Sherwood Forest Hospitals
NHS Foundation Trust

Quality Account and Reports

2020/21

Best NHS Acute Trust in the Midlands (2018, 2019 & 2020 NHS Staff Survey) ★ **CQC Outstanding hospital** (King's Mill)

Healthier Communities, Outstanding Care

Contents

Introduction to the quality account

This report is designed to assure patients, the public and commissioners about the quality of care at Sherwood Forest Hospitals NHS Foundation Trust. The report provides a review of the Trust's quality improvement activities and achievements during 2020/21. Due to the COVID-19 pandemic, most of the quality improvement activities have remained the same as those for 2019/20.

The report also identifies and explains the Trust's quality priorities for 2021/22. The 2020/21 sections of the report refer to quality improvement activities completed during the 2019/20 financial year. These sections include the mandatory reporting requirements set out by NHS England and NHS Improvement as referenced in the following documents:

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2020/21
- Data Dictionary

Part 1 - Statement of the quality account from Richard Mitchell, Chief Executive

I am proud to present our quality account for 2020/21. The report explains how we performed against our priorities last year and sets out our priorities for the year 2021/22. We also provide an overview of our key performance indicators and assurance statements.

We believe how colleagues are treated significantly influences care provision and organisational performance. Our aims are to provide the best care possible to all patients; and for all colleagues at Sherwood to feel they are supported, included and listened to. We have made progress against these aims in 2020/21, despite the pressure COVID-19 has brought on our working and personal lives. I am grateful for the care, compassion and kindness shown by all colleagues during the most difficult of years. As well as improving as a provider of healthcare and as a place to work, our relationships across the wider health and care system in Nottinghamshire have strengthened and we can evidence delivery at a system level.

We were pleased with the results of the NHS Staff Survey for 2020. Despite the challenges we have all faced over the last year, engagement has improved at Sherwood Forest Hospitals NHS Foundation Trust for the fifth consecutive year. For the third year running we were the best Acute Trust in the Midlands for engagement. There are 128 trusts nationally in the Acute/ Acute and Community Trust category and some of the other highlights for us were; we were rated second best overall for morale, third best for quality of care and third best for "recommending my organisation as a place to work".

In 2016 only 51.8% of colleagues said they were given feedback about changes made in response to reported errors, near missed and incidents (the national average was 55.6%). This year 72.6% of colleagues reported positively about this question, which was the highest in the country, compared to an average of 61.9%.

The quality account has been prepared with our clinical teams and people who are closest to the service being reported on. Reporting on quality and performance necessarily involves judgment and interpretation. To ensure the report provides an objective review, it has been scrutinised by all stakeholders and by the Board, including our Non-Executive Directors and Governors.

I believe our services today are better than they were 12 months ago, and will be better again in another year's time. Thank you to the colleagues and volunteers who individually and collectively played a key role in providing safe patient care over the last year.

To the best of my knowledge, and taking into account the processes that I know to be in place for internal scrutiny, I believe that this report gives an accurate account of quality at the Trust.

I hope it will be read widely by colleagues, volunteers, patients, the public and our partners.

To conclude, over the last year we have received a clean bill of health from the Care Quality Commission and all services are rated Good for Safe Care. The rating at King's Mill Hospital has improved to Outstanding overall. In March 2021 we won the prestigious Health Service Journal Acute or Specialist Trust of the Year award. Our staff engagement improved dramatically. In January 2021 we were asked to buddy with Shrewsbury and Telford NHS Trust and we are working effectively with a range of partners to respond to COVID-19. We now have a strong national reputation and there are lots of reasons to feel positive and optimistic. Whilst the next 12 months will be tough, as we focus on restoring services; colleague welfare; and delivering on our financial expectations, we have a great opportunity in the first half of the year to shape the strategy and future of Sherwood and Mid Nottinghamshire for the next decade.

Signed:  Richard Mitchell, Chief Executive

Date 21 June 2021

Part 2 - Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Sherwood Forest Hospitals NHS Foundation Trust (the Trust) is committed to providing safe, high quality care to all patients and service users. The Trust focus is on continuous improvement and is driven by the Quality Priorities identified within the Quality Strategy 2018-2021. The programme is led by the Executive Medical Director, who, in conjunction with the Chief Nurse, receives regular progress reports. Formal reporting is through the Trust Quality Committee and also the Board of Directors, as part of the routine cycle of business. The Advancing Quality Programme is monitored, updated and amended throughout the year**.**

2.1.1 Providing high quality, safe care

The Trust accesses a number of internal and external sources to support and drive quality improvements. The following are examples that have been used to support the development and delivery of the Quality Strategy 2018-2021.

- Stakeholder and regulator reports and recommendations
- Clinical Commissioning Group (CCG) feedback and observations following their quality visits
- Commissioning for Quality and Innovation (CQUIN) priorities
- National inpatient and outpatient surveys
- Feedback from our Board of Directors and Council of Governors
- Emergent themes and trends arising from complaints, serious incidents and inquests
- Feedback from senior leadership assurance visits and ward accreditation programme
- Nursing and midwifery assurance framework and nursing metrics
- Quality and safety reports
- Internal and external reviews
- National policy
- Feedback and observations from Healthwatch through joint partnership working
- Feedback from Stakeholders, partners, regulators, patients and staff in the development of our Advancing Quality Programme

The Trust continues to build on the quality assurance and performance framework that is now well established throughout the organisation. This framework is regularly evaluated and reviewed where necessary, ensuring risks to the safety and quality of patient care are identified and managed resulting in clinically sustainable and financially viable services.

The achievement of each quality priority is measured through a range of metrics articulated in each campaign. Progress is underpinned by the Trust assurance processes, with the formal monitoring and measurement reported through a range of committees and groups with final approval by the Board of Directors.

2.1.2 Approach to Quality Improvement

The Trust's approach to Quality Improvement (QI) is based on well-defined and evidenced methodologies (the globally recognised Institute of Healthcare Improvement's 'Model for Improvement') that have been widely adopted across the NHS; it has an improvement brand - 'the Sherwood Six Step ' launched in 2018.

The three priorities over 2019/20 were as follows:

- **Continued scoping and defining of the 'Sherwood Six Step' QI approach within the organisation**.

This is based on a well-defined and evidenced methodology (the globally recognised Institute of Healthcare Improvement's 'Model for Improvement') that has been widely adopted across the NHS. The Service Improvement Strategy was approved by the Trust Board in July 2019. Since 2018, the Trust has trained over 200 staff in the Sherwood Six Step approach and, in March 2020, had 65 QSIR (Quality, Service Improvement and Redesign) Practitioners.

- **Developing QI capability within the organisation**.
  In addition to using internal intelligence sources to identify and drive improvement, the Trust works with surrounding health and social care partners to support wider improvement programmes. It has been nationally recognised by NHSE&I's ACT Academy as an exemplar site in delivering Nottinghamshire-wide training in Quality Improvement, using the nationally accredited QSIR tool. The Trust continues to share learning from this approach at both regional and national improvement events and has provided improvement input into Queen Elizabeth Hospital, Kings Lynn, as part of the Trust 'buddy arrangement'.

- **Developing a safety culture.**
  The Trust has a 'Human Factors Community of Practice' in place to support the development of the organisational approach to safety. There is evidence of cohesive and aligned learning from safety, improvement and governance via the shared 'Quarterly Learning Events'. These have been established to focus on themes emerging from incidents and feedback.

The Service Improvement strategy has a range of key performance indicators that underpin these priorities, and progress is reported on a monthly basis through to the Trust's Advancing Quality Programme. In addition to these measures, the Clinical Audit team has merged with the Improvement team. This has maximized opportunities for clinical staff to learn from, and engage more in, evidence based and improvement activities.

Priorities for 2021/22 include the further development of QI capabilities within the Trust and across the Nottinghamshire Integrated Care System (ICS). This will use a coaching approach to connect people and to embed improvement skills. We will raise the visibility of improvement work happening across the Trust. This will focus on activities supporting our organisational strategic goals. We intend to increase citizen involvement within our improvement work, to extend opportunities for improvement training and to actively co-design and co-produce improvements.

These priorities are aligned to national directives on supporting, enabling and empowering staff and citizens to engage with positive change and will be reported as part of the newly established People, Culture and Improvement Committee.

2.1.3 Quality priorities 2018-2021

During 2021/22 the Trust will continue with its aspiration to be rated as outstanding overall by the Care Quality Commission; we understand this represents an ever-increasing challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks. This has become more evident over the last 12 months in response to the COVID-19 pandemic.

The Quality Strategy led by the Executive Medical Director, reflects the Trust's ambition for sustainable, high-value, high-quality services, delivered in partnership with other health and social care providers across the Nottinghamshire footprint. As we move forward we will witness a much closer alignment between quality, activity and financial planning, boosting our combined efforts to deliver safe, effective and financially sustainable services in the longer term.

The Trust believes it can demonstrate outstanding care and be one of the best providers of healthcare in the country. The Quality Strategy provides the road map to get there. The Strategy reflects the quality priorities and takes account of national, local and independent reports and enquiries. The quality priorities support the Trust Strategy, which has been developed in wide consultation with staff and external stakeholders. Future plans and progress against the quality priorities are the focus of agenda items at the Trust Quality Committee, which has patient and public representation and attendance.

The Trust has made significant improvements in the culture of the organisation, in particular focusing on building an engaged staff body. By valuing our staff and providing a nurturing and supportive working environment, the quality and safety of care we deliver to our patients will improve.

Three improvement priorities for specific focus in 2020/21 are indicated below; these have been included in light of COVID-19 and Ockenden Report. The priorities described in 2019/20 were suspended following both national guidance and limitations posed by the Trust in response to Covid-19. The priorities from 2019/20 remain a focus of work in the coming year, alongside the described Quality Priorities. They will be reported on in the relevant sections in the Quality Account 2021/22

Specific Indicator	**Quality Priority**	**Success Measure**
Patient Safety	Improve in-patient mobility and movement to reduce hospital acquired functional decline and maximise discharge potential	85% of clinically appropriate patients are dressed and out of bed by 12.00
Patient Experience	Improve use of Personalised Care & Support Plans (PCSPs) for all women using our maternity services	Audit outcome which demonstrates provision of PCSP at booking and percentage of women who have a written plan at birth
Clinical Effectiveness	Review the pathway for diabetes to isolate potential crisis points and act on the analysis	Develop a health and well-being package for diabetes patients at the Trust.

Improving the quality of care we deliver is about making care safe, effective, patient-centred, timely, efficient and equitable. The Quality Strategy 2018/21, incorporating the Quality Priorities identified above to monitor service improvement, is the vehicle that will drive quality improvement across the organisation.

Progress against the quality priorities is monitored monthly by the Executive Medical Director and Chief Nurse through the Advancing Quality Oversight Group. A report is presented quarterly to the Quality Committee, which reports to the Board of Directors

2.1.4 Review of Quality Priorities during 2019/20

The exceptional year we have experienced has affected anticipated activities during 2020/21. Most have either not taken place at all or not in the manner planned. In view of this, in this section, we have evaluated the priorities we set for 2019/20 to demonstrate progress against this work, which started before the pandemic. The following section provides an overview of the Trust's quality priority performance during 2019/20. The three key priorities for 2019/20 were selected from each of the four quality campaigns of the 2018/21 Quality Strategy. The table below describes the Trust's 2019/20 Quality Priorities and progress to April 2021.

Quality Priority 1: Clinical care outcomes	**Outcomes:** Reduce harm for those using our services who have a learning disability **Success Measure** 10% increase in the use of learning disability pathways

Progress: In 2020/2021

All patients with a diagnosed learning disability, attending the Trust as inpatient, are started on a learning disability pathway and are referred to the learning disability team on admission.

For 2020/21, we have seen a 34% increase in the use of the learning disability pathway, compared to the previous year. Our position for this year and the preceding two years is indicated below:

Year	Number of patients admitted who began a new pathway	Number of patients seen as an outpatient who began a new pathway	Total number of patients who attend the Trust and started on a learning disability pathway
2018/2019	467	1,742	2,209
2019/2020	473	765	1,238
2020/2021	500	1,163	1,663

Once a patient starts on the pathway they remain on it, both in and out of hospital, which promotes multi-agency, individualised care provision. Admissions from this patient cohort have increased significantly this year; this may be due to COVID-19 pandemic and the additional health needs of those with learning disabilities. We will continue to monitor systematically over the next year.
In the coming year, we plan to re-evaluate the pathway and review its effectiveness. This will give assurance that the learning disability care pathway is effective and that it enhances the experience of patients with learning disabilities within the Trust.

Quality Priority 2: Patient experience	**Outcome:** Ensure we adhere to patient choice for their preferred location at the end of life **Success measure** Maintain at least 85% or more alignment with patient's preferred discharge location at the end of life

Progress: In 2020/21 progress has been made as follows:

Identifying and discharging dying patients quickly from hospital to their preferred place of care (PPC) is a complex process requiring many services to work collaboratively at short notice. The improvement target is for 85% of those with a successful Fast Track Continuing Health Care (CHC) application to achieve discharge to their PPC.

2020/21	Q1	Q2	Q3	Q4
Total Fast Track Discharges	63	77	111	115
Achieved PPC	58	70	82	94
Did not-achieve PPC	5	7	29	21
Percentage achieved PPC	**92%**	**91%**	**74%**	**82%**
Total % for the Year	**85%**			

The challenges with Fast Track discharges are recognised throughout the system and further alliance work is set to make appropriate changes to support a longer-term achievement of PPC for all patients across Mid-Nottinghamshire. This is ambitious but has been set as a priority for the End of Life Care Together Service, which is working with CHC to understand the scope of what could be achieved through the alignment and coordination of Fast Track referrals and end-of-life care services.

The Integrated Discharge Advisory Team (IDAT) continues to lead the Fast Track discharge process and has developed its practices throughout the pandemic to improve experiences. This has included trialling visits to care homes following discharge, to ensure support is continued and to prevent re-admission. It is important to acknowledge the extra involvement and commitment of the IDAT in terms of enhancing patient and carer experience:

"As Mr JB did not have any family or friends, I was asked by my Matron to support with the delivery and installation of oxygen at his home. This prevented any delays to his discharge and he was able to safely return home as per his wishes" ***IDAT***

Aims for 2021/22

- Launch the new Trust End of Life Care (EoLC) Strategy for 2021 -2025
- Participate in the next cycle of National Audit for Care at End of Life (NACEL)
- Enhance measures to capture patients' and their relatives' experiences
- Develop the business case for dedicated EoLC beds to support choice and enhance experiences of patients and their loved ones
- Ensure sustainability of the Macmillan EoLC Team resource
- Enhance the EoLC Champions network to include members of the multi-professional teams

Quality Priority 3: Patient safety-	**Outcome:** Improve effectiveness of discharge planning and resilience of discharge location **Success measure** Reduce by 10% the number of incidents or complaints concerning unsatisfactory/unsafe discharge (compared to 2018/19 figures).

Progress: In 2019/20 progress has been made as follows:

During 2020/21, 15.5% (40) of complaints investigated related to discharge concerns; this represents a 1.5% increase from the previous year. The majority of these complaints related to communication linked to discharge assessments and arrangements, which was compounded by the restricted visiting policy during the COVID-19 pandemic. This was recognised and as a result, the Family Liaison Team was established to support communications between wards and relatives. This proved to have a positive impact on the experiences shared by patients and relatives.
During 2019/20, there were 232 (1.6%) incidents relating to discharge in comparison to 227 (1.7%) in 2018/19. 2% of these resulted in moderate harm and none in severe or catastrophic harm.

As a result of the complaints and incidents, a triangulation of feedback including complaints; concerns; incidents; and Section 42 (enquiries according to the Care Act (2014), has taken place. Integrated Discharge Advisory Team (IDAT) and Safeguarding liaise closely in identifying learning and future planning. There are strong connections between adult safeguarding named nurses and social workers to address concerns. Key deliverables to date include:

- Review of our Discharge Policy focusing on key areas of learning
- IDAT continues to work closely with the Trust Safeguarding Team in relation to Section 42s, to ensure we learn when services feel that the Trust has unsafely discharged a patient.
- IDAT works in close partnership with our community colleagues to facilitate early, supported,

safe discharges.

- All patients that are assessed by the Frailty Intervention Team (FIT) in Emergency Department will have a post-discharge holistic needs assessment completed within 24 hours of returning home.
- We have a dedicated telephone line for palliative referrals to 'Call 4 Care'.
- The Home First leaflet, in conjunction with social services' 'Golden Number' and the 'Call 4 Care' patient line number is at every patient's bedside and is given to patients / relatives if required post discharge.
- The Trust sourced local additional capacity at Ashmere Care Homes, along with additional beds at King's Mill Hospital, which are fully supported by senior clinicians. This formed part of the Winter Pressure plans for 2019/20.
- We are in the process of trialing Discharge to Assess (D2A) to support safe, timely discharge.

2.2 Statements of Assurance from the Board

1. General Statement

During 2020/21 Sherwood Forest Hospitals NHS Foundation Trust provided and / or subcontracted various relevant health services.

Sherwood Forest Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2020/21 represents 78% of the total income generated from the provision of relevant health services by Sherwood Forest Hospitals NHS Foundation Trust for 2020/21. This year we looked after:

- 45,911 inpatients
- 348,734 outpatients
- 120,144 attendances to our emergency department
- 3,314 women who choose to give birth at King's Mill Hospital.

We employ 6500 staff, including 224 consultants doctors which includes 34 locum consultants, working in hospital facilities that are some of the best in the country.

2. Participation in clinical audit

Clinical audit submission to quality accounts

During 2020/21, the Trust participated in 58 national clinical audits. For national confidential enquiries, there were no new studies for the Trust to participate in.

Due to the COVID-19 pandemic, many of the bodies regulating national audits - Health Quality Improvement Partnership (HQIP) and the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) advised that, in order not to distract frontline clinical colleagues, the National Clinical Audit program was deemed non-essential; organisations were asked to submit data only if this was possible in light of local pressures.

The Trust stepped down all other clinical audit activity from March 2020 to June 2020 and then again from December 2020 to March 2021.

National clinical outcome review projects 2020/21

The Trust, along with many acute organisations nationally, has not submitted a full set of data to a number of national audits during this calendar year. This impact is reflected in the '% complete' column below.

The COVID-19 pandemic has significantly impacted the clinical audit programme in 2020/21. In line with national advice a number of reports have been suspended or curtailed. This is reflected in this report. A summary of the audits normally submitted is below

National Clinical Audit & Enquiry Project Name	Included in NHSE Quality Account List (2019/2020	Part of NCAPOP commissioned by HQIP (Y/N)
PHE Screening- antenatal and newborn screening	**Y**	**N**
BAUS Bladder Outflow Obstruction Audit	**Y**	**N**
Female Stress Urinary Incontinence Audit	**Y**	**Y**
Breast and Cosmetic Implant Registry (BCIR)	**N**	**N**
Case Mix Programme (CMP)	**Y**	**N**
Elective Surgery (National PROMs Programme)	**Y**	**N**
Fractured Neck of Femur (care in emergency departments)	**Y**	**Y**
Pain in Children (care in emergency departments)	**Y**	**N**
Infection Control (care in emergency departments)	**Y**	**N**
Fracture Liaison Service Database	**Y**	**Y**
National Audit of Inpatient Falls	**Y**	**Y**
Inflammatory Bowel Disease (IBD) Service Standards	**Y**	**N**
Learning Disabilities Mortality Review Programme (LeDeR)	**Y**	**Y**
Mandatory Surveillance of HCAI	**Y**	**N**
Perinatal Mortality Surveillance confidential enquiries	**Y**	**Y**
Maternal Mortality surveillance and mortality confidential enquiries	**Y**	**Y**
Maternal morbidity confidential enquiries	**Y**	**Y**
Mimic: A multi centre cohort study evaluating the role of inflammatory markers in patients presenting with acute ureteric colic	**N**	**N**
NAP7: Perioperative Cardiac Arrest	**N**	**N**

Paediatric Asthma Secondary Care	**Y**	**N**
Adult Asthma Secondary Care	**Y**	**Y**
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	**Y**	**Y**
National Audit of Breast Cancer in Older People (NABCOP)	**Y**	**N**
National Audit of Cardiac Rehabilitation	**Y**	**N**
National Audit of Care at the End of Life (NACEL)	**Y**	**N**
National Audit of Dementia	**Y**	**Y**
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	**Y**	**Y**
National Cardiac Arrest Audit (NCAA)	**Y**	**N**
National Audit of Cardiac Rhythm Management (CRM)	**Y**	**Y**
Myocardial Ischaemia National Audit Project (MINAP)	**Y**	**Y**
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	**Y**	**Y**
National Heart Failure Audit	**N**	**Y**
National Child Mortality Database	**Y**	**Y**
National Diabetes Foot Care Audit	**Y**	**Y**
National Diabetes Inpatient Audit (NaDIA)	**Y**	**Y**
NaDIA-Harms	**Y**	**Y**
National Core Diabetes Audit	**Y**	**Y**
National Pregnancy in Diabetes Audit	**Y**	**N**
National Early Inflammatory Arthritis Audit (NEIAA)	**Y**	**Y**
National Emergency Laparotomy Audit (NELA)	**Y**	**Y**
National Oesophago-gastric Cancer (NOGCA)	**Y**	**Y**
National Bowel Cancer Audit (NBOCA)	**Y**	**N**
National Joint Registry (NJR)	**Y**	**N**
National Lung Cancer Audit (NLCA)	**Y**	**Y**
National Maternity and Perinatal Audit (NMPA)	**Y**	**N**
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	**Y**	**N**
National Ophthalmology Audit (NOD)	**Y**	**N**

National Paediatric Diabetes Audit (NPDA)	**Y**	**N**
National Prostate Cancer Audit	**Y**	**N**
Perioperative Quality Improvement Programme (PQIP)	**Y**	**N**
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	**Y**	**N**
Society for Acute Medicine's Benchmarking Audit (SAMBA)	**Y**	**N**
Surgical Site Infection Surveillance Service	**Y**	**N**
Trauma Audit & Research Network (TARN)	**Y**	**N**
UK Cystic Fibrosis Registry	**N**	**N**
UK Registry of Endocrine and Thyroid Surgery	**Y**	**N**

Outcomes and learning from clinical audits undertaken during 2020/21

The number of clinical audits, both national and local, which formed part of the 2020/21 Audit Plan is as follows:

Total Number of audits in the 2019/20 plan: **265**
Number of local / other audits: **207**
Number of national audits, including NCEPOD: **58**
Number of audits fully completed: **60 (22%)**

Over 21/22, the continued alignment of clinical audit and quality improvement activities will enable us to strengthen our learning and understanding of both issues and opportunities within clinical audit, leading to measurable improvement in outcomes.

