

# Quality Account and Reports

## 2021/22



Best NHS Acute Trust in the Midlands (2018, 2019, 2020 & 2021 NHS Staff Survey)



## Healthier Communities, Outstanding Care

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## **Introduction to the quality account**

This report is published pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006. It 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 2021/22. Due to the COVID-19 pandemic, most of the quality improvement activities have remained the same as those for 2020/21.

The report also identifies and explains the Trust's quality priorities for 2022/23. The 2021/22 sections of the report refer to quality improvement activities completed during the 2021/22 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 2021/22
- Data Dictionary

## Part 1: Statement of the Quality Account: Paul Robinson Chief Executive

I am proud to present our Quality Account for the period 2021/22. The report provides an opportunity to reflect on our progress over the last year and to openly share our performance and outcomes for public scrutiny. There are details of our commitment to fulfil our vision of 'Healthier Communities and Outstanding Care for All'. It describes how we have performed against our priorities, key performance metrics and statements of assurance. It also provides details on the quality priorities we will work toward in the coming year.

The Quality Account has been prepared by the people closest to the services described and therefore provides confidence in the content. In addition, it has been reviewed by our Non-Executives Directors, our Commissioners, Healthwatch and our Local Authority.

Every day I have the pleasure of speaking with colleagues across our hospitals who are striving to deliver the very best care. During these conversations it is clear this has been another challenging year for many of us both at work and personally. Sherwood has worked hard to acknowledge this and provide a range of support offers for colleagues to access.

Our staff engagement results remain the best for an acute trust in the midlands and compares well against similar organisations nationally. There is more we can do in this area. Too many colleagues do not feel supported and experience poor behaviour during their time at work. It is important to me to see this reflected in the specific quality objectives we have committed to in this document.

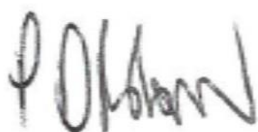
I am incredibly proud of the way in which we have responded to the impact of COVID-19. Our teams have continued to focus on taking care of patients and their families in difficult circumstances. Their continued ability to deliver some truly extraordinary work is testament to adaptability, resilience and dedication of our teams, who strive for excellence every day as they deliver care to the communities we serve. This has been possible because our values are at the heart of everything we do. We live our values every day in the way we treat each other, our patients, families, and communities. We have redoubled efforts to listen to our staff, our patients and our community.

Ensuring timely access to treatment is a major objective for us as we emerge from the pandemic period. We are pleased that we have increased our work at Newark and Mansfield Hospitals, and we can see and treat some of those patients who have waited so patiently. We will be building on this as we navigate the next few months in our efforts to recover, learn to live with the disease, and improve services for patients and our people for the future.

Finally, I want to acknowledge how extremely hard our staff are working to keep each other and our patients safe, to innovate and to change. Colleagues across all our services in Nottingham and Nottinghamshire, have worked ever more closely this year with our partners. As we move toward a system approach to health and social care, these trusted relationships will be ever more critical.

I am confident that the information in this report accurately reflects our performance and provides an honest and consistent reflection of where we have succeeded and exceed in delivery on our plans. I hope you find this account informative and see that our patients are very much at the centre of everything our colleagues at Sherwood do. I am proud of each and every one of them.

Signed



Paul Robinson, Chief Executive

Date 30.06.2022

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

### **2.1 Priorities for Improvement**

Sherwood Forest Hospitals NHS Foundation Trust (SFHT) 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 and embedded in the renewed 2022-2025 Strategy, currently in draft. The programme is led by the Executive Medical Director, who, in conjunction with the Chief Nurse, receives regular progress reports via the Advancing Quality Programme. Formal reporting is through the Trust Quality Committee and the Board of Directors. The Advancing Quality Programme is monitored, updated, and amended throughout the year.

#### **2.1.1 Providing high quality, safe care**

The Trust uses several 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. These include:

- 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.

During 2021 the Trust has developed a new Quality Strategy including new Quality Priorities. This will be published in 2022 and cover a three-year period to 2025. The campaigns and priorities will be shaped and monitored by the Advancing Quality Programme with assurance process to the Board.

#### **2.1.2 Approach to Quality Improvement**

Patient safety, clinical effectiveness and quality of care are at the heart of the Sherwood strategic vision. Every day colleagues demonstrate their commitment to providing outstanding patient-focussed care, as they strive to do their very best, in often difficult circumstances. Our commitment to continuously learn and improve is firmly embedded within this strategy, the purpose of which is to outline how we will deliver

safe person-centred care to our citizens and support our colleagues by providing the best possible practice environment. This includes not only our Sherwood people, but everyone we collaborate with across health and social care in Nottinghamshire. This is underpinned by the Sherwood approach to quality improvement and our ambition to become a level 5 exemplar site for continued learning and improvement.

