trust deliver care and services to the people of Somerset, during the pandemic and with the merger.

COVID-19 Pandemic

The Trust should be commended in their response to the COVID-19 pandemic, working hard to reduce transmission of the infection in line with national guidance whilst maintaining the safety of staff and patients. Work was undertaken at pace to ensure the redeployment and recruitment of staff, training for Personal Protective Equipment (PPE) and providing health and wellbeing support across the Trust and improving the use of digital technology.

During what has been a very challenging time for the organisation, staff have shown resilience under immense pressures, following the extensions of Intensive Care areas, upskilling of staff and providing valuable and essential assistance in the Nightingale hospitals as well as being instrumental in the vaccination programme.

Quality Improvement Priorities for 2020/21

It had been agreed within the Trust that the Quality Improvement Priorities for 2020/21 would focus on the CQUIN initiatives outlined below.

Prevention of ill health	Mental health	Patient safety	Best practice pathways
Appropriate antibiotic prescribing for UTI in adults aged 16+	Staff retention and wellbeing	Recording of NEWS2 score, escalation time and response time for critical care admissions	Treatment of community acquired pneumonia in line with BTS care bundle
Cirrhosis and fibrosis tests for alcohol dependent patients	Increase staff capability and respond to those with mental health needs	Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery	Adherence to evidence based interventions clinical criteria
Prevention strategy – personalised care planning		Safer care: falls, medication and pressure damage, never events	Rapid rule out protocol for ED patients with suspected acute myocardial infraction (excluding STEMI)
Staff flu vaccinations			

The COVID-19 pandemic significantly impacted the progress of the Trust's priorities and there was a national agreement that CQUINS would not be required for 2020/21.

Despite the pandemic we are pleased to see other improvements the Trust have made which include:

- Electronic discharge summary for inpatients replacing the paper copy.
- Digital diagnostic ordering for outpatients.
- Ambulatory Emergency Care (AEC) have introduced the use of surgical pumps for the delivery of intravenous therapies that would have normally been delivered on an inpatient basis - saving 113 bed days. This will be an on-going priority for next year.

- The Trust worked with the AHSN to develop and implement the COVID-19 virtual care ward, as step down supporting an early and safe discharge. The Virtual ward had enhanced remote monitoring with daily calls.
- The virtual ward is being explored further for AEC Patients.

We are pleased to acknowledge the Trust Priorities for 2021/22 will be working in collaboration with the system, focusing on the management of the COVID response, the restoration of services and the recovery for elective care, alongside preparing and managing Infection Control Services.
The Trust will also continue to work on Quality Improvement projects such as the Virtual Ward and maintain and their learning culture within the Trust and share learning across the system.

The Trust had an unannounced routine visit from the CQC in February 2021 focusing on Infection Prevention and Control. We are pleased to note the findings were wholly positive with good vision and strategy for continuously improving Infection prevention and Control Practices, outlining the increased benefits of bringing in the bed management team in the management of COVID-19.

Patient Safety

The CCG would like to recognise the introduction of a Medical Examiner (ME) in July last year and the increase in the number of cases being reviewed following a death within hospital. The learning from the reviews has been highlighted within the Quality Account and we look forward to seeing the improvements over the coming year.

We acknowledge the Trusts aim to improve the incident reporting culture and are pleased to see that there has been a 9.1% increase from last year.

The CCG are happy to see the input that the Tissue Viability team have had through the Pandemic, especially considering the challenges they have faced over the last year due to an increase in acuity due to self-isolation, anxiety in getting medical care and limited or no support at home. The Tissue Viability Team have significantly increased the pressure relieving equipment within the Trust and have implemented daily clinical ward reviews, assisting in supporting and educating staff. This is well evidenced that despite the challenges there was no increase in the number of grade 2 and above pressures sores from last year.

The CCG commend the Trust undertaking a full review of patients who, using the NHSE/I category guidance, were deemed either probable or definite hospital acquired COVID infections. The Trust have identified learning and themes from the reviews, identifying any risks and have amended pathways and management of patients to try and reduce the risk in the future.

The CCG has noted that there has been a slight increase in falls compared to 2019/20 and are pleased to see that the falls group re-started at the end of 2020/21. The group have identified key aims and priorities for the coming year which the CCG are looking forward to seeing the outcomes of these initiatives.

- Implementation of the Frailty Roaming Service, which includes Occupational Therapists and Social Workers, reviewing patients in the Emergency Department.
- Where there has been an increase in falls in EAU a member of the Falls Group has been focusing their work in this area.
- Introduction of the Rapid review template, allowing immediate review of a patient following a falls and necessary actions being taking identifying learning.

We applaud the Trust on the improvements within the Pharmacy service over the last year, offering a 7 day service, with 95.5% of patients being reviewed by a pharmacist within 24 hours of admission. Developing numerous Trust wide policies and procedures, improving safety and financial benefits. There are a number of developments planned for next year including the implementation of electronic Prescribing Medication Administration. (ePMA) which the CCG are eager to see.

Maternity

The CCG applaud all the work the Trusts maternity unit has undertaken during this difficult period. We recognise that the Trusts maternity unit has continued with its transformation programme as well as adapting to the requirements for COVID-19.

We acknowledge all the work that has gone into The Ockenden Report action plan and submission of evidence into the Ockenden Portal. We look forward to reviewing the report from NHSE in time.

The Trust has been a vital member with the Local Maternity Neonatal System and have continued to work on quality improvement project to improve patient safety and experience.