We have positive foundations to build on:

The National Hip Fracture Database (NHFD) reported that the Trust achieved all six of the criteria for treating patients who had suffered a hip fracture as well as scoring above the national average.

The Parkinson's National Audit shows that we are consistently performing ahead of the national average in the standards being measured. An example of this is that 96.4% of patients surveyed within our service had been reviewed within the last six months compared to 62.7% nationally. 100% of our patients are seen within specific Parkinson's/ Movement Disorder clinics compared to 50% nationally.

The National Emergency Laparotomy Audit shows that there is a consultant anesthetist and consultant surgeon present in 99% of cases where the risk of death is calculated at being equal to or greater than 5%. This is 10% higher than the national average. The Trust average post-operative stay is recorded at 13 days which is three days lower than national level, and two days lower than the local Academic Health Science Network region.

The Chronic Obstructive Pulmonary Disease (COPD) Audit results show that 35% of patients requiring acute treatment with NIV received it within two hours of arrival. This is 11% above the national target and an increase of 6% on the previous year. We also saw an increase in the percentage of discharge bundles completed on the previous year rising from 80% to 85%.

We are targeted to provide systemic steroids to an adult patient experiencing an asthma attack within one hour of arrival at the hospital. **The Adult Asthma audit** shows that we achieve this in 50% of cases against a national target of 27%. We also achieve the standard of a respiratory specialist carrying out a review within 24 hours of arrival at hospital.

Below are some examples of the local audits completed in 2020/21 with the outcomes captured and actions to aid improvement:

Oxygen Prescription re-audit, King's Mill Hospital
The British Thoracic Society (BTS) 2015 audit demonstrated that 14% of hospital inpatients were on oxygen, with 42.5% of these not having a valid prescription. The primary objective was to assess the compliance with the BTS guidelines for oxygen prescription at King's Mill Hospital and compare to previous Trust audit against the BTS standard carried out in 2019.

The documentation audit demonstrates improvements in completion of paper work related to target oxygen saturation (from 37.5% to 60%) and name, date and signature (from 35% to 58%).

Further actions included a prescribed 'target range' for all hospital patients at the time of admission so that appropriate oxygen therapy can be started as soon as possible.

Improved communication with GPs following patients with Acute Coronary Syndrome (ACS), to meet NICE standards
Discharge summaries are often the only patient communication between secondary and primary care. Following ACS, hospital admissions are short and most care is provided in the community. Good secondary prevention (both medication and lifestyle) is required to improve management of coronary conditions. Feedback was received from both GPs and from consultants that current discharge summaries often lacked relevant information.

Following improvement cycles, the re-audit results showed an increase in the results of investigations being included in the discharge communication from 85% to 100%. The inclusion of information on ACEi and/or beta blocker medication increased from 6% to 67%.

Imaging in cauda equina syndrome - re-audit (Jan-Aug 2020)
Cauda Equina Syndrome (CES) is due to compression of the nerve roots below the level of the conus and is an absolute indication for emergency surgical decompression. Clinical examination alone is unreliable having a high false-positive rate. MRI remains the gold standard investigation to distinguish between true CES requiring consideration for surgery and those with another cause of their symptoms. The East Midlands Spinal Network - Emergency Radiology Imaging policy recommends that a patient with suspected CES should be scanned and reported within an appropriate time-frame determined by the responsible clinician. This is usually within 12 hours and will facilitate surgical intervention within 24 hours when indicated.

In the re-audit

Standard parameter	**Re-audit result (Previous Audit)**
Referral made to time of report within 12 hours	100% (76%)
Order to report within 12 hours	100% (50%)
ED presentation to report within 12 hours	96.7% (24%)

Longest exam to report time decreased from 24hours 23 minutes to 6 hours 15 minutes.

Review of 2020/21

Although disrupted by the COVID-19 pandemic this year we have:

- Introduced a new approach to the Trust-wide audits programme, in order to standardise the approach and to re-connect colleagues to meaningful data collection.
- Successfully implemented AMAT - the Clinical Audit system incorporating the registration of projects, data collection and analysis, alongside monitoring of both the progress and action plans. This combines both improvement projects and audits into one visible platform, to support organisational learning and knowledge management.
- Integration of the Clinical Audit and Improvement web pages, in sharing learning, outcomes of audits and the in-house support available to progress these effectively.

Looking forward to 2021/22 we aim to:

- support the continuous cycle of improvement within the organisation, by increasing the visibility of audit activities via the QI Hub,
- engage with clinical teams via the Shared Governance agenda and via targeted activities with junior doctors.
- fully integrate AMAT as the knowledge management platform for capturing audit and improvement
- develop more ownership of audit information/knowledge at local level, and knowledge of how this contributes to improving patient outcomes
- provide further tangible measures of improved patient outcomes
- increase re-audit rates and support colleagues to achieve sustainable improvement

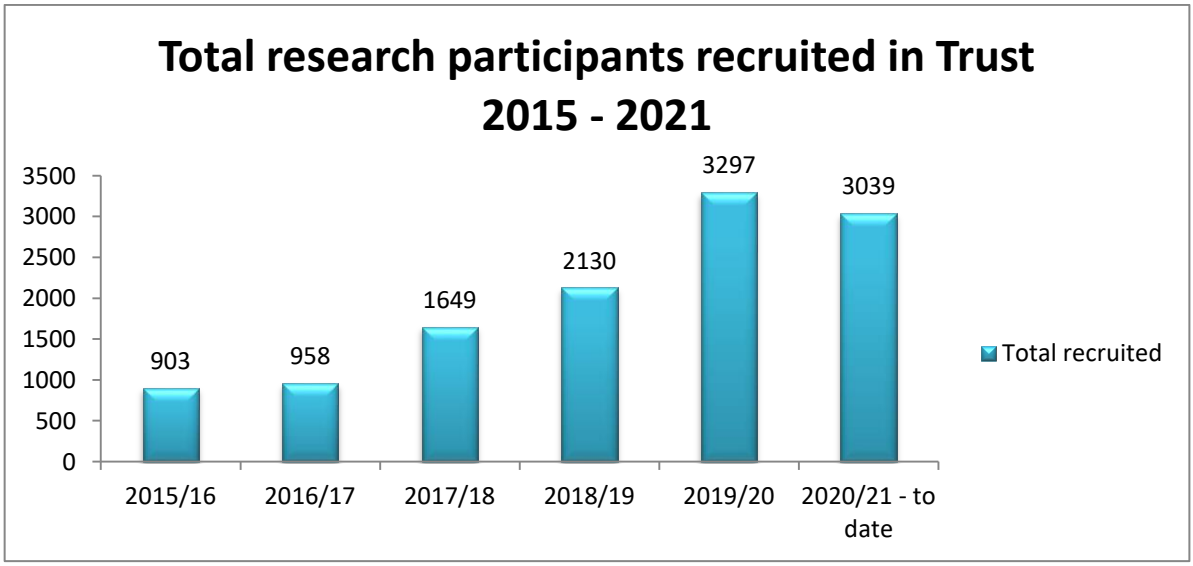
3. Participation in clinical research and innovation

3039 patients receiving relevant health services provided or sub-contracted by the Trust in 2020/21 were recruited to participate in research approved by the Research Ethics Committee during that period. This includes patient data and tissue samples.

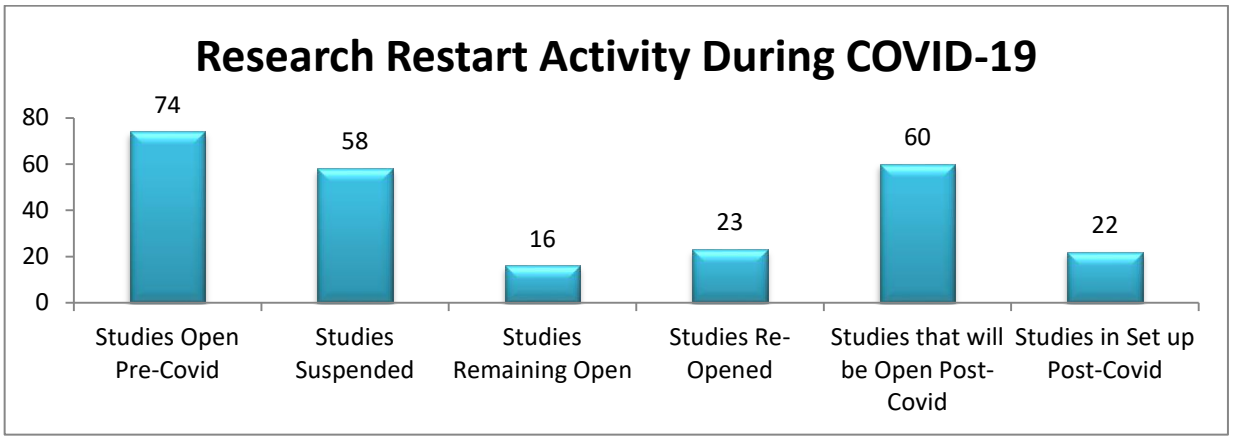
The Trust is actively involved in clinical research and has a dedicated Research and Innovation department (R&I). The R&I team is responsible for developing and supporting a varied research portfolio that creates better opportunities for patients and staff to participate in research activity, whilst informing the provision of high quality, evidence-based health care. Patient participation in research is mainly through studies adopted by the National Institute for Health Research (NIHR). The Trust is involved in a small number of non-adopted studies which are typically undertaken for educational purposes.

Research activity in the organisation has shown a year on year increase over the past five years. This demonstrates an 84% increase over the last four financial years (see graph 1). The majority of research activity was suspended in March 2020; 58 studies were suspended, with only 16 remaining open due to the patient safety impact of suspending them (see graph 2). The majority of research activity focused on Urgent Public Health (UPH) studies as defined by the National Institute for Health Research in order to find suitable treatments to combat the global pandemic. The Trust participated in 13 UPH studies and recruited 2,849 participants. 190 participants were also recruited from non UPH studies (see graph 3). Overall recruitment activity exceeded the set target of 2,500. All data is based on local recruitment figures from the research management database EDGE.

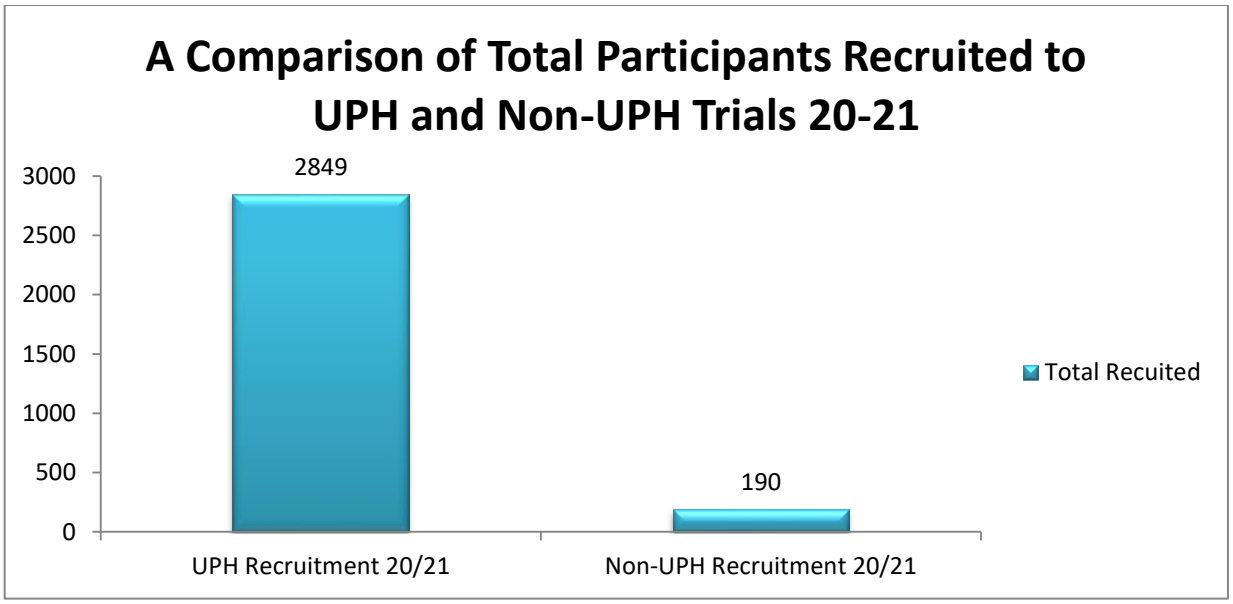
Graph 1



Graph 2



Graph 3



In 2021/22 the focus for R&I is to restart suspended studies and to continue to grow the research portfolio in line with the DHSC 'UK Clinical Research Recovery, Resilience & Growth' approach. This provides an opportunity to restore and improve pre COVID-19 research. This will include continuing to embed research into clinical care at the Trust.

In 2020/21 the Trust's commercial research activity decreased due to the COVID-19 pandemic, with two studies remaining open and seven participants recruited. In 2021/22 we plan to re build our commercial activity by prioritising restart and set up of trials; strengthening our reputation for delivery; and attracting more commercial companies to bring clinical trials to the Trust. We will also continue to identify a suitable space for a dedicated Clinical Research Facility. This will be at the centre of the growth of commercial research locally and will expand the access to clinical trials for patients in the region, enabling the uptake of more complex trials in a comfortable and relaxed environment.

Research is a partnership between participant and researcher. Every year, as part of the NIHR research participant experience survey, we ask people who have volunteered for health research at the Trust to feedback on their experience so we can make improvements. Our survey focused on two main questions and we found that of the respondents, 98% reported that they would agree or strongly agree that they had a good experience of taking part in research and 96% surveyed would consider taking part in research again.

The Trust is committed to expanding research activities and facilities and has developed strong associations with universities, other NHS Trusts and stakeholders. To expand the types of research studies available to the local population and to support workforce capability and capacity to undertake research, the Trust has developed collaborative relationships with Nottingham University Hospitals NHS Trust and Nottingham Trent University (NTU). R&I is also working closely with research partners across the Integrated Care Partnership to ensure research opportunities and engagement is offered system wide, not just in hospitals.

R&I is part of a Trust wide group working closely with the East Midlands Academic Health Science Network (EMAHSN), NTU, other partners in social care and the County Council, which has been successful in getting to the final stage of a Health Foundation bid to become an Innovation Hub. If successful, the hub will support the local health system in facilitating effective adoption of health care innovations. In doing this, long-lasting impact for patients and patient care can be realised.

At a local level the Trust R&I team is working closely with divisional teams to begin to embed clinical research into frontline care. The department will restart the support of research secondments as part of the Trust Research Academy and network of Research Champions, alongside supporting nursing and midwifery colleagues to develop capacity and capability to undertake research through collaborations with HEIs.

R&I presents a quarterly update to Trust Board and a performance update to the Quality Assurance Cabinet each quarter. The Research Governance Committee meets quarterly to oversee and monitor activity. The Trust has an external reporting responsibility to the Department of Health and Social Care via the Clinical Trials Platform. This is a national Key Performance Indicator for NHS Trusts; “Performance in Initiation and Delivery of Clinical Research” in which the Trust continues its sustained performance improvement.

4. Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN) is offered by NHS commissioners to providers of healthcare services commissioned under an NHS contract. It rewards excellence by linking a proportion of the provider’s income to the achievement of local and national improvement goals.

A proportion of the Trust income in 2020/21 would normally be conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

During 2020/21 the Trust planned engagement in all eligible national CQUINS and specifically identified specialised CQUINS and had received positive endorsement for all work undertaken by our commissioners (Clinical Commissioning Group and NHS England).

In March 2020, NHS England directed both providers and commissioners to suspend delivery of all CQUINs for the year 2020/21 as a result of the Covid-19 pandemic. This directive ensured a block payment was received by providers for the year 2020/21.

As a result of the NHS England directive, CQUINs were not started or delivered during 2020/21 at the Trust.

5. Registration with the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration is fully registered without conditions. the Trust currently has no restrictions on registration. The Care Quality Commission has not taken enforcement action against Sherwood Forest Hospitals NHS Foundation Trust during 2020/21.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has four locations registered;

- King's Mill Hospital
- Newark Hospital
- Mansfield Community Hospital
- Ashfield Health Village

During 2020/21 the Trust has supported the development of two mass vaccination centres

- Kirkby-in-Ashfield Vaccination Centre located at Ashfield Health Village
- Mansfield Vaccination Centre located in Mansfield Town Centre previously a DIY store

During 2020/21 the Covid-19 pandemic caused restrictions on visitations by external regulators including the CQC. There were no on site assessments of services by the CQC during this reporting period, however the Trust maintained a positive working virtual relationship with the CQC to maintain the ratings from the 2020 visit.

The CQC carried out an inspection during January and February 2020 and visited the following core services:

King's Mill Hospital

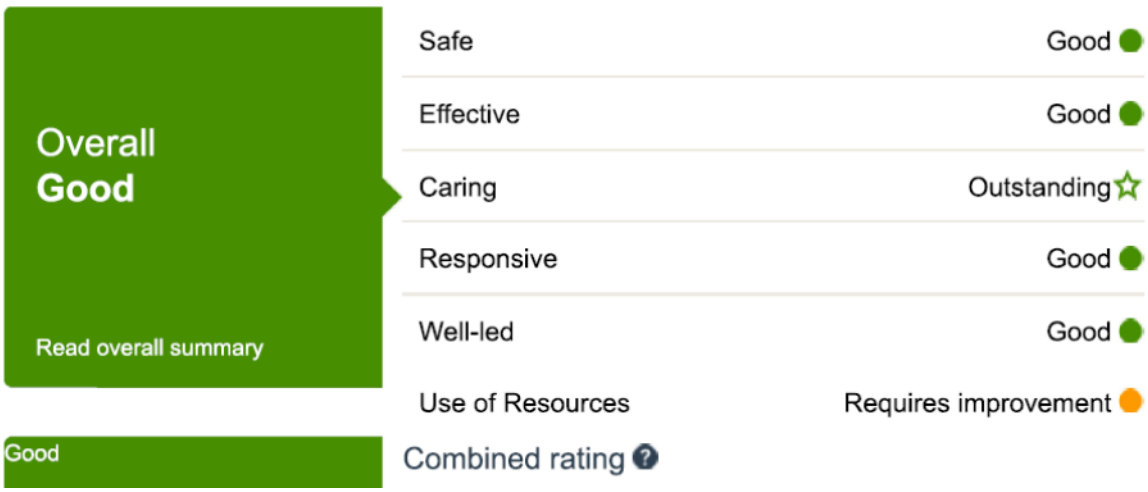
- Critical Care
- Children and Young People
- Surgery and Anaesthetics

Newark Hospital

- Children and Young People
- Surgery and Anaesthetics
- End of Life

In addition to the core service inspection CQC undertook a well-led inspection of the Trust on the 11 and 12 February 2020

The Trust received the final report in May 2020 indicating the improvements made had resulted in a re-rating, giving an overall rating for the organisation as GOOD comprised of the following ratings for each domain:



6. Information on Secondary Uses Service for inclusion in Hospital Episode Statistics

The Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

99.8% for admitted patient care
100% for outpatient care and
98.8% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;
100% for outpatient care; and
98.6% for accident and emergency care

7. Information Governance

The Trust Data Security Protection Toolkit Assessment Report overall score for 2020/21 was all standards met and the Trust was graded as fully compliant.The Data Security and Protection Toolkit for 2020/21 included **111** items: out of **111** mandatory evidence items complete **no** improvement plan to meet the standards was required.

Data security aims for 2021/21
The Data Security and Protection Toolkit will encompass Cyber Essentials PLUS certification which is a rigorous test of the organisation's security systems. The Trust will be working towards achieving the certification to provide assurance that data is protected at the highest level.

How was this achieved?
The Data Security Team were audited by 360 Assurance our internal auditors who undertook a review of some of the standards. The overall assessment provided the Trust with substantial assurance which provides a high level of confidence in our data security.

Monitoring and reporting for sustained improvement
All actions taken from internal audits are monitored by the Information Governance Committee and the Audit and Assurance Committee.

Serious incidents requiring investigation
In 2020/21, the Trust reported two data security serious incidents, reported on the Data Security Protection Toolkit. The incidents included paper documents not being adequately protected and images being shared on social media.

To date the Trust has received no regulatory action as a result of the incidents reported. Lessons have been learned and recommendations implemented to mitigate further reoccurrence.

8. Clinical coding audit

Sherwood Forest Hospitals NHS Foundation Trust was not subject to the Payment by Results (PbR) Clinical Coding audit during 2020/21 by the Audit Commission.

The Trust has a dedicated team of qualified and trainee clinical coders that are responsible for coding approximately 123,931 inpatient activities for 2020/21. Coded activity data is submitted to Secondary User Services (SUS) which is used to support commissioning, healthcare development and improving NHS resource efficiency.

Clinical coding aims for 2020/21

- Deadline and targets: Achieve 100% coding target by the fifth working day after the month end.

- Audits: Improve coding accuracy by conducting monthly audits of coded data before the final submission.
- Recruitment and Training: Recruit and train trainee clinical coders
- Clinical engagement: Improve clinical engagement and raise coding awareness among the junior doctors.

Performance against this target

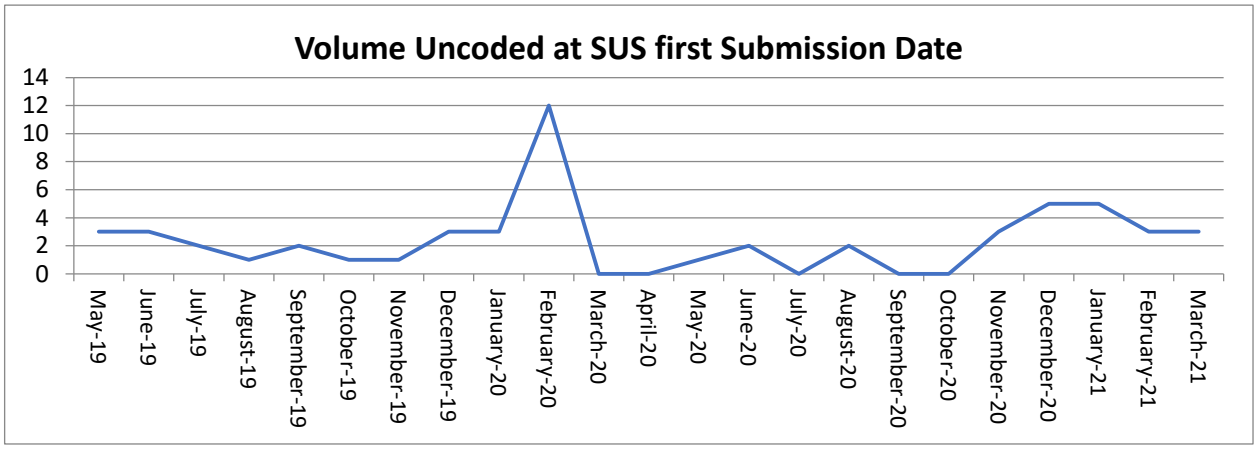
The Trust has consistently achieved over 99.9% coding targets by the fifth working day after the month end.