The Trust's approach to Quality Improvement (QI) is based on well evidenced methodologies, based on the widely acknowledged 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.

### **2.1.3 Quality priorities 2018-2021**

The 2018-2021 Quality Strategy saw the launch of a robust programme of innovative initiatives, underpinned by key priorities and measures. Key successes include the accreditation of Sherwood Forest Hospitals as a Schwartz Round site, the development of the PASCAL Safety Attitude Questionnaire that was launched in key services such as ED, Maternity, Theatres and across all wards. This involved over 2,000 front line colleagues sharing their views on safety within their services. From this action plans were developed to target areas of both strength and areas for development. We focussed on awareness of quality at local levels, through clinical audit and activities such as quality rounds and '15 step' deep dives led by Governors Non-executive directors and members of the Executive team.

The strategy also led to a focus on external benchmarking and visits to peer organisations via Getting It Right First Time (GIRFT) and peer reviews. The above activities aligned to, and complimented the QI Strategy, the focus of which was to develop an evidence-based QI approach, and to build improvement capabilities as part of an inclusive offer to all colleagues. This led to a system QI training offer, delivered in collaboration with partner organisations.

During the time, the Care Quality Commission inspected the organisation; in 2020, Sherwood was rated 'Good' overall and the main site, King's Mill Hospital was rated 'Outstanding'. We believe that this revised strategy will further build on these successes. We will deliver the very highest quality of care and outcomes for our patients alongside ensuring our staff wellbeing. Our ambition is to be one of the leading healthcare organisations in the country, and to be at the forefront of services that will see us provide innovative, efficient, effective, and meaningful health and social care pathways.

During 2022/23 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.

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 system-wide alignment between quality, activity and financial planning, boosting our combined efforts to deliver safe, effective and financially sustainable services in the longer term.

The Quality Strategy provides the road map to achieve this aspiration. 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.

Three improvement priorities for specific focus in 2022/23 are indicated below; these have been included in light of local, national and international priorities and in addition COVID-19 and Ockenden Report. They have been agreed by AQP and in consultation with the board of governors. They will be reported on in the relevant sections in the next Quality Account.

Specific Campaign	Quality Priority	Success Measure
Create a positive practice environment to support the safest most effective care	SFH accredited as a designated 'Pathway to excellence' organisation	Awarded Pathway to Excellence designation by the American Nurses Credentialling Centre (ANCC)
Deliver high-quality care through kindness and 'joy at work'	Introduce a Trust-wide 'Cultural Humility' programme	Programme to be visible and rolled out to all colleagues across 2022
Excellent patient experience for users and the wider community	Increased service user/citizen engagement at key SFH meetings	Assurance processes / Terms of Reference/Meeting Minutes.

Improving the quality of care we deliver is about making care safe, effective, patient-centred, timely, efficient and equitable. The Quality Strategy, 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

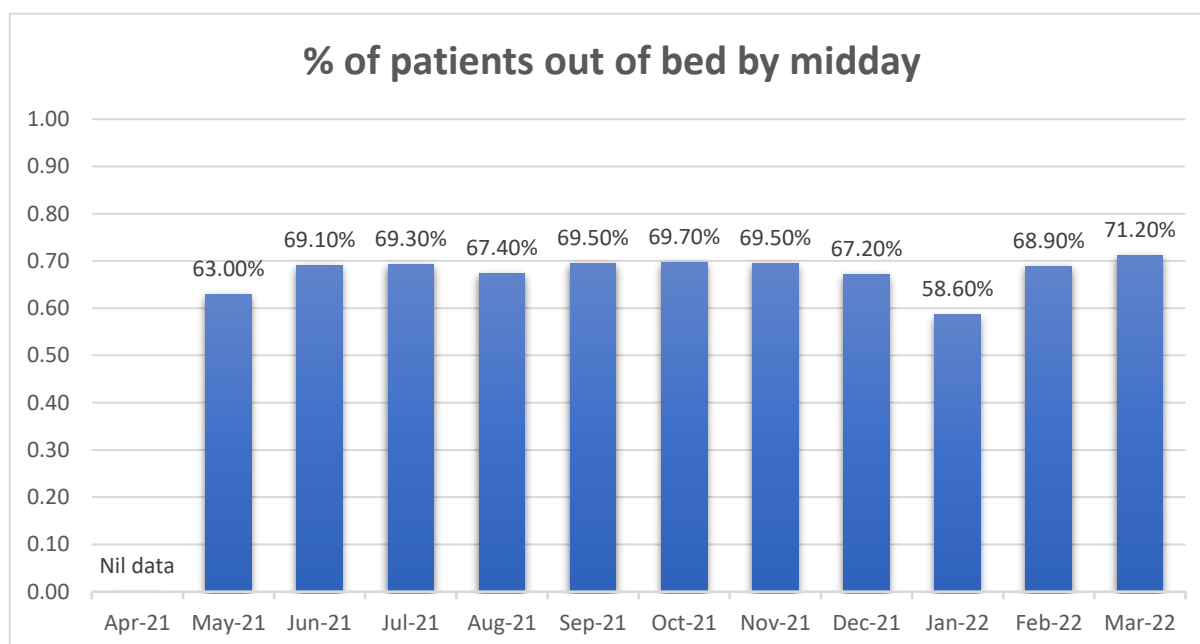
#### 2.1.4 Review of Quality Priorities during 2021/2022