Clinical Effectiveness

We are pleased to see the involvements in Clinical Audits and the aim to learn from results for quality improvements.

"We are concerned that the number of staff who received up-to-date training covering learning disabilities / autism awareness in 2018/19 is currently below national average, especially as the mandatory national LD/Autism training has been delayed and won't be ready until (at least) April 2022. We understand that specific learning inputs have been identified and are implemented to ensure an increased awareness and confidence of all members of staff around the needs of this particular patient group. We look forward to hearing more about the impact of these interventions as well as any further actions that will be identified and implemented working with the wider Somerset system."

We recognise that the COVID-19 pandemic has caused some significant challenges against the Sentinel Stroke National Audit Programme (SSNAP). The Trust has considerably improved from last year on stroke patients being seen by a stroke specialist nurse, with last year averaging 6 hours and 19 minutes to this year being 2 hours and 43 minutes. For areas of improvement the Trust have recently started a service enhancement programme and the CCG will continue to monitor this over the coming year.

Patient Experience

We have acknowledged that the need for collecting responses to the Friends and Family test was suspended during the pandemic, we are pleased that this was restarted in December and acknowledge the current low responses but with new initiatives such as the QR code hope to see an improvement in the coming year.

The CCG are excited to read about the Health and Wellbeing Hub enabling people to improve mental health and wellbeing. This has been supported by patients newly diagnosed with cancer and staff.

The National Inpatient Survey has shown good outcomes with 5 areas being significantly higher than the national average with improvements from 2019, we note the areas of improvement identified and will review this with the Trust over the coming year.

The Trust has continued to work tirelessly on international recruitment being recognised by NHSE/I for this work with a published case study on NHS Employers. The Trust has led on a multitude of programmes including aiding the government target of recruiting 50,000 international nurses within 5 years, Radiographer programme, Mammography programme and the implementation of Mental Health Nurses. The work to support and improve recruitment across the South West and the Country is fantastic.

The Trust is also commended for being within the top 20% of all trust in the country for 61 of the 78 questions asked within the Staff Survey.

There is a note that areas for improvement are regarding abuse or violence against staff, in which the Trust are planning and reviewing ways of improvement which we will discuss with the Trust going forward.

The CCG appreciates the continued support the Trust has taken, to support system wide working. We recognise the challenges the Trust will encounter in the coming year in sustaining their focus on improvement work as the NHS enters the recovery phase of COVID-19 and also as Somerset moves further along the journey of an integrated care system. There is still much work that we all need to do and we look forward to the positive contribution that the Trust will make in achieving better outcomes for the populations of South Somerset .

Val Janson

Director of Quality and Nursing

Annex C: Statement from Dorset Clinical Commissioning Group

Dorset Clinical Commissioning Group welcomes the opportunity to provide this statement on Yeovil District Hospital's Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of the information we have received during the year as part of limited monitoring discussions due to the COVID-19 pandemic during 2020/21.

In 2020/21 Yeovil District Hospital identified quality improvement priorities in four areas; prevention of ill health, mental health, patient safety and best practice pathways. The pandemic led to many priorities being paused or delayed. However, they were able to implement the introduction of electronic discharge summaries and electronic ordering of diagnostic tests which has supported the streamlining of patient care.

For 2021/2022 Yeovil District Hospital has set priorities that focus on elective care recovery including improving the pre-operative pathway for patients whilst also ensuring activates add value for patients and staff. Following the successful use of virtual wards for step down COVID-19 care their use for Ambulatory Emergency Care is being explored further. The use of portable pumps by the Ambulatory Emergency Care service will be a priority to implement following a successful trial.

Vanessa Read

Director of Nursing and Quality

Annex D: Statement from Healthwatch

Healthwatch Somerset welcomes the opportunity to comment on the Yeovil District Hospital NHS Foundation Trust quality account for 2020/21. Healthwatch Somerset exists to promote the voice of patients and the wider public with respect to health and social care services. We work with the health and care system to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

It is important to acknowledge that it has been an exceptionally challenging year for the health and care sector. Yeovil District Hospital NHS Foundation Trust has continued to deliver services throughout the Covid-19 pandemic and the commitment of its staff should be commended. Work to support infection control measures should also be commended. The vision 'to care for you as if you are one of our family' demonstrates a commitment to patients and to staff and Healthwatch Somerset recognises this and the principles of 'iCare' that underpin this vision.

We were interested to read about the development of the 'virtual ward' initiative and would be happy to support monitoring its effectiveness with patients and carers to ensure they are involved fully with ongoing developments.

We are pleased to note that patient safety remains high on the Trust's agenda especially for vulnerable patients such as those who are being treated for haematology and oncology at St Margaret's Hospice. Patients have also been able to continue their treatment throughout the pandemic through the Attend Anywhere Virtual system which should be commended. We welcome the development of the health and wellbeing hub which enables patients and their families to access good quality information, advice and support.

We are pleased to note that the Trust recognises that they need to improve their communication with patients, their families and carers. Patients can feel overwhelmed at times, especially at the point of discharge so it is important that they and their families and carers are involved fully with these processes. Healthwatch Somerset would be happy to support the review of any patient information leaflets.

Healthwatch Somerset would be pleased to work with the Trust to support progress against this year's quality improvement priorities and the Trust's Patient Engagement team in ensuring that the experiences of patients, their families and unpaid carers are heard and taken seriously.