Table 1

		Spell Discharges				
FCE Month	**1st SUS Submission date**	**Total Number of Episodes**	**Volume Uncoded as SUS first Submission Date Actual & Trajectory**	**Actual Uncoded %**	**% Total Uncoded Trajectory**	**% Coded at 1st Submission**
January-18	19/02/2018	9,003	3	0.03%	2.0%	100.0%
February-18	16/03/2018	7,899	0	0.00%	2.0%	100.0%
March-18	19/04/2018	8,840	3	0.03%	2.0%	100.0%
April-18	21/05/2018	8,196	0	0.00%	2.0%	100.0%
May-18	18/06/2018	8,907	3	0.03%	2.0%	100.0%
June-18	18/07/2018	8,558	5	0.06%	2.0%	99.9%
July-18	16/08/2018	8,741	0	0.00%	2.0%	100.0%
August-18	18/09/2018	8,783	2	0.02%	2.0%	100.0%
September-18	17/10/2018	8,504	2	0.02%	2.0%	100.0%
October-18	16/11/2018	9,411	2	0.02%	2.0%	100.0%
November-18	17/12/2018	9,117	3	0.03%	2.0%	100.0%
December-18	17/01/2019	8,614	4	0.05%	2.0%	100.0%
January-19	15/02/2019	10,062	2	0.02%	2.0%	100.0%
February-19	22/03/2019	9,2,92	0	0.00%	2.0%	100.0%
March-19	17/04/2019	9,747	1	0.01%	2.0%	100.0%
April-19	17/05/2019	9,385	2	0.02%	2.0%	100.0%
May-19	17/06/2019	10,044	3	0.03%	2.0%	100.0%
June-19	15/07/2019	9,326	3	0.03%	2.0%	100.0%
July-19	19/08/2019	10,357	2	0.02%	2.0%	100.0%
August-19	27/09/2019	9,676	1	0.01%	2.0%	100.0%
September-19	15/10/2019	9,761	2	0.02%	2.0%	100.0%
October-19	15/11/2019	10,725	1	0.01%	2.0%	100.0%
November-19	13/12/2019	10,422	1	0.01%	2.0%	100.0%
December-19	16/01/2020	10,124	3	0.03%	2.0%	100.0%
January-20	14/02/2020	11,175	3	0.03%	2.0%	100.0%
February-20	19/03/2020	10,014	12	0.12%	2.0%	99.9%
March-20	17/04/2020	8,796	0	0.00%	2.0%	100.0%
April-20	18/05/2020	4,885	0	0.00%	2.0%	100.0%
May-20	15/06/2020	5,860	1	0.02%	2.0%	100.0%
June-20	15/07/2020	6,929	2	0.03%	2.0%	100.0%
July-20	17/08/2020	8,109	0	0.00%	2.0%	100.0%
August-20	16/09/2020	8,356	2	0.02%	2.0%	100.0%
September-20	16/10/2020	8,860	0	0.00%	2.0%	100.0%
October-20	17/11/2020	8,946	0	0.00%	2.0%	100.0%
November-20	17/12/2020	8,684	3	0.03%	2.0%	100.0%
December-20	20/01/2021	8,469	5	0.06%	2.0%	99.9%
January-21	15/02/2021	8,320	5	0.06%	2.0%	99.9%
February-21	12/03/2021	8,298	3	0.04%	2.0%	100.0%
March-21	20/04/2021	9,416	3	0.03%	5.1%	100.0%

Notes:
The table above (table 1) provides an indication of the volume of un-coded episodes for discharged hospital spells within each month. The first submission date and percentage un-coded (graph 4) will aid users on what period to select for mortality reports to ensure a more robust picture. All discharges are coded for the Post PbR Reconciliation deadlines and a refreshed SUS submission sent.

Graph 4



Audits

The Trust has a coding quality assurance programme that automatically assesses clinical coding prior to monthly submission of activity data. This is supplemented by targeted audits to improve quality of the coded data conducted by Clinical Classifications Service Approved Auditor.

Due to the pandemic, the Trust was unable to carry out the missing comorbidity audit and instead began an audit of individual clinical coder's work, where a minimum of thirty consultant episodes per clinical coder was audited. A post-audit discussion where any errors found during the audit were fed back to the clinical coder and reasoning explained. Areas of both good practice and improvement were highlighted.

Data security standard One - Data quality:

As part of Data Security and Protection Toolkit, the Trust has undertaken an audit of 201 completed consultant episodes (April-September 2020) to assess the accuracy of clinical coding. The Trust's coding accuracy met the required percentage across all four areas.

The table below (table 2) illustrates the clinical coding audit results compared to the recommended percentage of accuracy scores from the Terminology and Classifications Delivery Service.

Table 2

	Primary diagnosis correct	**Secondary diagnosis correct**	**Primary procedure correct**	**Secondary procedure correct**
Standard exceeded	>=95%	>=90%	>=95%	>=90%
Standard met	>=90%	>=80%	>=90%	>=80%
Sherwood Forest Hospitals	*94%*	*95.8%*	*95.2%*	*93.8%*

Recruitment and training

The Trust has successfully recruited three trainee clinical coders.

Clinical coding awareness

Clinical coders conducted bite-size learning events to raise coding awareness amongst administrative and clerical staff. Clinical coders also deliver specialty-coding presentations to doctors at Clinical Governance meetings.

Clinical engagement

Clinical engagement is in place in order to improve the accuracy of coded data. This includes specific coding queries via email, one-to-one meetings with clinicians, clinician-led teaching sessions and observing procedures.

How was this achieved?

Improvements have been seen as a result of additional hours by the permanent coding team, 1.5 WTE additional agency coders and by implementing new ways of working within the office. This includes the collection/delivery of case-notes, deceased notes coding and workload distribution. The first tranche of trainee coders have now moved onto being responsible for particular specialties or areas and now only have a random sample of their work audited. Particular key achievements are:

- Better planning, organisation and target-setting have helped to achieve monthly deadline targets
- A regular internal programme of clinical coding auditing and training ensures a high quality of coded clinical data to satisfy NHS regulatory bodies; that the organisation exemplifies best practice; and promotes a culture of continuous improvement.
- Raising coding awareness among administrative and clerical staff has helped other departments in sending the case notes of discharged patients to the coding office in a timely manner. This enables the department to code more efficiently.
- Raising coding awareness among clinical staff has led to more easily available information in medical notes. This allows coders to code quickly and accurately. Engagement with clinical staff has allowed quicker resolution of coding queries, leading to greater coding accuracy.

Monitoring and reporting for sustained improvement

- All coding staff have access to the un-coded report, which helps them to monitor and plan their daily workload.
- The department has two senior clinical coders who are responsible for the organisation and planning of workloads to ensure 100% of monthly deadlines are achieved. They also liaise with the Trust's wards and departments to put processes in place for faster delivery of notes to the coding department.
- Individual audit feedback is given in a timely manner to ensure high individual coder accuracy. Training sessions are established as necessary.

The Trust will be taking the following actions to improve data quality:

- Ensuring that both operational and clinical staff are made aware of the importance of data quality and validation. This will be achieved through addressing training and educational needs, awareness sessions and regular communication.
- Improving engagement between clinical and administrative staff.
- Considering all challenges to the accuracy of data and where necessary update processes to reflect these constraints.
- Celebrating good performance and highlighting good practice amongst staff.
- Seeking to understand where data accuracy requires improvement and engaging with administrative staff to improve.

- Developing local performance reporting tools that demonstrate, following audit, the accuracy of data.
- Empowering line managers of administrative staff to engage with data accuracy and quality.
- Providing accurate, complete and timely information to support commissioning.
- Ensuring that data items are valid and adhere to data standards set out in the NHS Data Dictionary and any locally developed standards are consistent with the NHS Data Dictionary

9. Data quality strategy for 2020-21

The Trust's Data Quality Strategy describes our approach to optimising the quality of our information, to enhance and improve our decision making and services to patients. We continue to strive to embed data quality into the values, cultures, and ethos of the organisation such that 'right first time is the only accepted outcome.

The Trust has invested in ensuring that the recommended six data quality dimensions: accuracy, validity, reliability, timeliness, relevance and completeness are adhered to. Each is fundamental in providing fit-for-purpose information thus providing assurance that all information reported is as robust as possible.

The Trust maintains three key behaviours in our approach to providing data quality. These are:

- Responsiveness
- Proactivity
- Continuous improvement.

The Trust will be taking the following actions to improve data quality:

Responsiveness

Validation – in response to known areas of data quality concern (as identified through reporting or operational processes) we will:

- Actively validate information to ensure decision making is based upon accurate information
- Ensure operational and clinical teams are informed in cases where patient care is affected, to enable appropriate action to be taken

Addressing errors – where data errors are identified, in addition to informing operational and clinical teams to enable the patient impact to be understood and addressed, we will:

- Identify the root cause
- Correct the information, as necessary
- Ensure feedback is provided to the originator of the root cause (e.g. user, system provider etc.)
- Ensure action is taken to reduce or prevent repetition of the issue

Proactivity

Reporting – we will develop and use Key Performance Indicators (KPIs) to:

- Monitor levels of data quality
- Identify improvements or deterioration in data quality
- Identify areas for validation, corrections, training, process improvements or ad-hoc audits

Auditing – we will develop and implement an audit programme to:

- Systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback
- Allow for ad-hoc audits in response to suspected data quality weaknesses

Continuous improvement

Training – we will develop and deliver consistent data quality training for relevant members of staff. In addition, we will provide targeted training in response to themes or repeated errors, as identified through:

- Audit
- Reporting
- Operational issues

Process improvements – where necessary, we will systematically change operational processes to maximise data quality. Any such process changes will be:

- Clinically and operationally owned, designed and supported
- Underpinned by procedural documents
- Not be to the detriment of patient care
- Reviewed once implemented

Data quality training

The Trust continues to review all system based and operational data quality training materials, including Nottinghamshire Health Informatics Service (NHIS), and Standard Operating Procedures to ensure that they are fit for purpose in terms of data collection, recording, analysis and reporting adherence to Data Dictionary Standard Requirements.

Medway is the Patient Administration System (PAS) used by the Trust. Training is delivered by NHIS trainers and is a prerequisite to obtaining access to the Trust's PAS. The Trust continues to deliver a comprehensive training plan for both data quality and elective care.

The Trust will be taking the following actions to improve data quality training:

- Develop a suite of non face-to-face electronic solutions to support the delivery of the Elective Care Training Plan in light of social distancing constraints both during and post the COVID-19 pandemic.
- Support home and distanced working.
- Develop a similar system for non-elective training to support for admitted patient care.

Data quality improvement KPIs

The Trust has a fully developed Data Quality Analytical Dashboard to support the improvements of data collection in the following areas:

- Outpatient referral management
- Outpatient activity
- Inpatient activity
- Elective waiting list management
- Referral To Treatment (RTT)
- Maternity
- Medway PAS maintenance generic DQ

This enables the team to proactively identify areas of potential data quality improvement or issues that need to be addressed.

Data quality internal audit programme

The data quality team has an agreed schedule of targeted audits that are undertaken throughout the year to systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback at divisional and governance meetings.

Robust communication channels
The data quality team coordinates communication through the following channels:

- Trust articles and bulletin
- Dedicated data quality web page
- Training sessions and e-learning tools
- Awareness sessions
- Progress reports to the Board of Directors and Risk Committee
- Dedicated data quality and clinical coding support provided to all divisions (and service lines as appropriate)

The data quality team will be taking the following actions to improve data quality:

- Continuing to keep the Trust informed of emerging data quality issues through our regular communication channels
- Maintaining the process of continuous evaluation of documentation designed to support system users to maintain data quality standards e.g. Standard Operating Procedures
- Amending documentation and delivering appropriate user awareness sessions in response to system upgrades taking place

Trust data quality position March 2020
The Data Quality Maturity Index (DQMI) is a quarterly publication intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality.

The Trusts' average total DQMI score is 88.9%.

The percentage of records in the published data which included the patient's valid NHS number (as at Nov 2019)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
99.8%	**100%**	**98.8%**

The percentage of records in the published data which included the patient's valid GP Code (as at Nov 2019)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
100%	**100%**	**98.6%**

The Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The Trust will be taking the following actions to improve data quality:
- To examine individual data items within the DQMI to identify areas that require improvement
- To aim to increase total average DQMI score to > 90%

1. Improving care and learning from mortality review

During 2020/21 1,782 of the Trust patients sadly died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 371 deaths in the first quarter;
- 307 deaths in the second quarter;
- 484 deaths in the third quarter;
- 620 deaths in the fourth quarter

By 31st March 2021, 1145 case record reviews and 25 investigations had been carried out in relation to 1782 of deaths.

The number of deaths in each quarter for which a case record review or an investigation was carried out was

- 204 in the first quarter;
- 227 in the second quarter;
- 377 in the third quarter;
- 372 in the fourth quarter

These reviews are used to capture themes and examples of learning where the care provided to the patient has been excellent as well as to identify any concerns or lapses in care provided. Following review of the structured case reports during the Covid waves, we have begun to institute a data and quality improvement process aimed at strengthening consistency of approach and distribution of learning.

The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form facilitates an early discussion with the patient and their family about their wishes towards the end of life or at the time of a significant medical event. To support these difficult patient conversations the Trust implemented the national ReSPECT Tool in April 2019 and this has now been rolled out across all providers within our ICS. Clinical teams have been trained in the appropriate application of the ReSPECT form, with ongoing support provided by the End of Life team. This information remains with the patient with a copy retained in the notes. Use of the ReSPECT form and the appropriateness of the decision-making has been audited through the 2020/21 period to identify areas of good practice and where further support and training may be required. It will be further reviewed and refined in light of the recent CQC DNARCPR report.

The Trust has continued to support and develop the Medical Examiner Service. The medical examiner provides independent scrutiny for any death where initial concerns have been raised, not only in relation to the cause of death but where the care provided to the patient in the day prior to death may have identified a failing, whether it contributed to the death or not. The medical examiner also provides support, advice and guidance to the trainee medical staff to ensure an accurate completion of the Medical Certificate on the cause of death. As the Trust moves into 2021/22 there have been further actions developed to improve the learning from deaths process. This includes;

- Increased number of medical examiners recruited from the Trust
- Wider Structured Judgment Review (SJR) training and process development to enhance consistency and quality of learning outputs
- Changes to the provider of the mortality surveillance tool to increase user ability and data capture
- Developing the medical examiner service to meet national requirements to scrutinise all deaths within the community alongside hospital mortality.

2.3 Reporting against core indicators

1. Summary Hospital Level Mortality Indicator (SHMI) banding

The Trust considers that this data is as described for the following reasons. 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 here. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

The table below (table 3) illustrates the Trusts SHMI banding as being consistently recorded as a two, which indicates 'as expected' level of mortality.

Table 3

Year	**SFHFT SHMI Value**	**SFHFT SHMI Banding**	**National Average**	Highest Performer	Lowest Performer	SHMI banding - Worst	SHMI banding - Best
Oct 16 – Sep 17	101.62	2	100.5	72.7	124.73	1	3
Jul 17 – Jun 18	97.72	2	100.35	68.92	125.72	1	3
Oct 17 – Sep 18	96.72	2	100.3	69.17	126.81	1	3
Jul 18 – Jun 19	93.80	2	100	69.89	119.11	1	3
Oct 18 – Sep 19	94.7	2	100	69.79	118.77	1	3
Jul 19 – Jun 20	96.75	2	100	67.64	120.74	1	3
Oct 19 – Sep 20	97.72	2	100	68.69	117.95	1	3

Percentage of Patient Deaths Coded as Palliative Care

The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between Trusts in the way that palliative care codes are used. Using the same spell level data as the SHMI, this indicator presents crude percentage rates of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level. The Trust considers that this data is as described for the following reasons. This is an indicator designed to accompany the SHMI. The table (table 4) below provides the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

Table 4

Year	**% of deaths with palliative care coding**	**National Average**	Highest Performer	Lowest Performer
Jul 17 – Jun 18	15.00%	32.90%	58.70%	13.40%
Oct 17 – Sep 18	15.20%	33.40%	59.50%	14.20%
Jul 18 – Jun 19	14.57%	36.0%	60.0%	14.57%
Oct 18 – Sep 19	11.95%	36.0%	58.77	11.95%
Jul 19 – Jun 20	9%	36.0%	60.0%	9.0%
Oct 19 – Sep 20	9%	36.0%	60.0%	9.0%

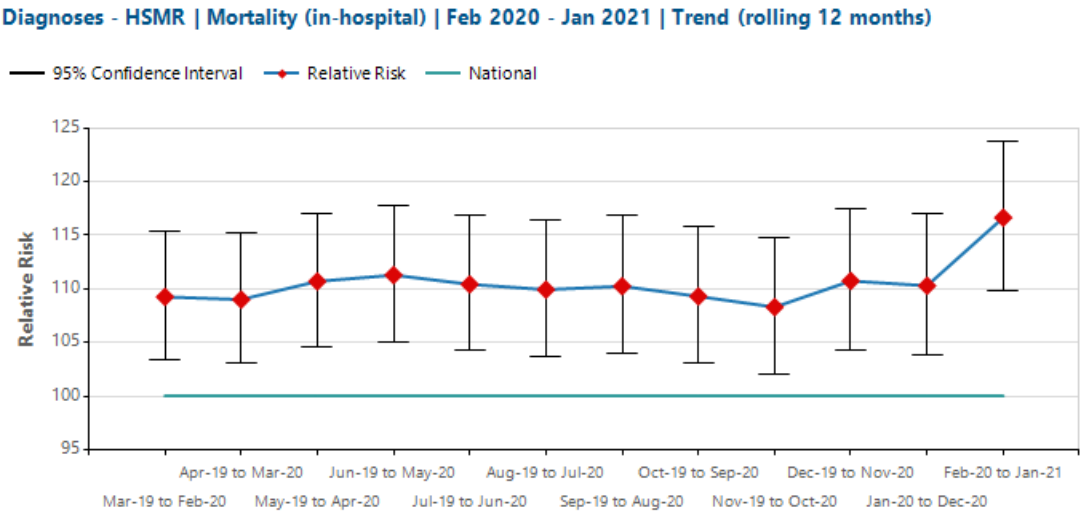
Hospital standardised mortality rate (HSMR)

The HSMR uses risk modelling to compare the number of expected deaths per month against actual deaths within the Trust. The HSMR is calculated using Hospital Episode Statistics provided by the Trust

with analysis in the Healthcare Intelligence Portal tool, the Trust HSMR score is produced by Dr foster Intelligence.

Figure 1 displays the Trust's HSMR for all inpatient admissions for 12 months of the time period February 2020 to January 2021.

Figure 1



The Trust HSMR is elevated. There is a program of work looking at the data cleansing and coding submissions along with deep dives into any highlighted outlying clinical patient groups. This will be monitored by the Learning from Deaths group, to date, we have not identified any other of indicators of concern that support the HSMR position.

2. Patient Reported Outcome Measures (PROMs)

The Trust considers that this data is as described for the following reasons; it is made available to the Trust through NHS Digital.

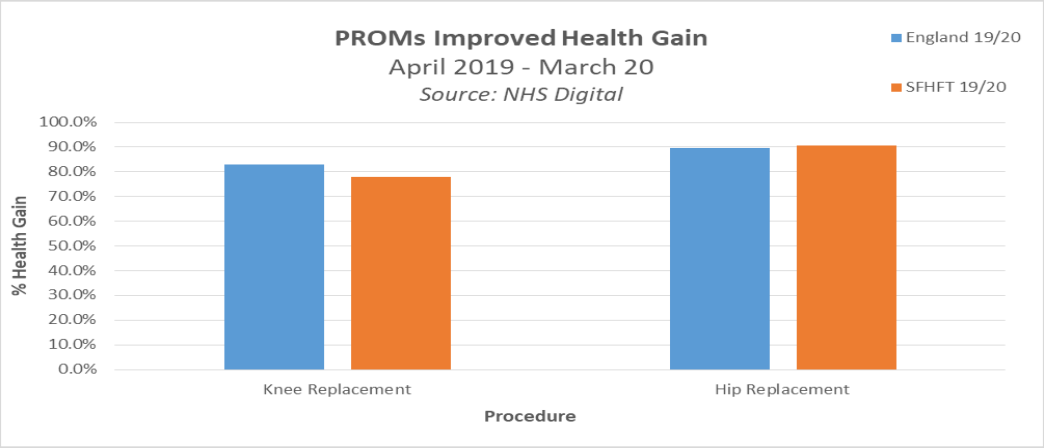
PROMs measures health gain in patients undergoing hip and knee replacement surgery in England based on responses to questionnaires before and after surgery. This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009.

The graph below (graph 5) shows how the Trust compares to the England average for measuring generic health status. This is one of the most commonly used generic health status measurement and has high levels of validity and reliability reported in various health conditions.

Improved health gains – April 2019 – March 2020

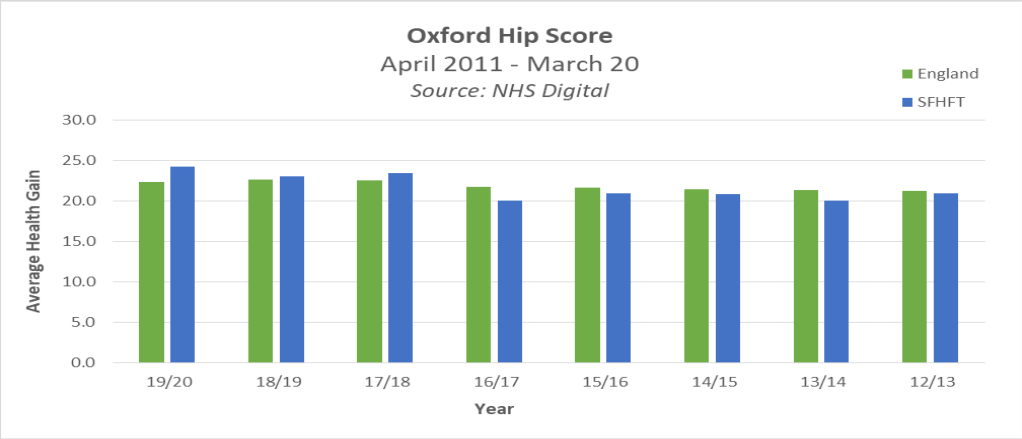
In response to the 2019/20 results the Trust's pre-operative assessment department are working with local councils to develop strategies to ensure patients are optimised and in the best health prior to surgery. We have implemented strategies to improve patients' 'general health prior to undergoing surgery, through smoking cessation and gym memberships.