<b>Patient Safety</b>	<b>Improve in-patient mobility and movement to reduce hospital acquired functional decline and maximise discharge potential</b>
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Acute hospital care can result in overall functional decline when mobility is reduced during recovery and is widely described as 'PJ-paralysis'. The decline can lead to increased risk of falling whilst in hospital and in recovery following discharge. This priority focusses on reducing functional decline and associated risks. It is predicted this will lead to increasing the number of people discharged onto the less complex pathways.

During the past year we have continued to collate data related to inpatients who are sitting out of bed at lunch time. Falls prevention practitioners have supported reporting and celebrated the successes reported across our inpatient areas. We have seen a slight improvement though the dataset is not reflective of every inpatient area (graph 1). Expanding the data collection would be helpful for Trust wide monitoring.

*Graph.1*



SFHT have experienced increased falls throughout the past year. This is covered later in the report.

<b>Patient Experience</b>	<b>Improve use of Personalised Care &amp; Support Plans (PCSPs) for all women using our maternity services</b>
<p>Progress on the PCSP has not been as predicted, due to the re-occurrence of COVID-19 pressures and a subsequent pause within the Local Maternity and Neonatal Services (LMNS) workstream. The workstream has since recommenced and at SFHT we continue to be active participants. Through this workstream we have identified that digital alignment between our organisations is a key priority, with the planned system alignment to take place in November 2022, following the digital procurement.</p>	
<p>PCSP will feature heavily within the digital plans and teams from both organisations, and we are working with our local service users' groups to reflect how the format is shaped and how these will be accessed. Maternity Voices Partnership are involved in the redesign of the process to co-produce PCSP and to bring this into the digital transformation programme.</p>	

Clinical Effectiveness	Review the pathway for diabetes to isolate potential crisis points and act on the analysis
<p>The diabetes team within SFHT trust have been working on several projects aimed at improving the quality of diabetes care within both the trust and the wider system. This have been led by the findings of the GIRFT report received 2020 and changes to NICE guidance associated with Diabetes.</p> <p>Over the last year the antenatal team has implemented the use of Continuous Glucose Monitoring (CGM) in all people who are pregnant with type 1 diabetes and Flash Glucose Monitoring (FGM) in the type 2 gestational disease and after 12 weeks gestation in line with NICE guidance.</p> <p>There have been changes within the technology available. The team continue to move forward with this to ensure that people with diabetes have the most up to date equipment and technology available to help them self-manage their diabetes. This continues to evolve alongside new guidance offering more access to the CGM, FGM and Looped insulin pump therapy. The Diabetes Specialist Nursing team (DSN) has supported these developments ensuring that there is equity in access and availability of the newer technology. They have focussed on working with the wider health community and people with diabetes to understand the data and how best to use it. There is increased engagement, better self-management and it is hoped this will improve future health outcomes. This is an ongoing project for the year to come.</p> <p>The diabetes Specialist team has been looking at how improve inpatient care withing the trust.</p> <p>SFHT contributes to the National HARMs audit and has undergone a GIRFT review. It was identified by GIRFT there was a requirement for 7 day working in the diabetes service. The team initiated a business case and began the service in spring 2022. It is expected this will reduce length of stay. It is also hoped it will reduce diabetes related admissions via ED.</p> <p>The DSN team is developing closer monitoring of glucose management system in the trust to help to reduce the diabetes crisis events causing harm. Education support is expanded to support staff in their understanding and decision making when treating people with diabetes.</p>	

## Statements of Assurance from the Board

### 2.2 General Statement

During 2021/22 SFHT provided and/or subcontracted various relevant health services.

SFHT 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 2021/22 represents 78% of the total income generated from the provision of relevant health services by SFHT. This year we cared for:

	Yr2021/22	Yr2020/21
ED Attendances KMH	111,164	85,733
Newark UCC Attendances	25,317	15,289
	<b>136,481</b>	<b>101,144</b>
PC24 Attendances	30,901	19,122
<b>Grand Total</b>	<b>167,382</b>	<b>120,144</b>

Births	3,453	3,134
Outpatient Attendances (all sites)	446,554	348,734
Inpatient activity	54,179	45,911
Day Case Activity	37,896	25,672

We employ 5,735 substantive people. We engage with a large number of people through the bank system which raises this number to 8,926 including 219 consultant doctors which includes 33 locum consultants, working in hospital facilities that are some of the best in the country.

## 1. Participation in clinical audit

### Clinical audit submission to quality accounts

The COVID-19 pandemic continues to have an impact on Clinical Audit activities across 2021/2022 following two years of significant pressure. This has reduced opportunities to deliver and receive training, reduced learning and sharing events and opportunities across the organisation and has impaired colleague's capacity to participate fully within this agenda.

Over 2022/23, the focus is on re-engaging colleagues with the clinical audit agenda, and to strengthen the focus and visibility of patient/service outcomes and learning. This will be achieved by having more direct team input at Divisional Governance level and focussing on Trust-wide themes, for example, the focus on Antimicrobial Stewardship.

### National Clinical Outcome Review Projects 2021/22

During 2021/22, SFHT participated in 52 of 52 (100%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SFHT was eligible to participate in during 2021/22 are as follows:

Project name (A-Z by project name)
Case Mix Programme (CMP)
Elective Surgery (National PROMs (Patient Reported Outcome Measures) Programme)
Emergency Medicine QIPs (Quality Improvement Project) - Infection Control
Emergency Medicine QIPs - Pain in Children
Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls
Falls and Fragility Fracture Audit Programme (FFFAP) - National Hip Fracture Database (NHFD)
Falls and Fragility Fracture Audit Programme (FFFAP) - Fracture Liaison Service Database
Inflammatory Bowel Disease (IBD) Audit - Inflammatory Bowel Disease (IBD) Biological Therapies Audit
LeDeR - Learning Disabilities Mortality Review
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal confidential enquiries
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality surveillance

Maternal, Newborn and Infant Clinical Outcome Review Programme- Maternal mortality surveillance and confidential enquiry
National Adult Diabetes Audit (NDA) - National Diabetes Foot Care Audit
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care
National Asthma and COPD Audit Programme (NACAP) - Paediatric - Children and young people asthma secondary care
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD)
National Audit of Breast Cancer in Older People (NABCOP)
National Audit of Cardiac Rehabilitation
National Audit of Care at the End of Life (NACEL)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
National Cardiac Arrest Audit (NCAA)
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management Devices and Ablation
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit
National Child Mortality Database (NCMD)
National Comparative Audit of Blood Transfusion
National Comparative Audit of Blood Transfusion programme - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA)
National Gastro-intestinal Cancer Audit Programme (GICAP) - National Oesophago-Gastric Cancer Audit (NOGCA)
National Gastro-intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)
National Joint Registry
National Lung Cancer Audit Programme
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP)
National Paediatric Diabetes Audit (NPDA)
National Perinatal Mortality Review Tool
National Prostate Cancer Audit (NPCA)
Respiratory Audits - National Outpatient Management of Pulmonary Embolisms Audit
Respiratory Audits - National Smoking Cessation Audit
Sentinel Stroke National Audit Programme (SSNAP)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Society for Acute Medicine Benchmarking Audit
Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.
Trauma Audit & Research Network
UK Cystic Fibrosis Registry
Urology Audits - Cytoreductive Radical Nephrectomy Audit

## National clinical outcome review projects 2021/22

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals NHS Foundation Trust participated in during 2021/22 are as follows:

National programme name	Work stream / Topic name	Has data been submitted?	Case Ascertainment
Case Mix Programme (CMP)		Yes	100%
Elective Surgery (National PROMs Programme)		yes	100%
Emergency Medicine QIPs	Infection Control	Yes	100%
Emergency Medicine QIPs	Pain in Children	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database (NHFD)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database	yes	100%
Inflammatory Bowel Disease (IBD) Audit	Inflammatory Bowel Disease (IBD) Biological Therapies Audit	Yes	100%
LeDeR - Learning Disabilities Mortality Review		Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality surveillance	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry	Yes	100%

National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Adult asthma secondary care	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Paediatric - Children and young people asthma secondary care	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)		Yes	100%
National Audit of Cardiac Rehabilitation		Yes	100%
National Audit of Care at the End of Life (NACEL)		Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	Yes	100%
National Cardiac Arrest Audit (NCAA)		Yes	100%
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%