Graph 5

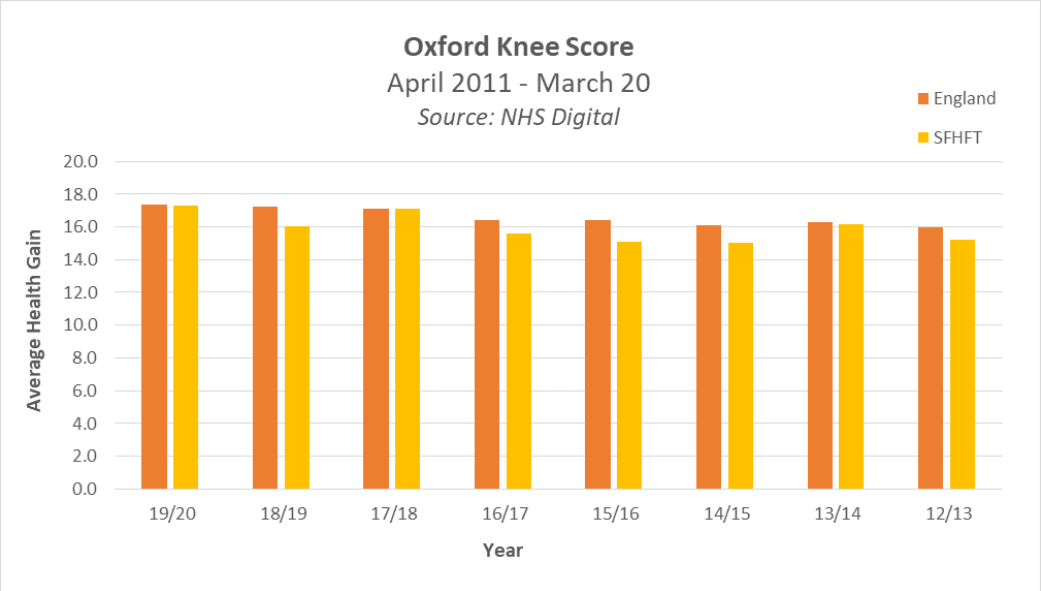


The graphs below (graph 6 and graph 7) show the Oxford Scores for hip and knee replacements. The Oxford score is a patient-reported outcome instrument. It contains questions on activities of daily living that assess function and residual pain in patients specifically for undergoing total hip or total knee replacements.

Graph 6



Graph 7



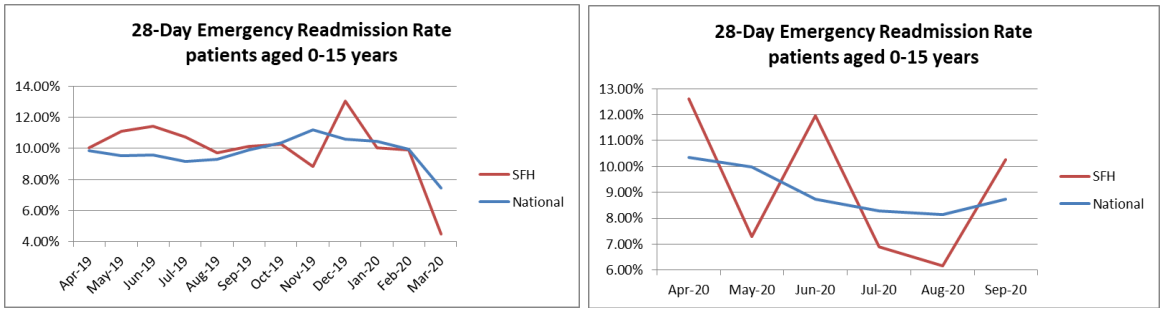
The Trust has continued to show improvement in these scores and is working in collaboration with our Clinical Commissioning Group to enhance and further develop our Musculoskeletal (MSK) pathways. In September 2020 the Trust implemented an elective joint replacement site at Newark Hospital following a Getting It Right First Time (GIRFT) review. Sites that offer purely elective services have a significantly lower risk of cancellation. This will result in greater patient satisfaction, improved clinical outcomes, fewer infections, shorter length of stay, reduced re-admission rates and a reduction in waiting times. Patients who have a hip replacement at the Trust have seen the greatest improvement in daily living when benchmarked against other acute sector providers within the Midlands.

3. Percentage of patients readmitted to hospital within 28 days

In April 2020 – September 2020 (graph 8):

- 9.00% of patients aged 0 to 15 were readmitted to a hospital within 28 days of being discharged during the reporting period.
- 10.08% of patients aged 16 or over were readmitted to a hospital within 28 days of being discharged during the reporting period.

Graph 8
Data Source: Dr Foster



The Trust intends to take the following action to improve the quality of its services, as measured by these percentages by:

- Safe, timely discharge planning, which ensures patients are discharged to the appropriate place of residence. The Trust continues to build effective relationships with community and external partners to ensure patients are supported safely through their discharge.

The 28 day readmission rate for patients across the Trust continues to be monitored monthly through the executive-led divisional performance meetings and is reported to the Board of Directors on an exception basis.

4. Trust responsiveness to the personal needs of patients

The Trust is committed to resolving any concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the team. The Patient Experience Team (PET) is available to provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/service directly, or where they have done so but their concern remains unresolved. The PET aims to resolve any concerns that are raised with them quickly and informally.

The Trust operates a centralised complaints service. It ensures that a patient-centred approach is taken to the management of complaints. All complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt. Learning and improvements that result from individual concerns or complaints are also analysed to identify any themes and the intelligence generated is shared across the organisation to drive the necessary improvements.

Complaint management was paused on 29 March 2020 during the first wave of COVID-19 following guidance from NHS England and NHS Improvement for three months. This allowed staff to concentrate on front-line duties. During this time all complaints were acknowledged and reviewed for any patient safety concerns, safeguarding issues, etc. Where concerns were identified, action was taken in accordance with the complaints policy. Complaints management resumed three weeks later.

During 2020/21 we received 256 complaints, showing a 30% decrease from 2019/20. During April, May and June the number of new complaints reduced by 50%T This is likely due to the reduction in outpatient activity during the COVID-19 pandemic. We responded to 92% within the recommended 25 days. In the remainder a revised timescale of 40 working days were agreed with the complainant.

The most complained about areas were emergency medicine (51), acute medicine (19), trauma and orthopaedics (18), gynaecology (18) and maternity (14). Acute medicine and gynaecology had not previously featured in the top five reported specialities.

There are no patterns to receipt of the complaints, most related to episodes of care provided during 2020/21.

The top five themes of complaints differed in 2020/21:

	2019/20	**2020/21**
1	Clinical treatment	Clinical diagnosis
2	Clinical diagnosis	Clinical treatment
3	Communication – doctor	Communication – nurse/midwife
4	Clinical discharge	Admissions / transfers / discharge procedure
5	Administration communication	Communication – doctor

Clinical diagnosis and clinical treatment continue to be reported as the subject of dissatisfaction. Themes relating to poor communication from both nursing and medical colleagues are now also within the top five this year, along with admissions/transfers/discharge procedures. These complaints have been triangulated, with all relevant concerns raised with the safeguarding team to further analyse for themes and trends and escalated to division and the Trust Mental Capacity Task and Finish Group.

Additional examples of the subjects include:

Clinical treatment (37):

- Patient unhappy with care and treatment in breast care.
- Concerns regarding care of patient on Ward 31
- Complaint regarding trauma and orthopaedic surgery

Clinical diagnosis (35):

- Delay in son’s diagnosis of Trysomy-21
- X-Ray wasn’t requested and fracture missed which later required surgery.

Communication - doctor (20):

- Lack of communication surrounding DNACPR
- Poor communication with family prior to patient’s death.

Communication - nurse/midwife (25):

- Unhappy with communication on medical wards
- Concerns regarding communications on Sherwood Birthing Unit

Admissions / transfers / discharge procedure

- Concerns regarding patient assessments, communication and discharges

A total of 256 complaints were investigated and findings were shared with the complainant by a written response, 93% of these were completed within 25 working days or agreed timescales with the complainant.

While performance against the 25 working day standard was reduced, the overall caseload was carefully managed to avoid complainants experiencing inordinate delays in receiving a response to their complaint. All complainants were kept updated on the progress of their complaint and a personal written apology was provided to all complainants.

Of these, 55% were upheld/partially upheld, which shows a slight increase of 2% compared to the previous year. This has provided an opportunity for learning and service improvements. One per cent of complaints were withdrawn after local resolution was achieved following initial investigation and discussions with the patient.

A total of 14 complaints were re-opened as it was identified that the complainant had raised new concerns. All requests are formally responded to, reiterating the options relating to the next steps, which include PHSO, independent advocate and access to medical records procedure.

To help the NHS focus resource on tackling the COVID-19 pandemic, the Parliamentary and Health Service Ombudsman (PHSO) paused work on existing NHS complaints and acceptance of new health complaints in March 2020, resuming on 1 July 2020. A total of 19 applications were received from the PHSO during 2020/21, 6 cases were not accepted by the PHSO. 4 were upheld/partly upheld and action plans and learning has been completed. PHSO currently have 13 on-going investigations at the time of writing this report

The PHSO decided to investigate five new complaints between 2020/21, with a total of 12 cases under ongoing investigation. In response to the COVID-19 pandemic, the PHSO paused all investigations in March 2020.

5. Staff Friends and Family responses and recommendation rates

Approach to staff engagement

In 2017 the Trust launched its Maximising our Potential (MoP) workforce strategy which brought previous HR, training and education, well-being, engagement and organisational development strategies under one integrated strategy. This strategy was designed to develop and improve our organisational culture and to enable our people to deliver outstanding healthcare through empowering them with the knowledge, skills and tools to improve our culture and make a difference. It supports the Trust strategic objective of Maximising the Potential of our Workforce.

2020 was the final year of this strategy and a new People, Culture and Improvement strategy based upon the NHS People Plan and NHS People Promise will be developed and launched in April 2021; this will build on the success of the previous strategy.

Each year the MoP action plan is refreshed and has specifically focused on improving themes from our annual staff survey and Friends and Family Tests (FFT). Evidence from our staff surveys, Staff Friends and Family Test, Freedom to Speak Up Guardian and HR workforce data indicates that many of our HR, Improvement and Organisational Development (OD) initiatives have contributed to improving our culture

During the COVID-19 pandemic the Trust significantly increased its engagement with colleagues through daily communication updates which were valued by staff. We also strengthened our wellbeing offers with the creation of a Den, psychological support services and wellbeing road shows. We undertook a 'Learning from Covid' exercise which helped to make further improvements in our organisational engagement; wellbeing; leadership development; and colleague experience offers.

This year has seen the introduction of several organisational engagement initiatives such as leading remote and virtual teams toolbox talks, using MS Teams to deliver training online, significant expansion of e-learning programmes and 14 bespoke organisational development team interventions.

The Trust culture and improvements include:

- Colleagues would strongly recommend the Trust as a great place to work as they feel valued and want to stay at the Trust. This has improved 9% over the last three years in our staff survey.
- Colleagues want to stay at this Trust because of the way we support and develop them.
- We have improved our on-boarding experience for new starters to ensure that it is a personal experience that is slick, informative and effective.
- Improved communication and engagement through the COVID-19 pandemic.
- Responded to PPE requests, FFP3 fit testing and improved access to COVID tests.
- Invested in buying IT equipment to support working from home (500 laptops).
- Recruited over 300 more bank staff to help maintain safe staffing and provide outstanding patient care.
- Launched a wide range of health and wellbeing offers and resources.
- Opened Wellbeing DENs at KMH and Newark
- Delivered over 50 welfare and wellbeing road shows and ran a week long wellbeing fayre across Mid Nottinghamshire health and care
- Supported colleagues to get to work more easily by public transport.
- Ran Schwartz rounds to discuss emotional & social aspects of work.
- Worked with Costa to be open 24/7 and Morrisons to have dedicated NHS hours.
- Increased access to hot meals during COVID-19.
- Created a hardship fund.
- Created online engagement sessions with local schools and colleges and themed career sessions to support succession planning.
- Supported over 150 staff to undertake apprenticeships.

The NHS Staff Survey

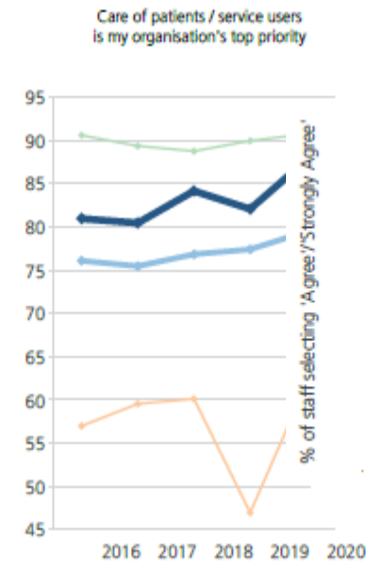
In 2020 the Trust engaged staff in its annual staff survey through a mixed mode approach of electronic and paper surveys.

For the third year running the Trust scored the highest engagement score as the best acute trust to work at in the Midlands and was the third best acute or acute/community Trust in England, which is a fantastic achievement.

Our Equality and Diversity (EDI) analysis also shows that the Trust is trending higher than the national average for acute trusts nationally which is extremely positive.

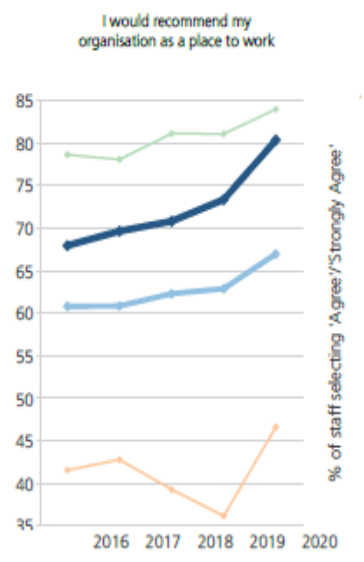
The graphs (graphs 9a,b &c) below summarise the Trust 2020 staff survey results.

Graph 9a



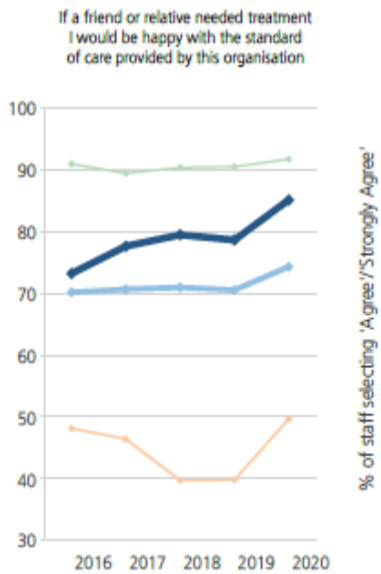
	2016	2017	2018	2019	2020
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	80.9%	80.4%	84.1%	82.1%	87.7%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%

Graph 9b



	2016	2017	2018	2019	2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	67.9%	69.6%	70.8%	73.3%	80.3%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

Graph 9c



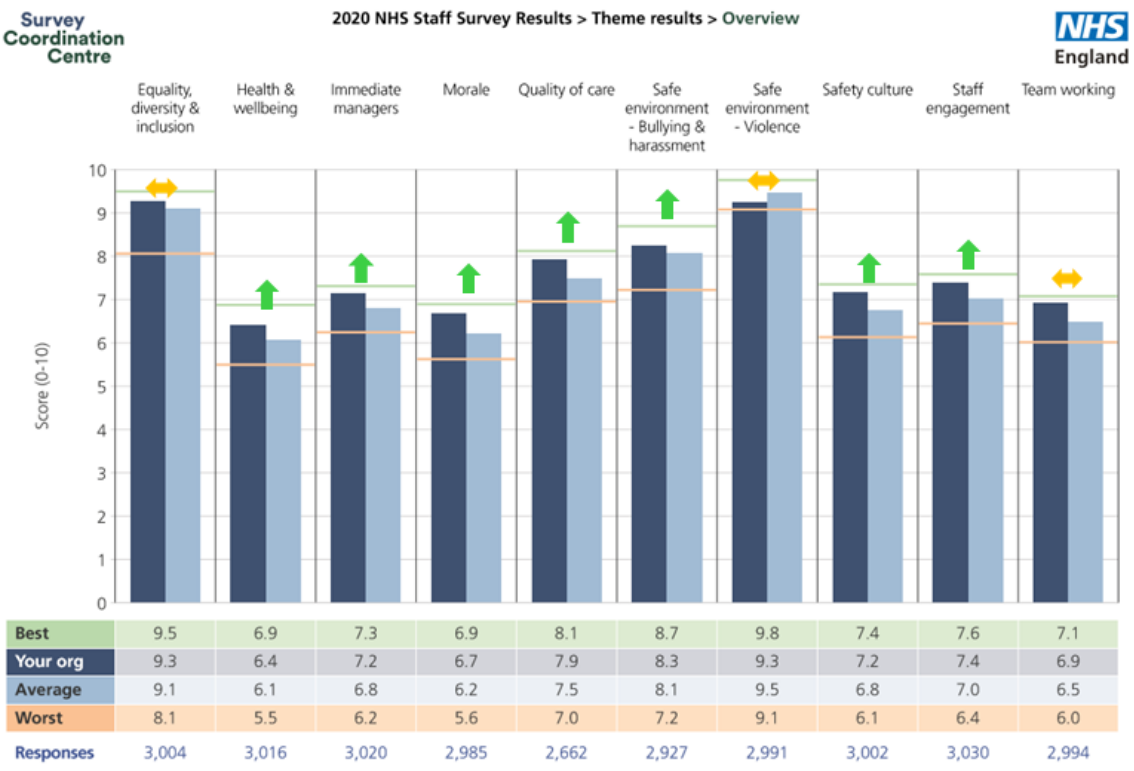
	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	73.2%	77.6%	79.5%	78.6%	85.1%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

The table below (table 6) gives an overview of the key staff survey themes at a Midlands and national level showing how the Trust ranked. With the exception of violence, the Trust scored in the top three trusts in the Midlands region for all domains and in the top quartile nationally.

Table 6

Staff Survey Results - Themes	Midlands rank (Out of 21)	National rank (Out of 129)
Participation rate	*1*	*5*
Overall Theme score	1	3
Equality & Diversity	3	17
Safety Culture	1	5
HWB	1	8
Immediate Managers	2	9
Quality of care	1	3
Morale	1	2
Engagement	1	6
Bullying & Harassment	3	23
Violence	20	119
Teamworking	1	4

Below are the ten key indicator themes from the 2020 Trust Staff Survey:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.3	6.4	7.2	6.7	7.9	8.3	9.3	7.2	7.4	6.9
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	3,004	3,016	3,020	2,985	2,662	2,927	2,991	3,002	3,030	2,994

Areas for development for 2021/22

- Build on what has been achieved and support the post COVID-19 recovery.
- Reduce variation of colleague experience.
- Better understand of the experiences of colleagues that identify as disabled and our younger and mature workforces to improve their experience.
- Focus on further improvements in how we treat each other; Civility, Respect, Bullying and Harassment, Diversity, Equality and Inclusion.
- Targeted staff engagement to better understand colleagues experiencing and reporting physical violence from patients/service users and families.
- Better understand why colleagues work additional paid hours in order to deliver a service.
- Reduce variability of management capability through targeted leadership training and development.
- Increase visibility and support for our Diversity Staff Networks.
- Further develop our talent management approach and offer to support succession planning.
- Better inform the Trust about cultural improvements made at a Trust and local level through the development of a new Staff Engagement Framework and our 'You Said, Together We Did' campaign.
- Focus our people and improvement coaches to better support colleagues in an inclusive and compassionate manner.
- Improve well-being and resilience offer for colleagues, as part of our Wellbeing Strategy.

Actions and monitoring

The results are to be communicated to colleagues in a number of ways including electronic and face-to-face briefings. Some of the positive results will also feature in our recruitment campaigns.

The reports are analysed including scrutiny of the individual (anonymous) comments that were captured in the free text as these provide further important context. Analysis is also undertaken by staff group, division, department and site. Our People, Culture and Improvement Committee will consider the themes and comments in detail.

Our divisions are sent a copy of the Trust report, their divisional results and the free text comments. They explore the themes further with their teams and develop action plans pertinent to their division to address areas of concern. This also applies to corporate areas. We will undertake engagement sessions with divisional triumvirate leadership teams for them to present their reflections on their findings and to identify what support they would like to improve the culture within their divisions.

The results are triangulated with other data sources such as the quarterly pulse surveys, workforce KPIs and Speaking Up concerns. This enables more targeted actions and interventions to be identified, supported by our OD Team and HR business partners.

There will be Trust wide initiatives for incorporation into the People, Culture and Improvement Strategy 2021/22 Implementation Plans, particularly in relation to our culture, improvement and leadership work. These include a strong focus on employee health, safety and well-being and diversity and inclusivity aimed at addressing recurrent themes.

The diversity and inclusivity results will be scrutinised by our Diversity and Inclusivity Group and appropriate actions incorporated into its work programme. The performance of the programme is reported through to the People Culture and Improvement Committee. Such performance and activity is reviewed in light of key priorities associated with the Trust's requirements under the Workforce Race Equality Standard (WRES) and the Equality Delivery System (EDS).

6. Venous Thromboembolism (VTE)

A VTE is a blood clot (thrombus) that forms within a vein that can cause occlusion within the lung (pulmonary embolism) or in the deep leg veins (deep vein thrombus). The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable, hospital acquired VTE every year. This includes patients admitted to hospital for medical and surgical care. VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long term morbidities is associated with considerable cost to the health service.