National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management Devices and Ablation	Yes	100%
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	100%
National Child Mortality Database (NCMD)		Yes	100%
National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines	Yes	100%
National Comparative Audit of Blood Transfusion programme	2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)		Yes	100%
National Emergency Laparotomy Audit (NELA)		yes	100%
National Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	yes	100%
National Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit (NBOCA)	Yes	100%
National Joint Registry	8 workstreams that all report within Annual report - see Inclusion and exclusion criteria (Column L) for further information	yes	100%
National Lung Cancer Audit Programme		Yes	100%
National Maternity and Perinatal Audit (NMPA)		Yes	100%

National Neonatal Audit Programme (NNAP)		Yes	100%
National Paediatric Diabetes Audit (NPDA)		Yes	100%
National Perinatal Mortality Review Tool		Yes	100%
National Prostate Cancer Audit (NPCA)		Yes	100%
Respiratory Audits	National Outpatient Management of Pulmonary Embolisms Audit	Yes	100%
Respiratory Audits	National Smoking Cessation Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)		Yes	100%
Serious Hazards of Transfusion (SHOT): UK National hemovigilance scheme		Yes	100%
Society for Acute Medicine Benchmarking Audit		Yes	100%
Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.		Yes	100%
Trauma Audit & Research Network		Yes	53%
UK Cystic Fibrosis Registry		Yes	100%
Urology Audits	Cytoreductive Radical Nephrectomy Audit**	No	0%

\*\* - SFHT has not seen any patients that meet the criteria for inclusion in this National Audit.

NCEPODs:

Study Title	Participation	Project Status	%
Epilepsy in Adults	Yes	Patients Submitted to study	100
Transition from Child to Adult services	Yes – New study	Clinicians Questionnaire completion underway	-
Crohn's Disease	Yes – New Study	Awaiting sample selection by NCEPOD	-

### Non-Participation/Exceptions

None to report.

### Outcomes and Learning from Clinical Audits Undertaken During 2021/22

The number of clinical audits both national and local which formed part of the 2021/22 Audit Plan are as follows:

Total Number of audits in the 2021/22 plan: = **365**

Number of local / other audits: = **313**

Number of national audits, including NCEPOD: **55**

Number of audits fully completed: = **142**

Some of the key learning from 2021/22 is as follows:

**The Sentinel Stroke National Audit Programme (SSNAP)** has reported that we have achieved the standard for 24 of the 30 standards of Care criteria that they audit against. We have shown strong performance against the criteria (100%) for patients starting Thrombolysis where eligible, the percentage of applicable patients receiving a joint health and social care plan on discharge and the percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation.

**Epilepsy 12 National Clinical Audit** The results of the audit show that 86% of our children and young people had an input to the care from an Epilepsy Nurse Specialist which is favourable against the national figure of 63%. The audit also found that 90% of patients had input into their epilepsy care from a paediatrician with expertise in Epilepsy.

**The Society for Acute Medicine Benchmarking Audit (SAMBA) 2021** provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 17th June 2021. SFHT met the key performance indicators in over 90% of the metrics. 92% (national average 77.4%) of patients had an early warning score recorded within 30 minutes of arrival to hospital. 96% (national average 87.4%) of unplanned admissions were seen by a tier 1 clinician within 4 hours of arrival to hospital. 98% (national average 67.8%) of unplanned admissions who required a medical consultant review were seen within the target time.

**National Lung Cancer Audit (NLCA)** Sherwood Forest Hospital Trust (79.8%) is above the national average (75% in 2020) for the percentage of patients that are seen by a Cancer Nurse Specialist. It also displays a favourable median time from diagnosis to treatment for patients of 13 days compared to the national figure of 27 days in 2020.

**National Emergency Laparotomy Audit (NELA) - Year 7** The report shows that Preoperative input by a consultant surgeon where there's a documented risk of death >5% has improved from 74.6% of

cases in Year 6 to 100% in Year 7. In addition, the results also show that we achieved a high score regarding consultant surgeon and anaesthetist presence in theatre when risk of death >5%.

The reports and outcomes of 142 local clinical audits were reviewed in 2021/22 at the Improvement and Clinical Audit Group, and, in future, will be reviewed at the Advancing Quality Group on a quarterly basis.

Examples of completed local audits are below:

Speciality	Audit code	Title	Post Project Impact/Actions
Radiology	Rad/CA/2020-21/22	Re-audit appropriateness of usage of Computed Tomography Pulmonary Angiography (CTPA) investigation of suspected Pulmonary Embolism (PE).	After the initial Audit in 2019, educational posters and emails have been sent to all clinician to make sure they are aware of the guidelines and the local protocols. The second data collection showed an improvement in appropriate CTPA request from 21% to 36%. There is further work that needs to be done. A PE has only been diagnosed in 10% of cases, still below the target of 15%. Further education and monitoring is ongoing.
Acute Medicine	Acute Med/CA/2020-21/10	Appropriate utilisation of cardiac troponin in medical patients	Based on 90 patients, nearly half of the patients had non-specific chest pain or no chest pain at presentation, More than 50% of patients had non-specific ECG changes, more than 50% had a second troponin. Based on these findings we have devised and implemented a scoring system to help the clinician/nurse to select the patients who would benefit with a troponin test. To be re-audited.
Cardiology	Cardio/CA/2020-21/11	Cardiac function monitoring in patients on trastuzumab therapy (19-20-4185)	1. Only 50% of the patients had scans at 3 monthly intervals, 29% had scans at >3 months (4-8) , 22% patients had scans earlier than 3 months. 2. 36% patients had developed decline in LV function. Only 14% of patients had a decline in Ejection fraction (EF) meeting criteria to stop herceptin and commence heart failure treatment 3. Only 29% of patients with significant decline in EF developed symptoms. 4. 29% of patients with significant decline in EF were not commenced on heart failure treatment and not referred to cardiology. Actions completed: To establish new service for follow up of LV function for patients with Herceptin treatment. To display heart failure treatment algorithms in breast clinic. Working to develop a local pathway for Herceptin surveillance and make it available on intranet
Respiratory	Resp/CA/2021-22/03	Second cycle FiO2 recording on the ABG blood results	Re-audit post intervention showed a 53.33% (n=16) of total ABG records have documentation of FiO2. This is a 28.33% improvement in FiO2 documentation from the previous cycle.

			<p>We are in the process of liaising with ABG analyser machines providers, to prevent processing the blood sample unless FiO2 has been entered with the patient details.</p> <p>We have included the clinical importance of documenting the FiO2 level on the ABG result papers in an educational sessions to the new rotation junior doctors.</p>
Stroke	Stroke/CA/2020-21/06	Are Intermittent Pneumatic Compression Stockings for Stroke VTE being used correctly	<p>Patients who did not have IPC prescribed had an alternative VTE prophylaxis treatment prescribed. The majority of patients had a bodily worn device care plan in place and this was also signed for by a doctor. All patients had the correct size sleeves in situ.</p> <p>Actions: Ensure all entries are signed for on the drug card. Stop the use of IPC after 30 days. Feedback findings to the nurses on the stroke unit via performance meeting. Present the RCP guidance on how long IPC should be in situ for. Re-audit.</p>
Breast Surgery	Breast Surgery/CA/2021-22/01	Re-audit Breast Operative notes audit	<p>After re-designing of the Breast Operating notes, significant improvement was observed in our operative notes filling. Currently all fields are in the acceptable above 90% filling rate, except the local anaesthesia field.</p> <p>No further actions planned, except review.</p>
General Surgery	GS/QI/2021-22/02	Re-Audit: Foundation Trainee 2020 Surgery Induction at Kings Mill Hospital	<p>After developing an e-learning presentation and, delivering it to both cohorts in April and December, an improvement has been measured.</p> <p>Improvement was shown post-induction for overall confidence starting a surgical rotation: There was a reduction in trainees rating themselves 'not so confident' and 'not confident at all' post-induction.</p> <p>There was a 30% increase in trainees rating themselves 'confident' post-induction.</p> <p>There was a complete reduction in trainees rating themselves 'not at all confident' post-induction across all categories.</p> <p>4 out of the 6 areas identified for improvement, after FY1s confidence ratings in December, showed improvement in confidence of FY1s after the induction session in April vs December</p>