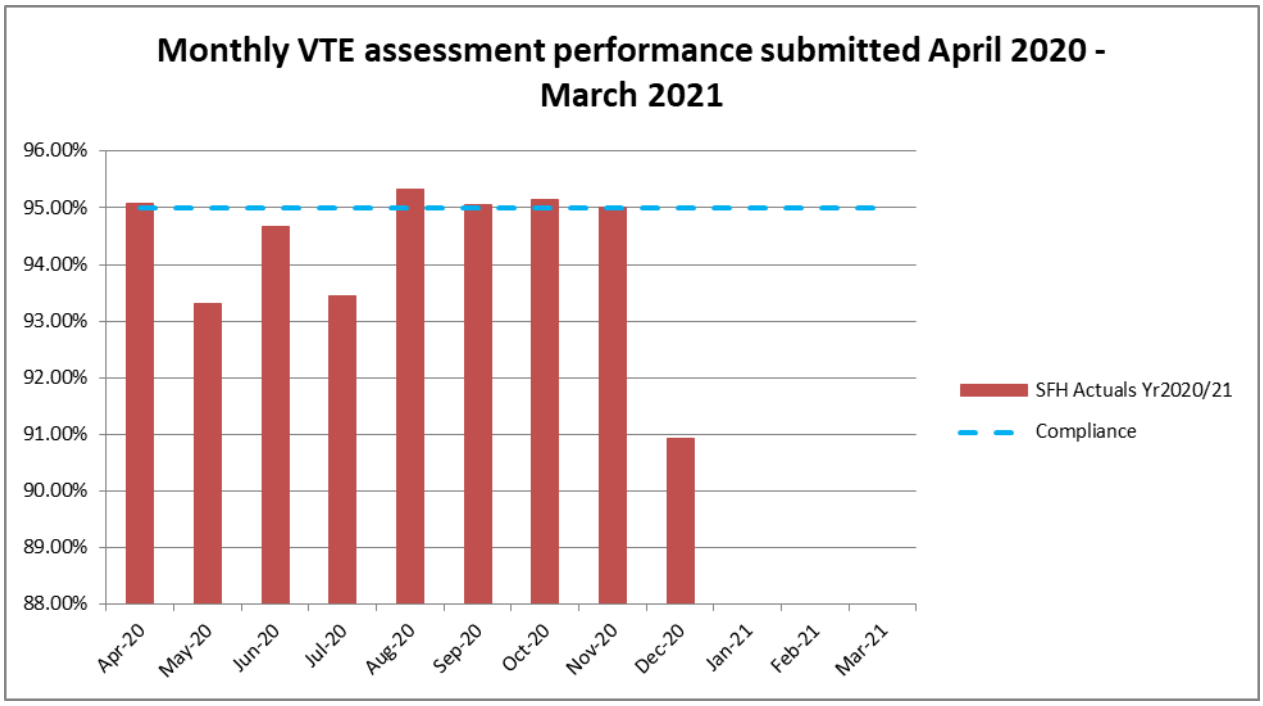
The Trust considers that this data is as described for the following reasons:

- All young people aged 16 or over and adult patients should have a VTE risk assessment on admission to hospital using a nationally recognised risk assessment tool.

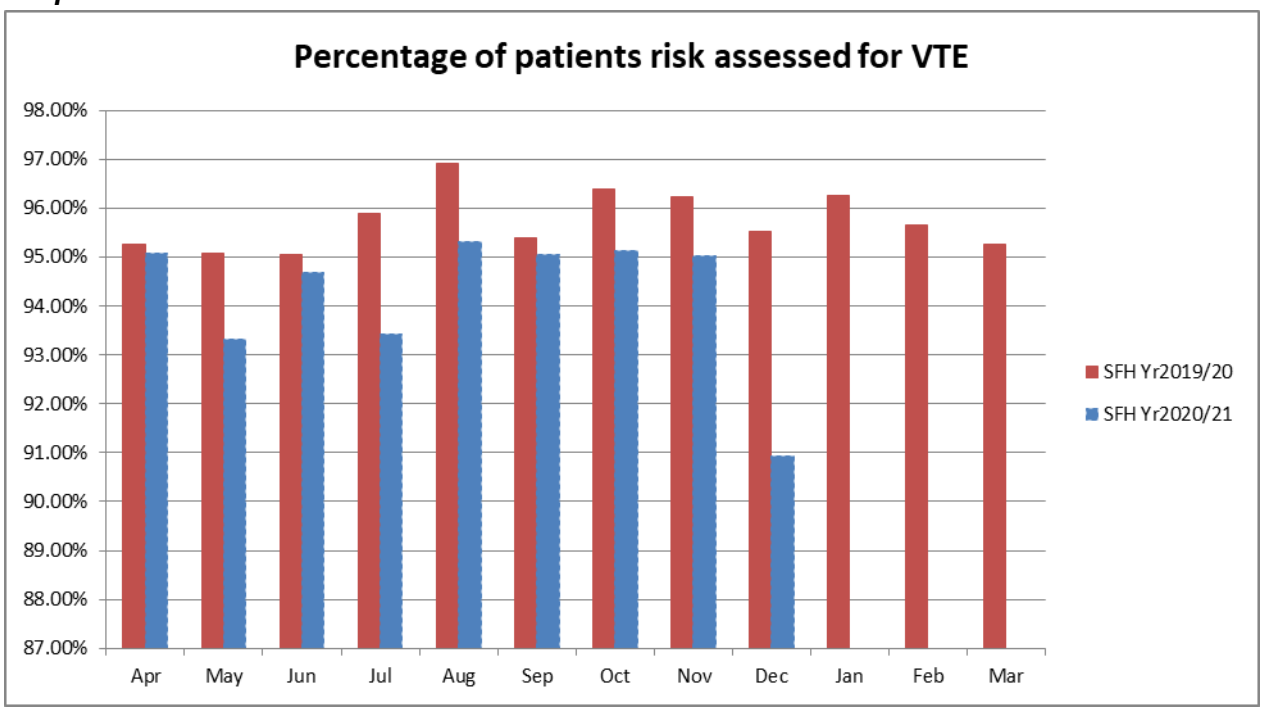
- The Trust aims to achieve 95% or above compliance with this standard. During the Covid pandemic national reporting of VTE screening compliance was halted. However Sherwood Forest Hospitals NHS Foundation Trust continued to internally collect and report on this data as a patient safety and quality measure. In the Trust the collection of data is a manual process requiring time on the wards gathering the risk assessments for analysis. Due to the infection control constraints normal practice had to be suspended and different ways of data collection identified and tried out. The consequence of this can be seen in a dip in the usual compliance rates and the increased delay in compliance data being available. During the reporting period April 2020 – November 2021, 95% compliance was met on the majority of occasions with May, June, July and December 2020 falling below the 95% target (graph 10 and 11). Data is not yet available for January, February and March 2021. After taking infection control advice, pre-Covid methods of data collection resumed from 1st April 2021.

- The Trust can report there have been no hospital acquired deep vein thrombosis incidents identified during this period. However, there are 20 investigations ongoing pertaining to this time period.

Graph 10



Graph 11



National performance figures are not available for this reporting period due to the suspension of Unify submissions in light of the Covid Pandemic.

The Trust intends to take the following action to improve these percentages, and so the quality of its services by:

- All patients' records are manually checked for completed VTE risk assessments. A process for targeted supplementary follow up is in place to collect the previous day's missed or blank assessments.
- Normal practice for data collection will resume on 1st April 2021.
- When national reporting restarts the Trust will ensure compliance with required submissions.

- When the planned Electronic Prescribing and Medicine Administration (EPMA) system is in place, VTE screening will become an electronic rather than a manual process. The implementation and roll out of EPMA is planned to take place within the next twelve months.
- Additional actions are in place and consist of reviewing patients who have a potential or confirmed VTE to identify if there were any missed risk assessments. A random sample of patient records is also undertaken to ensure that all eligible patients have had appropriate VTE prophylaxis in accordance with Trust guidance. To date this review demonstrates that appropriate VTE prophylaxis is being initiated.

7. Clostridium Difficile infections

Clostridium Difficile infection (CDiff) is acknowledged as an issue that impacts upon the whole health economy. There continues to be partnership working between colleagues from primary care, which began in 2014/15 and has evolved to consider all potential aspects causing infections across the health economy and includes joint working to promote infection prevention messages. The definition of a Trust acquired case changed for 2019/20 and the Trust is now responsible for any case identified more than 2 days after admission and any case where the patient has been an inpatient at the Trust within the preceding four weeks, known as Community Onset Hospital Associated (COHA). This year a trajectory has not been formally set and national advice is to work towards last year's rates according to this criteria. The CDiff tolerance was 79 and the Trust had 56 cases.

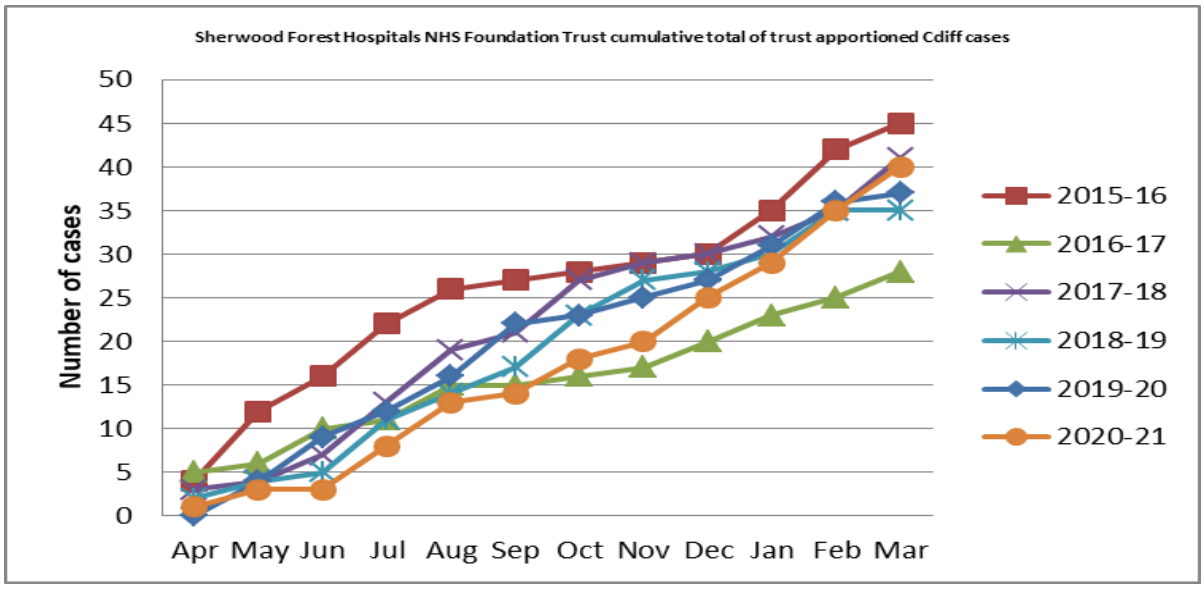
The Trust aims for 2020/21 are outlined below:

- To conduct root cause analysis on each case to identify common themes across organisations and within the whole healthcare economy.
- To share relevant learning between divisions in the Trust and with the local infection prevention teams.
- To ensure that the Trust attributable cases in the reporting period remain below 79.

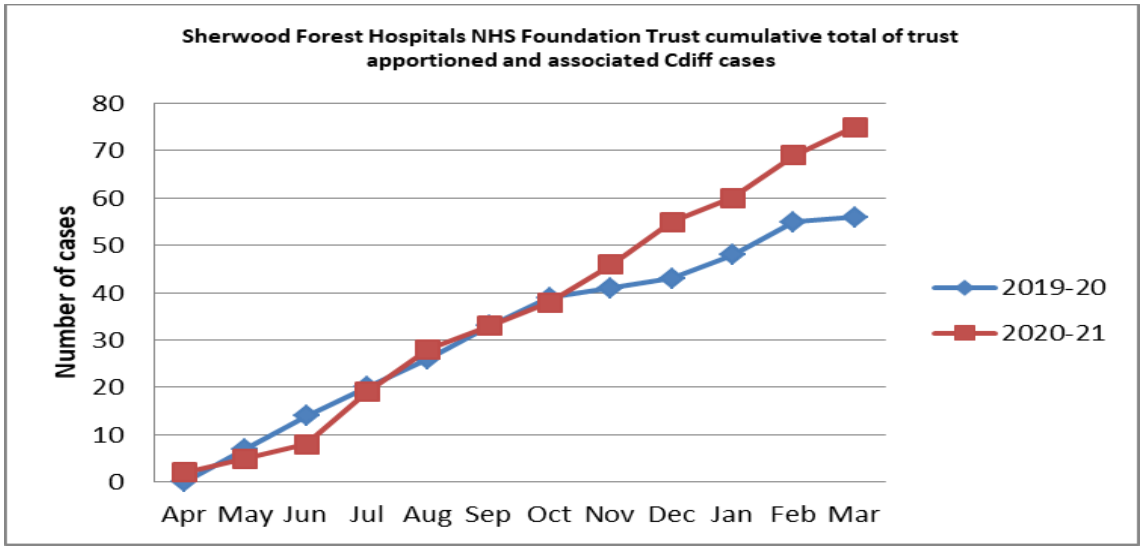
How was this achieved?

In 2020/21 the numbers of cases identified as post two days of admission were 40, this does not include the COHAs. The total number of cases identified including the COHAs is 75. A rise in numbers was identified during September and is displayed in the graphs (graphs 12 and 13) below.

Graph 12



Graph 13



A root cause analysis of all cases was performed to establish if there were any common themes and at this point, no link was established to suggest that there was any cross transmission. Lapses of care were monitored for all cases and these have decreased to seven during 2020/21, compared to 12 during 2019/20, 15 from 2017/18 and nine in 2018/19. These lapses in care include delays in obtaining samples and antibiotics prescribing issues, e.g. course duration or type of antibiotic given.

Patient management is a core element of improving patient outcomes following a diagnosis of *CDiff* infection and reducing the risk of onward transmission. Patient care is closely monitored by the Infection Prevention & Control Team (IPCT).

The Trust will take the following action to improve these numbers and so the quality of its services by placing even greater emphasis on CDiff management and implementing the interventions outlined below:

- Patient reviewed bi-weekly to monitor their treatment and their environment
- Antimicrobial stewardship rounds including the microbiologist and antimicrobial pharmacist are undertaken twice a week
- Where lapses of care have been identified, targeted actions in relevant areas have been undertaken and these actions are monitored at respective divisional governance meetings
- Learning boards developed to share learning across the organisation
- Increased environmental monitoring
- Introduction of 2021 cleaning standards
- CDiff training package to be created

Education and training:

- All educational programmes highlight the importance of preventing primary infections to avoid increased use of unnecessary antibiotics.
- Regular information was provided to all divisional, specialty governance forums.
- Weekly update to nursing teams, identifying key practice points requiring address.
- Information given to staff, patients and visitors as part of an infection prevention and control campaign
- Ensured all patients received an information leaflet with regards to their infection.

Cleanliness:

The standard of cleaning is fundamental in reducing the risks of transferring *CDiff*. The IPCT continue to work with Medirest, Skanska, Trust colleagues and commercial companies to improve the consistency of the cleaning processes throughout the rest of the organisation and ensure that all staff are aware of their responsibilities.

Auditing
Auditing is an important part of both monitoring existing practice and driving improvements in those areas required. There are standardised audits conducted monthly and quarterly, providing photographic evidence of issues identified; detailed specific immediate feedback and education at time of audit has been provided. In addition, Medirest monitor against national standards for cleanliness.

Monitoring and reporting
All cases of *CDiff* infections within the Trust are reported to Public Health England (PHE) and they have undergone a root cause analysis (RCA) to establish the underlying reasons why the patients have succumbed to the infection and whether the infection was avoidable. These have been reported within both internal corporate and divisional governance structures and externally. Themes have been identified and work undertaken to review and manage those actions both in the immediate and for future planning.

The threshold for 2021/22 has not yet been set. Monitoring will continue through the Infection Prevention and Control Committee.

8. Patient Safety Incidents

The Trust considers that this data is as described for the following reasons:

- The Trust is committed to reporting and investigating adverse events and near misses, as it is recognised that this provides the Trust with opportunities to learn, improve the quality of services and reduce the risk of those types of event happening again.
- The process for the management of reported incidents is described within the Trust's Incident Reporting Policy and Procedures.
- Any incidents that affect patients are graded according to the Data Quality Standards (September 2009) published by the National Reporting and Learning System (NRLS) and, along with all other types of adverse incidents, are reported and investigated using the Trust's Datix Risk Management System.
- All patient safety incidents recorded by the Trust are reported to the NRLS on a regular basis. The NRLS publishes a 6-monthly report which provides information on the quantity and types of reported incidents, comparing the organisation with other non-specialist acute trusts.

The data provided by the NRLS shows that the Trust is below the median average of reporters in terms of incidents reported per 1,000 bed days. However, the data also indicates that there is no evidence of under reporting and the numbers of incidents reported have increased since the previous twelve months' data was captured. Where there are discrepancies between the number of incidents recorded by the Trust and the number published by the NRLS these are reported to NHS England and NHS Improvement.

The NRLS report no longer includes median average of reporter data. This has been replaced with a reporting culture indicator. This indicates on the latest report that there is no evidence for potential under reporting.

The table below (table 7) shows the comparative level of patient safety incident reporting within the Trust compared with other non-specialist acute providers.

Table 7

	Sherwood Forest Hospitals			All non-specialist acute providers
Period	**Number of incidents uploaded to NRLS from the Trust**	**Number of incidents reported by NRLS**	**Rate per 1,000 bed days, reported by NRLS**	**Median average rate per 1,000 bed days**
1st Oct 2015 – 31st March 2016	3,687	3,657	34.63	39.31
1st April 2016– 30th Sept 2016	3,397	3,339	32.82	40.02
1st Oct 2016 – 31st March 2017	3,581	3,507	33.51	40.14
1st April 2017 – 30th Sept 2017	3,277	3,180	34.09	Report indicates 'No evidence for potential under reporting'
1st Oct 2017 – 31st March 2018	3,563	3,406	32.64	Report indicates 'No evidence for potential under reporting'
1st April 2018– 30th Sept 2018	3,904	3,739	37.76	Report indicates 'No evidence for potential under reporting'
1st Oct 2018 – 30th March 2019	4,160	4,068	39.8	Report indicates 'No evidence for potential under reporting'
1st April 2019 – 30th Sept 2019	4,190	4,083	40.82	Report indicates 'No evidence for potential under reporting'
1st Oct 2019 – 31th March 2020	4,457	4,388	44.58	Report indicates 'No evidence for potential under reporting'

Level of patient safety reporting

The Trust will take the following action to improve these percentages and in turn, the quality of its services by:

- Improving the quality of the data submitted to the NRLS. The Trust performs consistently better than the best practice standard for data quality and completeness of fields in six out of seven indicators. However, data from the NRLS shows the Trust has been responsible for a small increase in personal identifiable information upload breaches. There has been an increase from 1% for 2018/19 to the current figure of 3%, which is equal to the best practice standard of 3%. The problem has been identified and remedied and there is significant confidence that the next reporting period will again demonstrate figures better than the best practice standard.

From the 1 April 2020 to 31 March 2021 the Trust declared a total of 13 Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the 13 incidents, two were deemed to be a Never Event.

All Serious Incidents are investigated and action plans developed to mitigate the risk of recurrence. The number of Serious Incidents reported by the Trust has significantly changed compared to the previous year from 30 in 2019/20 to 13 in 2020/21. This reduction is in line with the general reduction of patient safety incidents overall which, in turn, mirrors the dramatically reduced number of patients in the Trust at the start of the Covid 19 Pandemic. The type of Serious Incident remains largely static with Delays to Diagnoses/Treatment being the most common category. These incidents have reduced slightly from seven to five when compared to 2019/20. Of the 13 investigations for 2020/21, six have been submitted to the CCG within agreed timeframes with extensions where required and seven are still under investigation.

Identifying and disseminating the learning arising from incidents in order to improve patient safety remains a key priority. Last year two new posts were appointed to support this process: the quality governance facilitator, to support the dissemination of learning both Trust wide and at a very local ward/department level and the clinical director of patient safety, to support the development of incident investigation processes that explore human factors and lead to robust action plans and mitigations to improve patient safety the quality of care. Unfortunately due to the Covid pandemic and the redeployment of staff, these roles have not yet had chance to gain momentum. As the Trust progresses with the recovery phase, these roles are picking up from where they left off and reviewing plans going forward in light of the pandemic.

The Trust has just committed to purchasing the DATIX DCIQ a web based incident reporting and risk management system. This will include incident reporting, risk register, legal module, complaints and concerns and the mortality review tool. The roll out is planned to take place over the next six months and the functionality will enable improved triangulation of information and data. The education of staff and the development of training in the use of Datix and the importance of incident reporting as a patient safety tool is ongoing, to raise awareness and encourage a good reporting and learning culture.

Duty of candour

The Trust has a statutory responsibility to formally offer an apology, verbally and in writing (within ten working days), for any patient safety incident which is graded moderate, severe or catastrophic harm and for any Serious Incident.

Table 8

Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total for 2020/2021
Number of qualifying incidents	0	0	3	4	3	1	3	8	3	3	2	2	39
Confirmation of notification complete	0	0	3	5	3	1	3	8	3	3	2	2	39 (100%)

Of the 13 incidents meeting the criteria for formal Duty of Candour (1 April 2020 – 31 March 2021), the Trust has provided Duty of Candour in 100% of these. From 1st April 2021 all incidents that go forward for investigation, regardless of whether they meet the formal Duty of Candour criteria, will have Duty of Candour undertaken. This demonstrates the Trust's continued ambition to be open and transparent.

Part 3 - Other information – additional quality priorities

3.1 Safety – Improving the Safety of our Patients

The NHS Patient Safety Strategy (NHSPSS) was launched in July 2019 under the title “Safer culture, safer systems, safer patients.” This strategy sits alongside the NHS Long Term Plan and the associated implementation framework. The document outlines the NHS’s safety vision; to continuously improve patient safety. To do this the NHS will build on two foundations: a patient safety culture and a patient safety system.

Three strategic aims will support the development of both foundations:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

Patient safety culture
At the Trust patient safety culture has been identified as an organisational priority and work has been ongoing. An associate director for service improvement was appointed by the Trust in March 2018 with a specific remit to deliver the Patient Safety Culture programme. The programme has delivered a series of outputs to support the organisation to identify current cultural levers and barriers to delivering safe care.

PASCAL patient safety culture surveys undertaken 2017 - 2021
To date, over 2000 clinical and non-clinical staff have had the opportunity to complete a survey involving several domains that influence patient safety (teamwork, job satisfaction, working conditions, response to errors etc.). This has been followed up by 1-1 sessions to share the results with staff, and to build on the response and identify any actions needing to be undertaken. This process has facilitated ‘safe ’opportunities for staff to share their experiences of delivering care, in often difficult circumstances. This has been delivered via ‘kitchen table’ events delivered in local areas. All outputs from the programme have also been shared with people who can influence decisions and who can progress actions, for example, local and senior managers. The Trust executive team is committed to this work and to providing input and support to help it to achieve its goals.

During 2020, inpatient wards across all three sites were re-surveyed, however, feedback at service level has been delayed due to COVID-19. It is planned to occur between May–August 2021.

Organisation-wide Schwartz Rounds.
This is an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

Clinical and non-clinical staff offered positive evaluations of the Schwartz Rounds and expressed the value of having the opportunity to discuss the emotional and social impacts of their work.