Trauma and Orthopaedics	T&O/CA /2021-22/07	re-audit Creating a Day 1 post-operative proforma for elective and trauma patients to enhance patient care and improve junior doctor confidence	The project has highlighted that doctors in training lack confidence and knowledge around completing Day 1 post-op checks. It showed that the Day 1 post op documentation included less than 50% of the needed information. As a result of this audit, a new pro-forma has been designed and implemented. The re-audit data showed an increase in completion of the Day 1 post op checks. Average composite score for post-operative review increased 2x after the proforma was introduced (7.7 to 14.5 out of 16). 100% documentation of operation type, site, neurological and vascular status. VTE plan increased from 15% to 80%. Junior doctor confidence improved in both performing and documenting the reviews. 100% neutral or disagreed prior to proforma, 0% felt this way following proforma. 80% strongly agreed they felt more confident at the end of the rotation.
Trauma and Orthopaedics	T&O/CA /2021-22/15	Re-audit Hip Fracture care plan by Orthogeriatric	After the initial audit, the Specialty developed an e-learning package. The results of the re-audit showed FRAX score: 94.73 % compliance compared to the first loop of audit which was 77% ECG: 85% compliance compared to the first loop of the audit which was 41% Lying/sitting blood pressure: 94.73 % compliance compared to the first loop of audit which was 79% 4AT assessment (delirium screen) : 100% compliance compared to the first loop of audit which was 77% Bone health bloods : 100% compliance compared to the first loop of audit which was 89% Plasma CTX : 60% compliance compared to the first loop of audit which was 56.41% The initial training in August 2021 influenced the above improvements.
Cardiology	Cardio/CA/2021-22/01	Prescribing in ACS	The audit highlighted that none of the criteria were met. All patients on DAPT for Acute Coronary Syndrome (ACS) treatment are co-prescribed a PPI 74% compliance. All patients on treatment for ACS are only prescribed fondaparinux for a duration of 3-5 days before converting to standard VTE prophylaxis 65% compliance. All patients discharged after treatment for ACS are prescribed all indicated secondary prevention medications (with documentation if medications are not started) 73% compliance. As a result, the specialty agreed to do a teaching session, display a poster and prepare powerpoint presentation that can be shared at appropriate meetings. A re-audit is planned.

## **Review of 2021/22**

Challenges posed by the pandemic has made this a difficult year to fully engage with clinical colleagues around the Clinical Audit agenda, and to connect audit activities through to positive patient outcomes and learning. Despite this, there have been several improvements taken forward.

- Introduction of QIP Club – the QI team has worked closely with the Chief Clinical Registrar to engage with trainee doctors early within their rotation. As part of a 'QIP Club' they were asked to 'pitch' an area for trainees to lead as part of an improvement and clinical audit project, with support from the organisation. Project areas have included flow/discharge and antimicrobial stewardship, with regular meetings and coaching events to build on both capability and networks.
- Development of an e-learning package for Clinical Audit training – this was in response to all face to face training being 'stood down' as a result of the pandemic. This is proving popular with colleagues who can access it at their convenience.
- The QI and Audit team are supporting wards involved in 'Pathway to Excellence', to engage with clinical audit and improvement to help them achieve ward accreditation as an Exemplar Ward, as well as providing QI training.
- Introduced 6 monthly cycle of data collection for trust wide audits – this was in direct response to clinical feedback that monthly data collection was not suitable for all areas (where there may not be eligible patients, which would result in that area failing the audit).
- New governance route via the Advancing Quality Group; this should provide an opportunity to strengthen the clinical effectiveness agenda and assurance process.

### **Looking forward to 2022/23 we aim to:**

Strengthen both the assurance and visibility of clinical audit within the organisation, via the Improvement in Clinical Audit Group, Advancing Quality Group and by learning from, and sharing activities on key Trust-wide themes. This has started via the 'Antimicrobial Stewardship group' which has brought together different teams, working in silos, into one cohesive project team.

To further connect audit to the continuous improvement and learning cycle; this will focus on process outcomes by being more directly involved as a team at Divisional Governance level, in order to influence more locally and to pull forward learning and good practice across the organisation.

Continue our focus on developing and progressing the QIP Club for trainee doctors, sharing this development both within and outside the organisation.

To align to and contribute to the People, Culture and Improvement Strategy, the Continuous Improvement Strategy, the Quality Strategy and to support the nursing 'Pathway to Excellence' approach.

## **3. Participation in clinical research and innovation**

The number of patients receiving relevant health services, provided or sub-contracted by SFHT in 2021/22, recruited during that period to participate in research approved by the Research Ethics Committee was 1,295. This includes patient data and tissue samples.