During the COVID-19 pandemic, the face to face model for Schwartz Rounds was adapted to include virtual sessions called ‘Team Time’ which were held bi-monthly. Topics included support for colleagues working and/or shielding at home, and also ‘what have we been most proud of during COVID-19?’

Just culture, kindness and civility.
This features prominently in the NHSPSS. Healthcare staff operate in complex systems, with many factors influencing the likelihood of error. These factors include medical device design, volume of tasks, clarity of guidelines and policies, and behaviour of others. A ‘systems ’approach to error moved away from ‘blame ’and considers all relevant factors, meaning our pursuit of safety focuses on strategies that maximise the frequency of things going right.

The Trust has an active Civility Saves Lives programme and the Trust hosted a national event in 2019 which featured Dr Chris Turner, the founder of the movement, and introduced the principles of just culture and systems approach to incident analysis.

The Trust has an on-going programme of similar events planned for 2020/21 with internal and external speakers from organisations such as NHS Resolution (NHS-R) and Healthcare Safety Investigation Branch (HSIB).

Patient safety system
NHSPSS includes the new Patient Safety Incident Response Framework (PSIRF). This is a work in progress and will replace the 2015 Serious Incident Framework which set the expectations for when and how the NHS should investigate Serious Incidents. However, compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver these.

The Trust continues to work within the existing framework but believes that the Trust can begin to move towards the systems approach described in the NHSPSS

Aims for 2020/21

- Development of a refreshed training programme to equip our investigators with the knowledge and skills to conduct 'systems 'investigations and also to provide additional support to those managing and scoping incidents, devising and implementing action plans and liaising with families and relatives.
- Creation of a 'Patient Safety Academy 'at the Trust which has diverse representation and crosses traditional organisational boundaries. One of the key elements of this plan is raising awareness and knowledge of human factors across all areas of the Trust to support the fundamental principle that patient safety is everyone's responsibility.
- Development of a bespoke human factors training programme.

Performance against this target
The COVID-19 pandemic has significantly disrupted plans for 2020/21 both nationally and locally. The national rollout of the new Patient Safety Incident Framework (PSIRF) has been delayed until 2022.

- Locally we did refresh our serious incident investigation methodology and report templates to align them with the changes expected in the PSIRF but the training was unfortunately suspended shortly after we began, due to clinical commitments related to COVID-19 and re-assignment of governance support staff to critical care areas.

    a. To support the investigations that have been conducted during the pandemic we have increased the level of support for the existing investigators, capturing more-specific key lines of enquiry at scoping, holding rapid multidisciplinary review meetings when investigators have been appointed and reviewing reports against these key lines of enquiry before they are presented for sign off.
    b. Whilst statutory duty of candour applies to incidents of moderate harm and above we have committed to communicate with all patients or relatives when any investigation that is undertaken beyond the scope of the local handler (ie anything considered at Trust-level scoping) and to offer to share the report.

- A governance reset was undertaken in the Trust. The proposed patient safety academy was not included in the current version of this structure. The Trust approved the training of a cohort of key stakeholders including Director of Culture and Improvement, Associate Director for Improvement and members of the improvement team, members of the governance team, and clinical representative from a variety of backgrounds to a more advanced level of Human Factors/ Human Performance knowledge. As the new Patient Safety curriculum is rolled out later this year it is anticipated that these colleagues will help bridge the gap between theory and

practice and ensure that those Human Factors concepts which are key to the new Patient Safety Strategy are represented on-going work streams. Examples include Electronic Prescribing, Electronic Patient Record projects and also the proposed theatres/ critical care redesign. Members of this cohort are also well represented in the Improvement and Learning sub-cabinet in the revised Governance structure.

Monitoring and reporting for sustained improvement
Informal feedback from both our CCG representatives (who attend both scoping and sign-off meetings) and the CQC has been very positive about the thoroughness of our approach to incident investigation and the quality of our reports.
We will aim to collect information around how many investigators we have trained

Aims for 2021/22

- Restart our incident investigator training and develop a programme of continuing professional development for colleagues who undertook the previous version of the training.
- Continue to prepare for the introduction of PSIRF.
- Work with specialties and divisions to agree the roles and responsibilities at sign off.
- A significant amount of data has been collected during the COVID-19 pandemic from which we believe there is learning for both future pandemics and other routine care. For example a retrospective review of all COVID-19 deaths thought to be hospital acquired (identified more than eight days after admission) is planned.
- The role of the patient safety specialist continues to evolve and we will work to both deliver and shape this.

3.2 Safety – reducing harm from falls

Aims for 2020/21

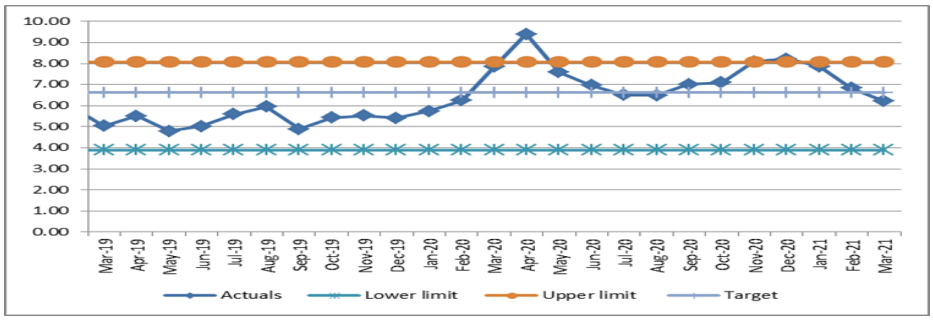
- Continue to promote and monitor mobility to reduce deconditioning and improve functional outcomes and falls mitigation
- Continue to reduce falls with harm
- Contribute to the local and national COVID-19 pandemic action plans by networking and sharing learning in relation to inpatient falls.

Performance against this target

Reducing harm from falls is identified as a quality priority in line with the Quality Strategy. Our aim as a Trust is to be below the Royal College of Physicians published standard falls per 1000 occupied bed days (OBDs).

The graph below (graph 14) demonstrates the percentage of falls calculated by 1000 Occupied bed days (OBDs) as per the National Audit of Inpatient Falls (2015) criteria. Currently, the Trust performance for the end of March 2021 indicates falls / per 1000 OBDs in comparison to published standard. Whilst the Trust has been below this for a period of months, this increased during each wave of COVID-19. This is also in line with national data reported via networking with neighboring Trusts.

Graph 14



How was this achieved?

Falls mitigation and improvement is guided by recommendations contained in the Trust's 2018/21 Multi-Disciplinary Falls Prevention and Post Fall Strategy in conjunction with the monthly Falls and Mobility Group Meetings. The strategy outlines best practice approaches for mitigating falls in the hospital including implementing standard falls prevention strategies and identifying falls risks.

The Trust acknowledges that the risk of patient falls occurring can never be entirely removed. In order to achieve successful rehabilitation some patients who are recovering from an acute illness may go through a period of increased risk of falls, as they are encouraged to regain their independence and autonomy. It is important to note that immobility of patients may cause deconditioning.

Continue to promote and monitor mobility to reduce deconditioning and improve functional outcomes and falls mitigation

- Education, promotion and visual information for staff, patients and carers to address the importance of regular mobility.
- Implement revised movement and mobility care plan for all inpatient areas.
- Improved partnership working and reporting of incidences with Allied Health Professionals within the Trust

Continue to reduce falls with harm

- Weekly meetings with staff and the falls prevention practitioners to address any issues or questions.
- Clinical working by falls team to provide support and bespoke education.
- Completion of the Post Fall Investigation Template by ward or department areas and any actions addressed by the Falls Team and Matrons.
- Falls team contribution to scoping meetings and actions as a result of a fall with for example a fracture.
- Monthly falls analysis, reports and feedback as to themes and trends provided by the falls (table 9)

Table 9

In-patient Falls by severity of harm	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Grade 1- No harm Falls	103	73	59	54	59	67	76	79	79	104	107	82	84
Grade 2 - Low harm Falls	17	11	18	23	21	20	22	25	38	25	30	24	21
Grade 3 - Moderate harm Falls	0	0	0	0	0	0	0	0	0	2	0	0	0
Grade 4 - Severe harm Falls	0	0	2	1	1	0	2	1	3	1	1	0	0
Grade 5 - Catastrophic harm Falls	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	120	84	79	78	81	87	100	105	120	132	138	106	105

- Clinical Fellow project to focus on reducing deconditioning
- Falls champions role review, in line with clinical fellow project
- National Audit of Inpatient Falls audit completion and implement any recommendations.

- Development of updated documentation and assessments
- Expanded falls team with further falls prevention practitioner and links with other harms teams.

Contribute to the local and national COVID-19 pandemic action plans

- Contributed to national audit – inpatient falls and COVID-19 May 2020
- Monthly networking and sharing of COVID-19 related themes with local Trusts
- Awareness and response to COVID-19 themes and trends both in-house and nationally. Examples include awareness and staff education of patients requiring enhanced observation, patients with delirium and reduced cognition.
- Partnership working in the Trust for the development of the Carers Passport
- Partnership working with the enhanced patient observation matron to develop new guidelines, educate and support staff.
- Continued education to address the importance of regular mobility to prevent deconditioning and awareness of patients admitted already deconditioned.
- Inclusion of COVID-19 awareness in falls assessment and care plans

Monitoring and reporting for sustained improvement

In 2020/21 performance was reported through the mobility and falls group. This group led the implementation of the Falls Mitigation and Post Falls Care Strategy 2018/21. The falls lead nurse reported monthly to the operational harm free care group which was then fed into the Nursing, Midwifery and Allied Health Professional Board. The progress is reported through the Patient Safety and Quality Cabinet. Falls performance was also monitored through monthly ward assurance meetings to discuss audit results and is reported on the ward communication boards. The progress is reviewed and systems are in place to challenge poor practice.

As part of monitoring we identified a trend of increased incidence of falls from September 2020 onwards. This coincided with the onset of the second wave of the Covid-19 pandemic and this was a contributory factor in the increase.

Aims for 2021/22

- Month on month decrease of in-patient falls in line with RCP target of 6.63 per 1,000 bed days and falls with harm
- Reduce deconditioning and mitigate risk of falls and harm from falls
- Increase community involvement and networking

3.3. Safety - To reduce the number of infections

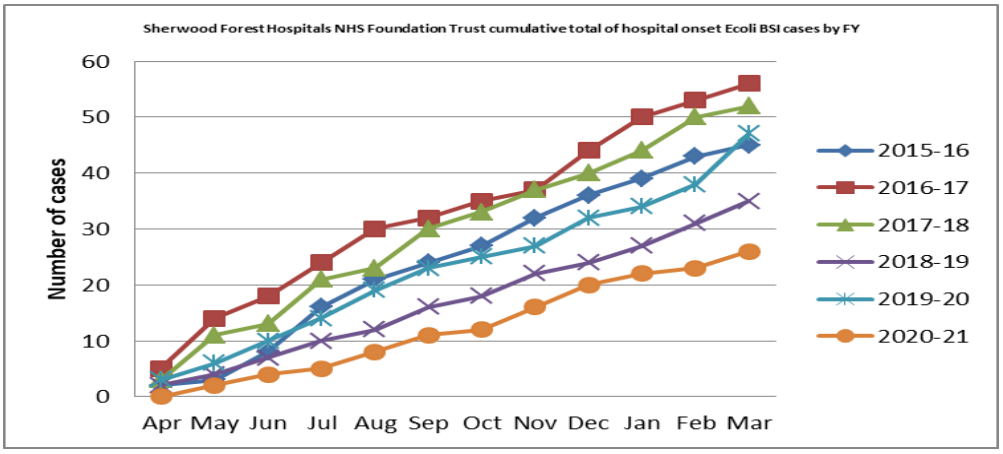
Aims for 2020/21

- To work to reduce the Trust's E-Coli in line with national targets.
- To work to reduce the Trust's surgical site infection rates in line with national target.

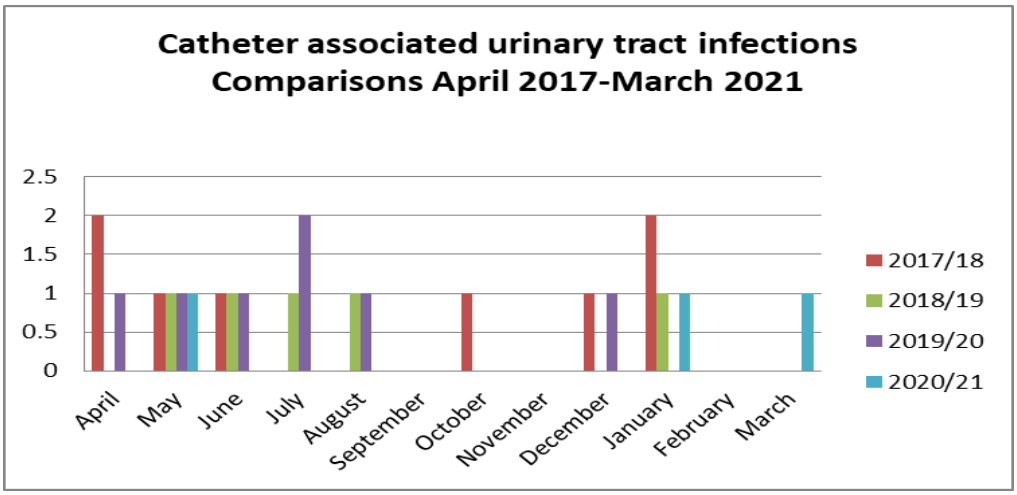
Performance against this target
Below is a summary of the performance against the two aims outlined above:

- Nationally there is a focus on the reduction of gram-negative blood stream infections (GNBSI) with an ambition to reduce these by 50% across our CCG by 2024. The main causative organism is Escherichia coliform (E.Coli). Data published by Public Health England (PHE) suggest that most positive E.Coli tests conducted at the Trust are not hospital acquired. In 2020/21 there has been a decrease in the number of Trust acquired cases (Graph 15). This decrease has corresponded with a reduction in the number of Catheter-Associated Urinary Tract Blood Steam Infections (CAUTI) (Graph 16).

Graph 15



Graph 16



The report from PHE for October – December 2020 (table 10) indicates that for the last four periods the Trust continues to perform in line and slightly better than national benchmarking. The table indicates the summary result that suggests in all three fields the Trust has a rate lower than the amalgamated average.

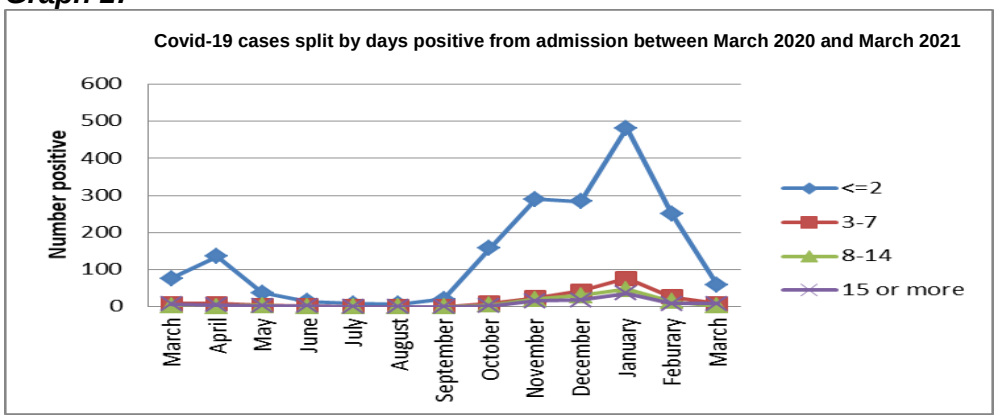
Table 10

Surveillance site	**% inpatient/readmission infected Sherwood forest**		**% inpatient/readmission infected All Hospitals**
	October-December	Last 4 periods	Last 5 years
Total Hip Replacement	0.0	0.0	0.3
Total Knee Replacement	0.0	0.0	0.3
Neck of Femur	0.0	0.2	0.9

COVID-19

During 2020/21 the Trust has been dealing with the COVID-19 pandemic and monitoring our cases closely. We have seen varying numbers of probable and definite hospital associated cases as shown in Graphs 17 and 18. The definitions are displayed in Table 11.

Graph 17



Graph 18

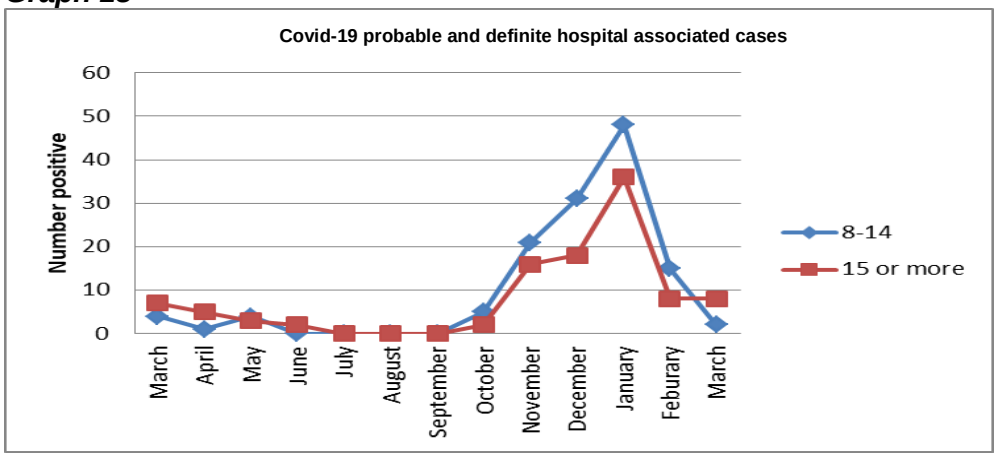


Table 11

Definitions of hospital onset Covid-19

Positive specimen date <=2 days after admission to trust	**Community Onset**
Positive specimen date 3-7 days after admission to trust	**Hospital-Onset Indeterminate Healthcare-Associated**
Positive specimen date 8-14 days after admission to trust	**Hospital-Onset Probable Healthcare-Associated**
Positive specimen date 15 or more days after admission to trust	**Hospital-Onset Definite Healthcare-Associated**

Actions in place to reduce the number of hospital associated cases:

- Root cause analysis is completed for all probable and definite hospital associated cases
- Increased frequency of audits to monitor compliance
- All clinical areas in the Trust are now cleaned with chlorine as standard
- All high risk areas receive twice daily cleaning
- Daily hand hygiene, PPE and social distancing audits of any areas with an outbreak or cluster of cases of COVID-19 are being conducted
- Regular meetings with NHSE/I and PHE to monitor outbreak progress
- Regular monitoring of screening compliance

- Monitoring of vaccine and lateral flow uptake for staff

Monitoring and reporting for sustained improvement

- All elements identified above are monitored and reported externally by PHE and NHS England.
- Internally these are scrutinised and challenged via the Trust's own governance processes.
- Information on infection rates is available publically via PHE via the link https://fingertips.phe.org.uk this website provides data against which the Trust can evaluate performance against the national dataset.

What do we aim to achieve in 2020/21

- To improve practice standards in use of invasive device.
- To achieve the new Clostridium Difficile Infection (CDI) target
- To work to reduce the number of hospital associated COVID-19 cases

3.4 Effectiveness – Improving the Effectiveness of Discharge Planning

Aims for 2020/21

- To develop new and improved ways of working to promote safe, timely discharge with the philosophy of 'home first'.
- To continue to work in partnership with local health and social care and voluntary providers to ensure safe and appropriate discharges.
- To continue to work with local housing authority in relation to new government legislation.
- To support patients to continue to live independently at home where possible and incorporate the true discharge to assess model.
- To review the current workforce in relation to these changes with a view to allow an integrated discharge to assess model.

Performance against this target

During 2020/21 the Trust has developed new and improved ways of working, along with continuing to work in partnership with local health and social care providers to promote safe, timely discharge with the philosophy of 'home first', supporting patients to continue to live independently at home wherever possible. Further to previous initiatives, good practices have been identified to build upon the integrated discharge model:

- Fully implemented daily hub call with community colleagues and other organisations to facilitate discharges of medically safe patients with the home first approach.
- Review of the Trust discharge policy.
- Distribution of timely removal letters for patients who are Medically Safe for Transfer (MSFT).
- Continue close working relationships with the Patient Experience Team to identify improvements that could be made to the Trust discharge planning arrangements and monitor compliments, complaints and Datix Incident Reporting.
- Working in partnership with our community services and local voluntary organisations.
- Continuing the existing good practice such as the ASSIST scheme from Mansfield District Housing which supports patients with housing needs, in particular the homeless. This has extended to 'safe and well visits' and medication deliveries
- Twice weekly reports of patients with a Length of Stay (LOS) between 5 and 14 days.
- Weekly reports to divisions with LOS 21 days and over; individual Ward Sisters/ Charge Nurses and Matrons have sight and are more proactive in the discharge of this cohort of patients.
- Reason to reside weekly meeting for all divisions.
- More cohesive working relationship with end of life care team.
- Extension of FIT Team to support admission avoidance in the emergency department.
- Introduction of front door IT system Nerve Centre and dashboard.

- Fully embedded Integrated Discharge Advisory Team Dashboard to Nerve Centre live and in real time.
- Discharge to Assess is fully embedded for a focus of patients with a MSFT of 48 hours and less.
- Non-weight bearing home pathway.

How was this achieved?

- Onward referral to community services where appropriate via a Discharge to Assess referral for all Nottinghamshire patients. Derbyshire patients would be through a Single Point of Access.
- Working alongside the frailty intervention team to promote hospital avoidance to support vulnerable patients, and enable them to remain safe at home until a longer term plan can be put in place.
- Dedicated referral line via Call for Care for end of care/specialist palliative nurses (both community and hospital teams).
- The introduction of the "Interoperability" system within SystmOne to enable staff to ascertain promptly the name and details of a patients care provider.
- IDAT use care home tracker IT system to allow view of care home bed vacancies.
- Nerve Centre - ensure patients are identified and placed on the appropriate pathway needed (in real time). Pathways are 0-3 and fully embedded within the Trust and Nerve Center.
- Instigation of the "Home first – planning your transfer leaflet" for all patients to keep them fully informed of the discharge process.
- Specific "Transfer of Care" letters for patients that are transferred back to a care home setting.
- Purchase of winter beds in Ashmere Care Homes which consists of three residential homes and would be 20 beds for ongoing rehabilitation.

Monitoring and reporting for sustained improvement

The IDAT dashboard on Nerve Centre has provided the team and the Trust with real time information on the current discharge status of every inpatient across the Trust, including the identification of simple and complex discharges and delayed transfers of care. This has coordinated all wards and areas to focus on reason to reside twice a day. It will also provide up to date 'predicted date safe medically' and MSFT dates. It also allows the wards to refer to IDAT directly and referrals are then responded to according to flow and capacity.

This monitoring process has given the Trust the ability to gather accurate, real-time information regarding LOS and any delays. This information is used to identify gaps in capacity across the local health and social care system. From the dashboard created, data specific to LOS and patients awaiting a social care assessment are visible in real time and auditable.

Nerve centre has empowered nursing staff to complete tasks in pathways 0 and some in pathway one. This has given ownership to ward staff to complete simple discharges.

IDAT administrator will also complete follow on calls for patients that have been discharged on the DTA pathway

Aims for 2021/22

- For the next stage of Nerve Centre development it is intended to give full access to the community partners. This allows them to review and input onto Nerve Centre which will allow real time updates for the wards.
- To implement a true Discharge to Assess pathway where patients can be discharged within 4-24 hours of them being MSFT.
- To offer an integrated workforce that can provide both acute and community services that in effect will be a wraparound service.

- To support clinical divisions with the introduction of criteria led discharge and have this fully embedded by 2021.

3.5 Effectiveness - improve our care and learning from deaths

The Trust recognises that learning from the care given to patients in their final days of life enables us to understand where we have provided excellent care but also where there are opportunities for learning and improvement. It is vital to recognise that acknowledging the care given to patients at such a difficult time will improve the standard of care for all patients.

The National Guidance on Learning from Deaths is now well embedded across the Trust. The Trust has a mortality review process supported by the Trust Learning from Deaths Group (LFD)

The Royal College of Physician's Structured Judgment Review (SJR) methodology remains the preferred vehicle for conducting a more in-depth mortality review should this be triggered by the initial Mortality Review Tool. The purpose of the SJR is to identify possible lapses in care and offer opportunities for learning and improvement. Any review that has necessitated a further avoidability assessment is presented to LFD for independent scrutiny and discussion.

Aims for 2020/21

As described in the 2019/20 Quality Account, the Trust planned to focus on mortality within specific services, in particular looking to improve our mortality rates for patients admitted with a cerebrovascular or cardiovascular diagnosis, a fractured neck of femur, known learning disability or a specified health condition.

This work has started and the Trust has worked closely with cardiology, stroke and critical care services. In addition, there is an established review process for patients with an identified learning disability, sharing the outputs of our reviews with the external Learning Disability Mortality Review Body (LeDER).

Performance against the Learning from Deaths Standard

A 'Learning from Deaths Report is presented to the Board of Directors each quarter, with an annual report summarising both compliance against the standard of reviewing >90% of all deaths and the subsequent learning themes identified.

How was this achieved?

The standard for completing a review within six weeks of a death remains a significant challenge for some specialties, particularly those where high numbers of deaths occur. The COVID-19 pandemic has also put additional pressure on maintaining this standard. This has been identified by the Trust as an area for improvement and the 2021/22 reporting period should see some significant improvement.

Monitoring and reporting for sustained improvement

LFD has continued to work closely with each division to support the overall mortality review process. The Trust has received regular intelligence from Dr Foster – who provide the external view of the Trust mortality position.

LFD has met monthly where performance against the specific mortality indicators are monitored for achievement and sustainability; however the key focus of the group is on the learning and improvement opportunities identified through the review process.

Aims for 2021/22

The focus for the forthcoming year will be on the further development of the mortality agenda at service level. The support from Dr Foster will be reconfigured to work more closely with individual clinical teams; helping them to understand where mortality fits into the care they deliver.

In addition to further develop the role of the medical examiner (ME). This became a statutory requirement from 1 April 2020. The first appointment of an external ME in 2019 has already proven to be invaluable in supporting junior medical staff in the completion of accurate Medical Certificates of Cause of Death (MCCD), the Coronial process and most importantly being the point of contact for bereaved families.

The aim through the year is to increase the service to provide five day (Monday to Friday) cover with the aim of having a seven day service in place by 31 March 2022. Quarter 4 of 2020/21 has seen the number of funded ME programmed activities increase and sessions have been allocated to medical staff within the Trust to initiate the implementation.

From 1 April 2021 it is now statutory for the medical examiner service to review community deaths alongside Trust deaths. The ME service is developing plans to meet this requirement with the aim to be compliant by 31 March 2022.

3.6 To improve the experience of patients who are coming to the end of their life.

Improving Palliative and End of Life Care (EoLC) remains a public priority across the country and for our local communities. The Trust is committed to support 'advance care planning' and training staff to listen to patient's preference for their treatment or care and help support people who are bereaved. This commitment is set out in the Trust EoLC Strategy and builds upon the 'Ambitions for Palliative and End of Life Care' national framework (2015-2020).

Aims for 2020/21

The quality of Palliative & EoLC for patients and those important to them remains a quality priority for the Trust and is a focus for improvement. The priorities identified by the Trust are:

- Ensure sustainability of the Macmillan EoLC Team resource
- Pilot and launch the combined Last Days of Life Individualised Care Plan
- Launch the new Trust EoLC Strategy for 2020 -2025
- Establish the EoLC Audit programme
- Enhance the EoLC Champions network to include members of the multi professional teams

Ensure sustainability of the Macmillan EoLC team resource

The Macmillan EoLC team has been funded for two years to undertake a project entitled "Delivering Choice in the Times of Need". This resource to the Trust's EoLC team has been fully operational since July 2019 and supports the substantive EoLC nursing and medical leads in the Trust.

Between 1st September and 31st December 2020, the EoLC clinical nurse specialist team made a total of 680 ward visits to patients across the Trust. This activity reflects Monday to Friday activity up to 1st January 2021; the EoLC CNS team then piloted a 7 day service to support EoLC patients across the Trust from 1st January to 31st March 2021; this was in addition to providing focused support to Ward 21 which is described later.

Pilot and launch the combined Last Days of Life Individualised Care Plan

All patients that are identified as dying have their care planned and recorded in an individualised care plan, in line with 'The Priorities of Care for the Dying Person' (Leadership Alliance, 2014). The Trust currently uses separate medical and nursing last days of life care plans and is in the process of creating a combined care plan that all members of the multidisciplinary team can contribute to. Following the

initial pilot and feedback, the Last Days of Life Care Plan has been updated and a combined nursing and medical plan has been created. This is in line with recommendations from the National Audit of Care at the End of Life (NACEL). A Trust-wide training and rollout plan are the next steps with the aim for completion by the end of May 2021.

Launch the new Trust EoLC Strategy for 2020-2025

The COVID-19 pandemic has paused further developments of national and local EoLC strategies in 2020. This activity has now resumed and the emerging work with regards to the National Ambitions for Palliative & EoLC, the Nottinghamshire Integrated Care System (ICS) EoLC and the SFH Nursing, Midwifery & Allied Health Professionals' strategies will all inform the Trusts future EoLC Strategy. This aim will be carried forward into the next year.

Establish the EoLC Audit programme

An audit plan has been produced and was ratified by the General Palliative & EOLC Committee on 17.9.20

Enhance the EoLC Champions network to include members of the multi professional teams

This aim will be carried forward to next year due to the COVID-19 pandemic.

Dedicated End of Life Care Beds

Currently, the Trust does not have a specific Palliative Care Ward. During the first wave of the COVID-19 pandemic we repurposed Ward 35 in the Urgent & Emergency Care Division, dedicated to caring for those patients who were sadly dying from coronavirus. The Ward was developed as part of the Trusts preparedness to deal with the COVID-19 crisis. Staff readily demonstrated the ability to adapt & interchange their approach to support the delivery of compassionate, high quality end of life care (EOLC) at one of the most challenging of times. A poster abstract was presented at the Ambitions for Palliative & EOLC Conference in November 2020 to showcase the success of this ward through the first wave of the COVID-19 pandemic.

The repurposing of this ward has received positive reviews by both patient and staff groups. It provides the basis for an on-going business case for a future dedicated Palliative Care Ward in the Trust. The positive experiences and learning from this initiative has proven the need for dedicated EoLC beds. As part of the Trust's future winter plans and in response to increasing numbers of EoLC patients, during the COVID-19 pandemic, 6-8 beds on Ward 21 were allocated in January 2021, to care for patients identified as being at the end of life.

During January to March 2021, the team identified a total of **399** patients on the EoLC model on Nerve Centre. The team undertake frequent visits to all wards areas with patients on the EoLC model, to support the care of these patients. The team made a total of **767** contact visits with patients between 1st January and 31st March 2021 to the **399** EoLC patients. Some patients were visited on multiple occasions.

Of the **399** patients identified between 1st January and 31st March 2021. **156** patients (**39%**) were being cared for on Ward 21.

The bed model is operating well. Patient and staff experience has been positive and some positive comments, expressed from relatives and staff as well as some challenges that have been dealt with contemporaneously are summarised below:

Positive observations:

- Patients are receiving excellent EoLC from an engaged workforce
- Compassionate visiting is being achieved for those relatives who wish to visit - relatives are expressing their gratitude for the care they and their loved ones are receiving on the ward.

Those who are not able to visit for any reason are grateful for the amount of telephone communication they are receiving from staff on the ward
- The specialist consultant input has been supported by the presence of the EoLC CNS Team/ Head of Service for EoL who liaise with teams on the ward and across the Trust – The EoLC CNS team are piloting a 7 day service at present to support this model
- Cross Divisional working together has been positive and demonstrates that EoLC is seen as 'everybody's business' across the Trust

Challenges:

- Patients are sadly dying very quickly therefore dependency is high for 'care after death'
- Specialist consultant review is not presently available at weekends – this is something to aspire to

There are plans in place for a full evaluation of the support for EoLC patients and their families.

We were able to attend our Trust Board to share a patient story. We wanted to share this lovely story as an example of true patient centred care that demonstrates how collaborative working led to a married couple being able to spend their last few hours of life together on Ward 21. They had been together for nearly 70 years and this was a wish that they and their family had once they were both recognised as dying on different wards within the hospital. The compassion & humanity was palpable and this was an example of Team SFH at its absolute best.

3.7 Patient experience – Improve the experience of care for dementia patients and their carers

The Trust is committed to improving the care for people living with dementia and their family/carers who access hospital services.

The Trust's Dementia Strategy 2020-2023 provides a clear vision for the development of dementia care that fosters a collaborative approach to provide outstanding services. It is our responsibility to provide people living with dementia the very best standard of care that is equitable, accessible, and community-focused from diagnosis to end of life.

The continued aim is to provide outstanding care to all our patients. The Trust needs to continue to maximise the potential of our workforce, by continuously learning and improving, choosing to adopt evidence-based practice, utilising information and digital technology whilst using research being innovative and improving for the benefit of the local community.

Aims for 2020/21

- The aims for 2020/21 will continue to focus on the assessment of patients during their hospital stay; with the aim to see the completion target for dementia screening, in patients over 75 years of age and above achieve the national target of 90%.
- Mandatory training will provide insight into some of the lessons learned as part of review of incidents and expressions of concerns or complaints identified, with the intention that by learning from incidents we can improve the experience for our patients.
- The focus on correctly identifying individuals with a confirmed diagnosis on digital systems will continue; working alongside the coding department the team will ensure that the correct information is added to both medical and nursing notes.
- The Trust has identified that there is a need to have a greater awareness of Working Age Dementia and the support needed for both the person with the diagnosis and the carers who support them. Education and raising awareness across the Trust will help us to support this group of patients and ensure colleagues have the knowledge and skills to be able to care for them should they require hospital admission for an acute illness.
- There is written evidence that supports the identification and treatment of hearing loss as a way to improve the cognitive decline caused by dementia. In collaboration with the audiology

department and our commissioners, we will develop a pathway for all newly diagnosed patients to undergo an audiology assessment as part of their diagnosis pathway.
- The Trust will utilise the learning from the report with Healthwatch to improve outcomes for patients newly diagnosed with dementia.
- The Trust will continue to work with the Integrated Care System to improve the overarching care of patients living with dementia and their families and carers.

Performance against this target

2020-2021 has been an unusual year, with the COVID-19 pandemic impacting greatly on many services in the NHS. In turn this has affected the potential achievements related to targets set for the year,

- Despite the pandemic impact, there have been some significant changes made to the process of completing the dementia assessment. Data has not been required to be provided externally for the whole year, although as a Trust we have continued to monitor compliance which has remained poor, particularly during the two waves of the pandemic. Following a discussion it was agreed in February 2021 that nursing staff would assist in the process of completion of the assessments, which started in March 2021. The aim for this coming year will be to achieve the target of 90% completion.
- Mandatory training was initially suspended, due to the challenge of social distancing. Dementia training has become part of the workbook part 2, which was produced electronically. Since then, three packages have been produced for the forthcoming year focusing on adults, paediatrics and maternity.
- The adding of alerts to allow easier identification of a dementia diagnosis continues to require considerable work, and will remain as one of the aims for the forthcoming year.
- Information relating to this topic was added to the mandatory workbook so by the end of this next financial year all staff will have an awareness of this group of individuals. An alternative newly diagnosed information pack is now available, which was requested by the local carers group and has age appropriate literature taking into consideration the fact that their needs differ greatly from that of the elderly.
- All patients who are newly diagnosed now receive a folder that has literature and contact details for the dementia specialist nurse who is available for advice and signposting. Discussions are currently underway with the CCG to look at the post diagnosis dementia pathway; this is in the embryonic stage and will be part of the 2021-2022 aims.
- We continue to be involved in the Integrated Care Systems whose responsibility is unchanged, which is to improve the overarching care of patients living with dementia and their families and carers.

How was this achieved?

A work plan is in place and this continues to be an evolving document that provides both realistic and achievable targets. These are monitored and updated to provide evidence of what has been achieved and the project's needs, with the consistent aim to maintain pace and drive. A gap analysis has been undertaken and the deficits identified have formulated a three year work plan, in line with the Dementia Strategy.

Monitoring and reporting for sustained improvement

The service would normally be required to report nationally on the percentage of dementia assessments completed. This has been suspended during the pandemic and there has been no date provided when this will restart. We have continued to monitor this at the Trust's Board of Directors meeting monthly through the Single Oversight Framework. All training in the organisation is reported onto a Trust database providing the attendance numbers and evaluations of the content and the presenter's skills. These are reviewed by the Professional Education Training Team and sent to the dementia nurse specialist allowing changes to be made accordingly.

Aims for 2021/22

- To focus on our registered nurses' ability to complete the dementia assessment, with the aim of achieving the national target of 90%, through a collaborative approach between nurses and doctors.
- The focus on identifying individuals with a confirmed diagnosis on digital systems will continue. A review of the necessary resources to achieve this will be required.
- As the post diagnosis dementia pathway review is in the embryonic stage at the time of generating this report, the aim in 2021/22 will be to progress this work, anticipating that by year end a pathway will be in place and patients and carers will be receiving the benefits from the new provision.
- The Integrated Care Partnership's shared aim is to ensure that all partner organisations provide Tier 1 dementia training for all employees. The Trust has achieved this as part of their induction, the group of staff that currently do not receive any training are the Healthcare Support Workers. There were plans in place pre COVID-19 to deliver on their induction but as the pandemic began these were put on hold. In 2021/22 we will revisit this and look to achieve the target set by the ICP.
- Volunteers play a huge role in the support of many of our services in the organisation. They would like to expand their knowledge of dementia and it has been agreed this will involve undertaking the dementia friend's session, which can be a face-to-face or online process. To be able to facilitate these sessions individuals need to undertake the Alzheimer's Society champion's course. Several individuals have expressed a desire to attend.
- Delirium continues to have a significant impact on our patients, as dementia is one of the predisposing factors associated with this. 2021-2022 will see the introduction of online delirium training for medical, nursing and healthcare assistants.
- Dementia champions are an essential component of this service. Following a review of champion roles in the Trust, it is planned to amalgamate dementia with falls, manual handling and enhanced patient observation. As a group that naturally enhances each other, the plan for the upcoming year is to develop a cohesive group to support this. It will provide the skills and knowledge to enhance the care delivery whilst assisting their colleagues with same endeavour.

3.8 Patient Experience – Using feedback from patients and their carers

Friends and Family Test (FFT) themes and trends

The NHS FFT is a quick and simple mechanism for patients who use our services to provide anonymous feedback. This helps the Trust to identify what is working well and to improve the quality of any aspect of patient experience. This has supported creating a stronger culture of listening and improvement at the Trust.

At a national level, the data is used by the CQC during inspections and is reported to the Trust Executive Board as part of the Single Operating Framework (SOF).

During the pandemic, NHSE paused the FFT feedback, however the Trust continued to collect the FFT feedback whilst complying with IPC guidance, by increasing services using the SMS text messaging service due to the increase in virtual clinics.

The FFT response and recommendation rates for the emergency department, inpatients and maternity services continue to fluctuate. The modes of collection have been restricted during the COVID pandemic, and where possible SMS messaging has been increased in the appropriate wards and departments. There is no FFT national or regional data available from March 2020 to provide comparison of response and recommendation rates due to the pause with NHSE reporting.

Table 12 FFT annual recommendation rates 2020/21

Indicator	**Plan / Standard**	**Period**	**YTD Actuals**	**Monthly / Quarterly Actuals**	**Rag Rating**
Recommended Rate: Friends and Family Accident and Emergency	93.0%	Mar-21	92.0%	93.1%	G
Recommended Rate: Friends and Family Inpatients	93.0%	Mar-21	98.0%	98.6%	G
Recommended Rate: Friends and Family Maternity	93.0%	Mar-21	89.0%	89.9%	R

The FFT feedback is shared with all divisions for learning and reflection to focus on areas of improvement, the following themes and trends have been highlighted during 2020/21:

- Delay in medicines To Take Out (TTO's) prior to discharge
- Long waiting times and telephone appointments delays in Sexual Health Service
- Within the emergency department patients feel it would be helpful for a patient information leaflet relating to after care and safety netting advice.
- Delays experienced in ante-natal clinic – running up to 2 hours behind
- Patient reported long waits and concerns regarding social distancing in Clinic 1 – fracture.
- Patient report they feel more comfortable with face-to-face appointments as opposed to virtual/telephone appointments for service in Clinic 7.
- Waiting long time for pain medication in emergency department.
- Patient report lack of communication and delays in discharge form the maternity ward.
- Patients felt the discharge lounge setting would benefit from television or radio as environment very quiet resulting in patients feeling uncomfortable. In response to this feedback SFH Charities have supported the Discharge Lounge with the purchase of televisions and reclining seating.

Actions taken to support increased response and recommendation rates:

- Staff members are offering support in the completion of the paper surveys where possible. The current restricted visiting in accordance with the national COVID guidance may be contributing to the decrease in response rates, as relatives/carers do often support the patient in completing the surveys.
- The maternity services transferred to SMS messaging collection only in September 2020 to increase response rates. The timing of this feedback was also adjusted following the new NHSE guidance with flexibility with the four touch points for maternity services. Responses have not increased as suspected and following further analysis an issue has been identified with the IQVIA. The timing of the SMS text messages being sent has led to over 50% of messaging not delivered successfully. The timing of the SMS text messaging has been adjusted and reminder messages will be sent and response rates monitored.
- Paper surveys and an iPad have been introduced within Maternity services to support feedback collection whilst SMS messaging issues are resolved.
- The teams are aware of the current issues with collection of patient experience feedback and have taken steps to ensure that feedback provided in other ways (usually concerns or complaints) is promptly addressed and responses made where appropriate. Themes and trends are still collated from available feedback and current work streams are discharge process; self-administration of medications in order to reduce delays in receiving analgesia; clearer

information in clinic settings to advise that waiting times can be extended in order to respond to emerging clinical information on the day of the appointment.

Aims for 2021/22

- FFT will continue to be monitored as part of the monthly ward assurance and SOF reporting along with plans with all divisions to continue to raise awareness and resolve data collection issues.
- Operational and IT issues continue to be addressed and monitored with IQVIA.
- Additional modes of data collection to be used in maternity services whilst resolving SMS issues.
- Review of national and regional FFT data as soon as published to track response and recommendation rates.

3.9 Patient experience – safeguarding vulnerable people

Aims for 2020/21

- The Trust will continue to ensure where there are safeguarding concerns; adults, children, young people and carers are recognised and consulted as partners
- The Safeguarding team will continue to embed the IDVA service that was commissioned with Women's Aid. We will review the process effectiveness and its outcomes for patients presenting with Domestic Abuse related issues. These will inform our reporting mechanisms
- The Trust will collaborate with external partners regarding the Trusts' response to the safeguarding agenda
- We will continue to learn from local and national safeguarding issues ensuring they are reflected within the service aims

Performance against this target

- The Trust continued to embed Think Family strategy and audit plans
- The IDVA post continues to be a key focus ensuring domestic abuse has remained a high priority during the COVID-19. This will continue to be an on-going priority, as evidenced through evaluation of the commissioned partnership model for 2020/21
- The Trust has continued to work with external partners through representation at safeguarding board and partnership events
- The Trust has continued to be part of local and national safeguarding reviews
- Learning is embedded into mandatory training and where urgent change is required; it is cascaded and reflected within the service

How was this achieved?

- The safeguarding named nurses initiated a programme to provide reports with key metrics and attendance at divisional governance meetings
- Whilst face-to-face training has been impacted by the COVID-19 response, training via e-learning has continued with monthly updates of progress being shared appropriately
- The safeguarding team has supported colleagues to provide focused interventions
- The team is represented at best interest meetings when appropriate
- An audit process was in place to evaluate key issues relating to child and adult safeguarding, domestic violence referrals
- A Mental Capacity Act (MCA) audit started in 2020
- Safeguarding named nurses have continued input to external local, regional and national forums to ensure that current trends, best practice and pressures are shared

Monitoring and reporting for sustained improvement

- The safeguarding team will continue to provide quarterly reports with key information
- Input into divisional governance meetings will continue
- An updated audit programme will be identified for key issues relating to the safeguarding and vulnerabilities agenda
- Systems will be refined to ensure appropriate scrutiny of safeguarding issues which are raised and deprivation of liberty safeguards which are put in place
- Teaching materials for the annual training programme are under constant review and are updated appropriately to ensure focus on key areas.
- Training compliance will continue to be monitored, with any concerns shared accordingly

Aims for 2021/22

As a result of lockdown and self-isolation during the COVID-19 pandemic, there has been an increased risk to vulnerable adults and children. For many, the home may not be a safe place and is a potentially dangerous environment, with routes to support and safety being shut down or limited. This has raised concern both locally and nationally. The Trust recognises safeguarding remains a priority within our care and service delivery. We will work to maintain the system safety processes in place and introduce recovery plans where appropriate. We will build on established work and strengthen our approach to 2020/21 by aligning with the Trust strategic objectives below:

To provide outstanding care

- Implement a Think Family audit plan, to focus on benchmarking safeguarding standards set out in the Markers of Good Practice and SAAF and be responsive to the priorities as set out by the NSAB and NSCP.
- Develop and implement the organisational legislative responsibilities to Liberty Protection Safeguards (LPS).

To Promote and support health and wellbeing

- Safeguarding priorities during 2021/22 will continue to ensure that where there are safeguarding concerns, adults, children, young people and carers are recognised as partners in the outcomes. This will focus around ‘Making Safeguarding Personal’ and the ‘Voice of the Child’.
- Further embed the integrated hospital IDVA role

To maximise the potential of our workforce

- Focus during 2021/22 in supporting the health and wellbeing of its workforce, particularly in relation to domestic abuse and mental health

To continually learn and improve to achieve better value.

- Continue to embed organisational learning through mandatory training, serious incidents and adult/child reviews
- Learn lessons from the COVID-19 pandemic and use this to contribute to future working with children, young people and vulnerable adults.

3.10 Mandatory Key Performance Indicators

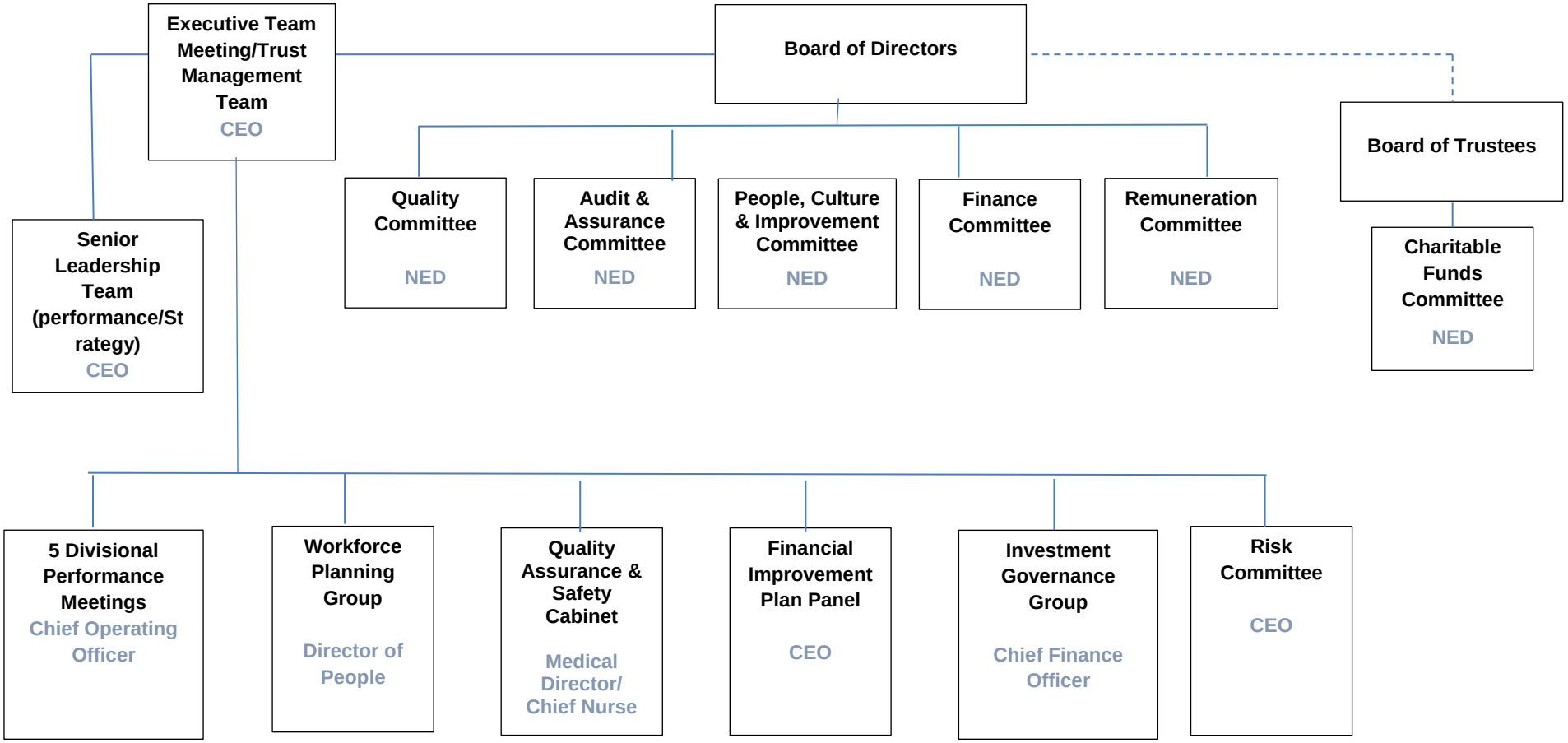
Indicators identified within the Single Oversight Framework	Target	Performance	
		Yr 2019/20	Yr 2020/21
*Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	87.6% (Average %)	69.7% (Average % Apr – Feb)
*A&E : maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	90.1%	94.1% (Apr-Feb)
Cancer 2 week wait: all cancers	93%	94.8%	95.8% (Apr – Jan)
Cancer 2 week wait: breast symptomatic	93%	96.8%	100% (Apr – Jan)
Cancer 31 day wait: from diagnosis to first treatment	96%	96.2%	92.4% (Apr – Jan)
Cancer 31 day wait: for subsequent treatment – surgery	94%	82.9%	81.0% (Apr – Jan)
Cancer 31 day wait: for subsequent treatment –drugs	98%	97.1%	92.0% (Apr – Jan)
Cancer 62 day wait: urgent GP referral to treatment for suspected cancer	85%	77.0%	67.6% (Apr – Jan)
Cancer 62 day wait: for first treatment – NHS cancer screening service referral	90%	81.8%	71.4% (Apr – Jan)
Maximum 6- Week wait for diagnostic procedures	99%	98.2% (Average %)	60.5% (Average % Apr – Feb)
Clostridium difficile variance from plan	48	37	35 (Apr – Feb)
**Summary Hospital-level Mortality Indicator (SHMI)	100	92.47-100.76	91.82-100.58 (Nov-19 – Oct-20)
VTE Risk assessment	95%	95.8%	94.7% (Apr – Nov)

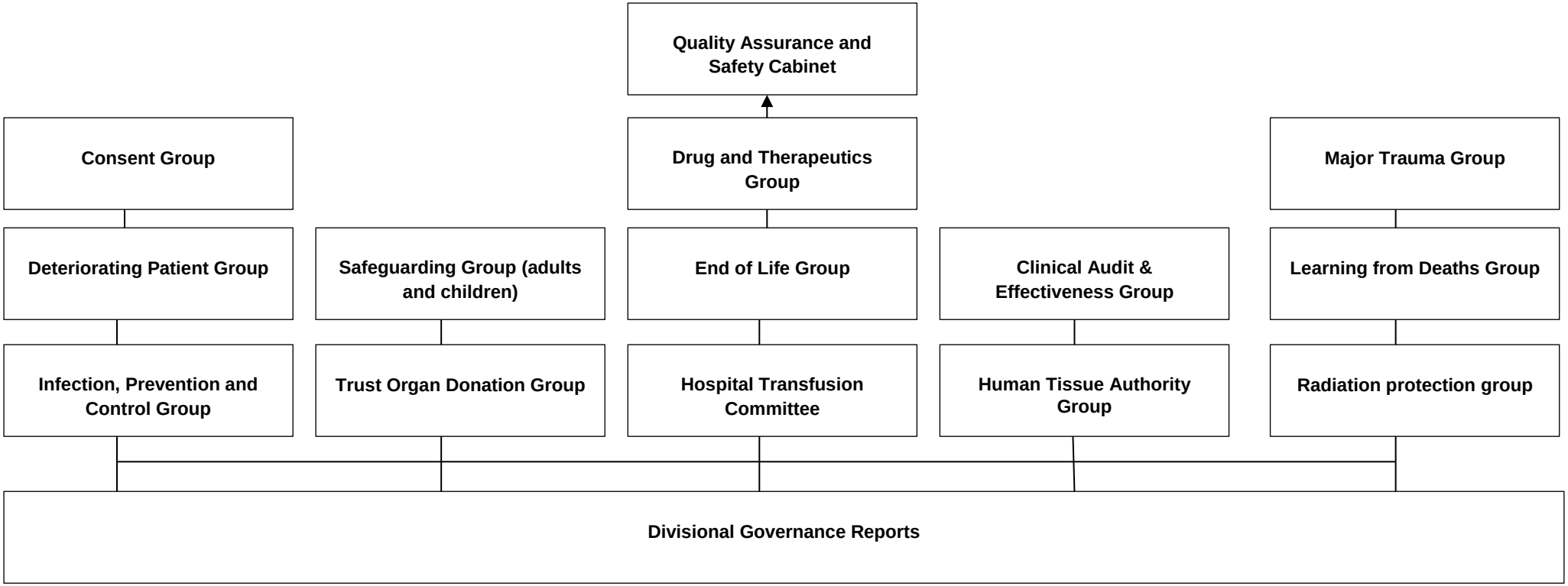
** The Summary Hospital-level Mortality Indicator (SHMI) is a rolling reporting period. The figures reported represent most current data available:

92.47-100.76 April 2019 - March 2020 and 91.82-100.58 October 2019 – October 2020

Appendix 1

Sherwood Forest NHS Foundation Trust –Committee Structure –2020





The Quality Assurance and Safety Cabinet (QASC) meet on the second Wednesday of every month. QASC is the key Governance Committee that operationally supports the delivery of safe, high quality care to patients. QASC also provides an Assurance Report from each meeting to the Board of Directors via the Quality Committee.

Annex 1 – Statements from Commissioners, Health Scrutiny Committee and Healthwatch .

This section includes the statements from our stakeholders about the Trusts quality performance during 2020/21 following review by Stakeholders

Statement from Mansfield and Ashfield and Newark and Sherwood Clinical Commissioning Groups (CCGs)

Introduction

Nottingham and Nottinghamshire Clinical Commissioning Group (NNCCG) welcomes the opportunity to review and comment on the 2020/2021 Quality Accounts for Sherwood Forest Hospitals NHS Foundation Trust (SFHT). NNCCG is committed to ensuring a high quality health service for our local population working as partners within the Integrated Care System (ICS) to improve health and change lives. We work collaboratively with system partners to collate and analyse information from a range of sources to ensure that safe, effective and caring health services are commissioned and delivered for our local population.

NNCCG wishes to extend special thanks to all Trust staff for the noteworthy achievements that have been accomplished by working together to confront a global pandemic in addition to the work that they normally undertake. The landscape of constant change imposed by the COVID-19 pandemic has added an extra layer of complexity to the resilience normally expected of staff during their day to day working.

The staffs of NNCCG wish to extend their sincere condolences to those members of Trust staff who have lost family, colleagues and friends during the global pandemic.

Quality Oversight

Throughout 2020/2021 the CCG has continued to work with the Trust to monitor the quality of services delivered and continuous improvement through reviews of information on safety, patient experience, outcomes and performance. This has looked somewhat different to previous years with adaptations to regular quality assurance processes in order to support providers to release capacity back to frontline services though delivery of safe and good quality services has remained a priority throughout for providers and commissioners alike.

This year in the absence of routine quality review meetings, the CCG has worked with SFH to gain assurances around patient safety, clinical effectiveness and patient experience through a variety of approaches: review of committee papers, informal meetings with the Trust Quality & Governance, CCG representation at a range of Trust Committees and Groups such as the Deteriorating Patient Group, Mobility and Falls Group, Harm Free Care Group, Infection Prevention and Control Committee, and the Quality & Safety Cabinet. This has further built relationships and understanding of the real-time challenges and proactive work.

The COVID-19 pandemic has significantly impacted the clinical audit programme in 2020/2021 however the Account demonstrates some good examples of the work and achievements to improve care with a commitment to clinical effectiveness against a very challenging backdrop.

The CCG can confirm that, to the best of its knowledge, the information provided within this Annual Quality Account is an accurate and fair reflection of the Trusts' performance for 2020/2021.

Achievements

Wider Organisational Achievements

The Quality Account identifies that the Trust has made significant improvements in the culture of their organisation, in particular focusing on building an engaged staff body. Trust results in the NHS Staff Survey for 2020 showed engagement had improved for the fifth consecutive year and for the third year running SFH was the *Best Acute Trust in the Midlands* for engagement.

During May 2020 the CQC published a report following an inspection providing an overall rating of 'Good' with 'caring' acknowledged as 'Outstanding'. The rating at King's Mill Hospital improved to 'Outstanding'. This is an excellent achievement demonstrating sustained changes over the past 5 years with clear evidence of improvements in both trust-wide culture and quality of care.

Another success has been the Health Service Journal (HSJ) award of 'Acute or Specialist Trust of the Year' celebrating the progress the Trust has made as part of their improvement journey.

During the COVID-19 pandemic the Trust supported and engaged with colleagues through daily staff communication updates; they also strengthened their wellbeing offers with the creation of a Den, psychological support services and wellbeing road shows. The Trust undertook a 'Learning from Covid-19' exercise which helped to make further improvements in their organisational engagement; wellbeing; leadership development; and colleague experience offers.

Achievement against 2020/2021 Priorities

The priorities described in 2020/2021 were suspended following both national guidance and limitations posed by the Trust in response to Covid-19. However progress against the quality priorities continued to be monitored monthly by the Executive Medical Director and Chief Nurse through the Advancing Quality Oversight Group and organisational Quality Committee. This included focus on reducing harm for those using services who have a learning disability; patient choice for preferred location at the end of life; and improving the effectiveness of discharge planning and resilience of discharge location. In 2020/21, the Trust saw a 34% increase in the use of the learning disability pathway and planned to review its effectiveness in the following year. In 2020/21 the Family Liaison Team was established to support communications between wards and relatives. This proved to have a positive impact on the experiences shared by patients and relatives.

The Trust has continued to play a vital role within the health and care partnership in particular Mid Nottinghamshire Integrated Care Partnership within the Nottingham and Nottinghamshire ICS. This has been evidenced through their integrated work with primary care networks in areas including; implementation of virtual ward for respiratory patients, the introduction of a primary and secondary care elective recovery board focussing on effective communication to those awaiting treatment, improving advice and guidance and joint education and improving direct access to diagnostic testing. SFH has also helped establish the priorities and roadmap for the Mid Notts ICP working with system partners outside of the hospital.

Quality Improvements

Although Clinical Audits have been disrupted by the COVID-19 pandemic this year the Trust has

- Introduced a new approach to the Trust-wide audits programme in order to standardise the approach and to re-connect colleagues to meaningful data collection.
- Successfully implemented AMAT - the Clinical Audit system incorporating the registration of projects, data collection and analysis, alongside monitoring of both the progress and action plans. This combines both improvement projects and audits into one visible platform, to support organisational learning and knowledge management.
- Integrated the Clinical Audit and Improvement web pages, in sharing learning, outcomes of audits and the in-house support available to progress these effectively.

The Trust has evidenced in the report their involvement in clinical research and has a dedicated Research and Innovation department (R&I).

The 'Improving Care and Learning from Mortality Review' captures themes and examples of learning where the care provided to the patient had been excellent as well as identifying any learning to be gained. Following a review of the structured case reports during the COVID-19 waves, the Trust has commenced the introduction of a data and quality improvement process aimed at strengthening consistency of approach and distribution of learning.

Learning from Incidents

A barometer of understanding patient safety is the use of information and learning around Serious Incidents (SI). From the 1 April 2020 to 31 March 2021 the Trust declared a total of 13 Serious Incidents; of the 13 incidents, two were deemed to be a Never Event. All Serious Incidents are investigated and action plans are developed to mitigate the risk of recurrence. Identifying and disseminating the learning arising from incidents in order to improve patient safety remains a key priority for the Trust and last year two new posts were appointed to support this process. Unfortunately due to the COVID-19 pandemic and the redeployment of staff, these roles have not yet had chance to gain momentum. As the Trust progresses with the recovery phase, these roles will become embedded and capacity will be built to drive the learning from incidents across the organisation reducing risk of harm to patients.

Challenges

The Trust has focused on the number of patients readmitted to a hospital within 28 days of being discharged with the intention of taking action to improve quality. This continues to be monitored across the division with Executive support and oversight in place.

Venous Thromboembolism (VTE) risk assessments are being addressed with a focus on data capture and quality of assessments. The implementation and roll out of Electronic Prescribing and Medicine Administration (EPMA) system will support and there are additional actions to identify and respond to those assessments not undertaken.

Within the Trusts Infection Prevention and Control (IPC) Board Assurance Framework there continues to be a partnership between the Trust and Primary Care to consider all potential aspects causing infections across the health economy with an emphasis placed on Clostridium Difficile around management and education and training, cleanliness, auditing, monitoring and reporting. The Trust Board receive quarterly oversight of progress against actions with operational implementation / developments reported through the Trust's IPC committee and Quality Assurance and Safety Cabinet.

The Trust has extensive Ophthalmology backlogs and is working in collaboration with Independent Sector Hospitals and community providers to reduce these where appropriate. SFH put in place processes for constant risk stratification and re-assessment of waiting lists and backlogs. Virtual outpatient reviews were introduced to support the macular and glaucoma services. On-going transformation work continues with the Trust to scope the opportunity to increase capacity by streamlining pathways.

2021/2022 Priorities

In addition to the 2020/2021 priorities the following areas will also form part of the quality objectives:

- Continue to develop a Patient Safety Culture: To date, over 2000 clinical and non-clinical staff have participated in engagement to inform a number of safety domains this process has given opportunity for staff to share their own experiences of 'safe care' learning lessons from the challenging times of the pandemic
- Implementation of Schwartz Rounds: Offering staff a safe environment in which staff can share their stories and offer support to one another. During the COVID-19 pandemic, Schwartz Rounds were adapted to include virtual sessions called 'Team Time' which were held bi-monthly

- Reducing Harm from Falls: An ambition to be below the Royal College of Physicians published standard falls per 1000 occupied bed days (6.63 per 1000 bed days). A Falls and Mobility Group is in place with the plan to draw upon local, regional and national learning
- Improving the Experience of Care for Dementia patients and their carers: Whilst reporting has been suspended around dementia assessments the trust has continued to monitor and will further strengthen approaches to improve performance
- Integrated Independent Domestic Violence Advisor (IDVA) role: As part of the safeguarding priorities the Trust will embed this post

Conclusion

The position statement issued by the National Quality Board during April 2021 emphasises the importance of prioritising the delivery of high-quality care setting out some core principles and operational requirements for quality oversight in systems. 2021-22 will bring some fundamental changes in the way that the CCG and the Trust work to foster even more collaborative and systems-based working.

The CCG welcomes the specific priorities that the Trust has identified for 2021-2022 which are highlighted within the report and considers that these are appropriate areas to target for continued improvement. The CCG looks forward to continuing to work in partnership with Sherwood Forest Hospitals NHS Foundation Trust.

Statement from the Health Scrutiny Committee

The Health Scrutiny Committee for Nottinghamshire welcomes this excellent Quality Account and the opportunity to comment on it.

The Quality Account is very factual and stacked with statistics regarding every area of the functionality of King's Mill Hospital, Kirkby Health Village and Mansfield and Newark Hospitals. It is also very upbeat and optimistic.

The Health Scrutiny Committee welcomes the improvements at the Trust that have been recognised by the Care Quality Commission with a rating of 'good.' And the committee is particularly pleased to see that the rating of King's Mill Hospital has improved to 'Outstanding' overall. The committee also acknowledges the improvements to staff engagement at the Trust – well above the national average.

The committee notes in section 2.1.3 of the report – that during 2021/22, the Trust will continue with its aspiration to be rated as outstanding overall by the Care Quality Commission. Looking at the trajectory of improvements – this is an achievable goal.

COVID-19 has been an immense challenge for the Trust, just as it has for other NHS providers. Staff have met this challenge head on, and this report reflects their hard work and commitment during this extremely challenging time.

Councillor Sue Saddington, Chairman of the Health Scrutiny Committee

Councillor Matt Barney, Vice-Chair of the Health Scrutiny Committee

On behalf of the Nottinghamshire Health Scrutiny Committee

Statement from Healthwatch in response to 2020-21 Quality Accounts

Healthwatch Nottingham & Nottinghamshire is the local independent patient and public champion. We hold local health and care leaders to account for providing excellent care by making sure they communicate and engage with local people, clearly and meaningfully and that they are transparent in their decision making. We gather and represent the views of those who use health and social care services, particularly those whose voice is not often listened to. We use this information to make recommendations to those who have the power to make change happen.

As part of this role we have taken the opportunity to review and comment on the Sherwood Forest Hospitals NHS Trust (SFHT) 2020- 21 Quality Account report.

The Trust has demonstrated its commitment to communicating with the public about the impact of COVID19 on services through Q and A sessions led by the Chief Executive. These ran on a regular basis from August 2020 to March 2021, and Healthwatch was included on the panel and also had the opportunity to raise questions.

The Quality Account includes significant details on the management of complaints and on patient feedback through the friends and family test. There is less information on patient and public engagement that has taken place, although the future intention is stated: '*We intend to increase citizen involvement within our improvement work, to extend opportunities for improvement training and to actively co-design and co-produce improvements'*. It would be helpful to see plans on how this will be taken forward.

There appear to have been issues in maternity responses precipitating significant work to improve reach and feedback rates via texts and timings. The development of the newly established People, Culture and Improvement Committee is a positive step, and it will be of interest to see the impact of this.

The Trust has actively engaged in a new Healthwatch project - *Listening, Signposting & Transparency with the public.* This project involves:

1. Reviewing and sharing best practice on assurance and governance of public communications, engagement and involvement between provider organisations;
2. Developing an Appreciative Inquiry (AI) review process to support implementing change and best practice;
3. Building partnerships between HWNN and provider organisations, while supporting integrated working between patient and public communications, engagement and involvement teams across providers.

For 2021/22 this project will explore system level provider scrutiny to reflect the move towards provider collaboratives, building partnerships and a process that supports the development of more integrated public communications, engagement and involvement.

Annex 2 - Statement of Directors responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    1. Board minutes and papers for the period April 2020 to March 2021
    2. Papers relating to quality reported to board over the period April 2020 to March 2021
    3. Feedback from commissioners dated 9 June 2021
    4. Feedback from governors dated expected August 2021
    5. Feedback from local Healthwatch organisation dated 28 May 2021
    6. Feedback from Overview and Scrutiny Committee dated 29 June 2021
    7. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009, dated 2020/21
    8. The 2019 national patient data survey dated January 2020 (Maternity services) and July 2020 (Adult inpatient). The 2020 survey is expected to be published in September 2021
    9. The 2020 national staff survey dated March 2021
    10. The Head of Internal Audit's annual opinion of the trust's control environment dated TBC
    11. CQC Inspection report dated 14 May 2020
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

……..Date ……Chairman

……..Date ……