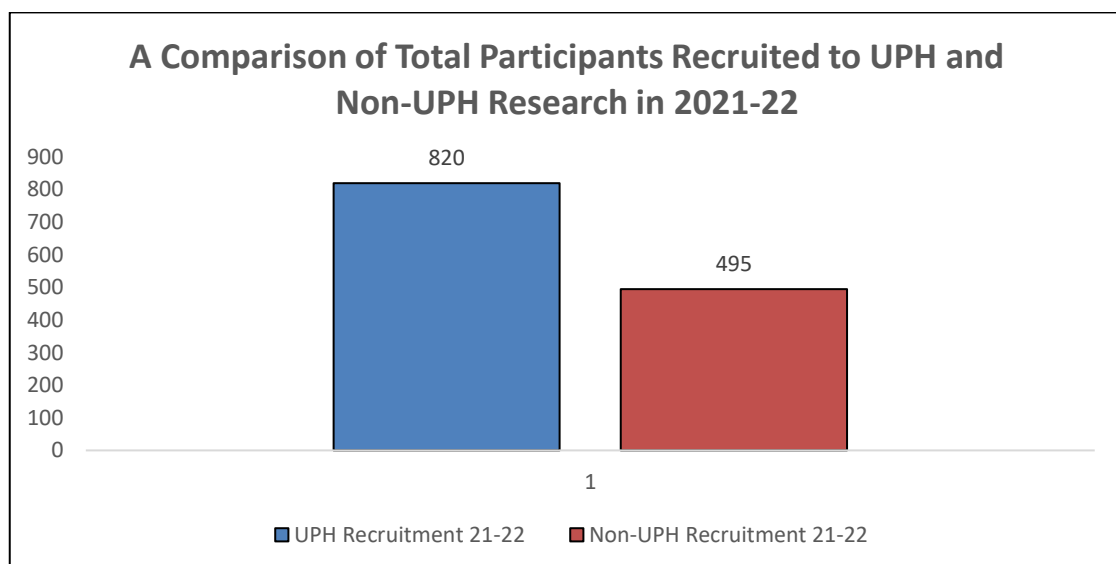
The Trust is actively involved in clinical research and has a dedicated Research and Innovation department (R&I). The R&I team is responsible for developing and supporting a varied research portfolio, creating better opportunities for patients and staff to participate in research activity, whilst informing 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.

Historically, research activity had shown a year-on-year increase, however due to the global COVID-19 pandemic, most of the non-Urgent Public Health (nUPH) research activity was suspended. In 2021/22, SFHT research activity focused on both Urgent Public Health (UPH) studies, (as defined by the NIHR), to find suitable treatments to combat COVID-19, and recovering the pre covid research portfolio to date, R&I have opened 13 UPH studies and recruited a total of 3717 participants. 820 were recruited in 2021/22 (graph 2).

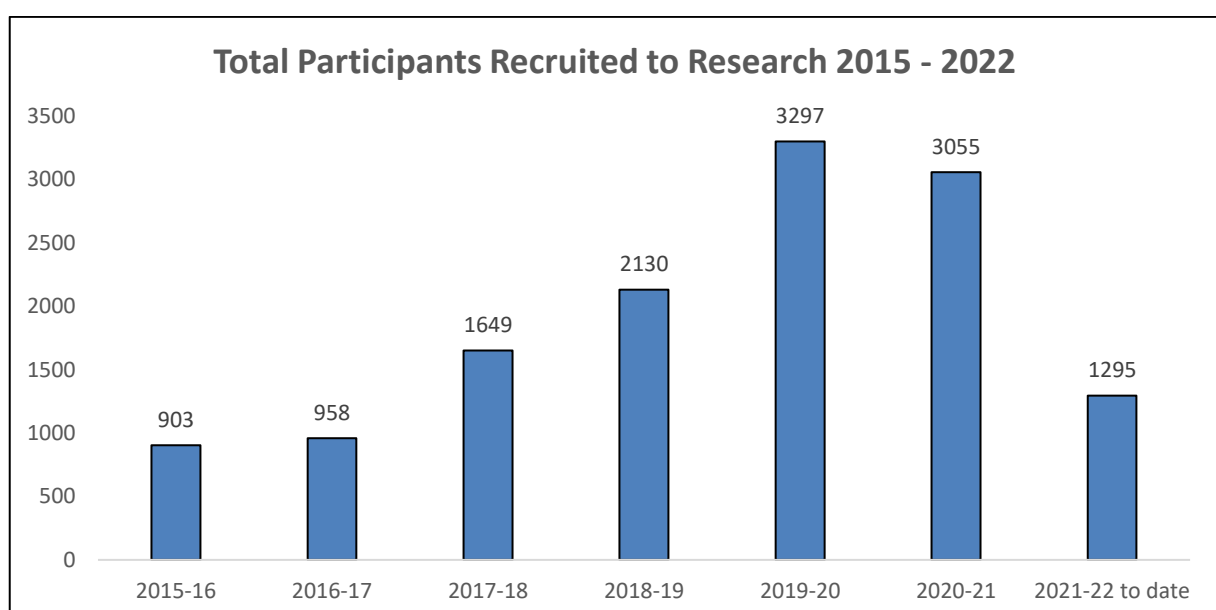
Remaining nUPH studies were restarted during 2021/22; however, some studies closed due to pathway changes resulting in nUPH portfolio and recruitment being lower than recent years. Total recruitment exceeded the target of 1,200 (graph 3)

Going forward, R&I will focus on the rebuilding of their portfolio balancing non-UPH research and UPH research together. Activity will be reviewed regularly as the situation surrounding the COVID-19 pandemic evolves. ( graph 4)

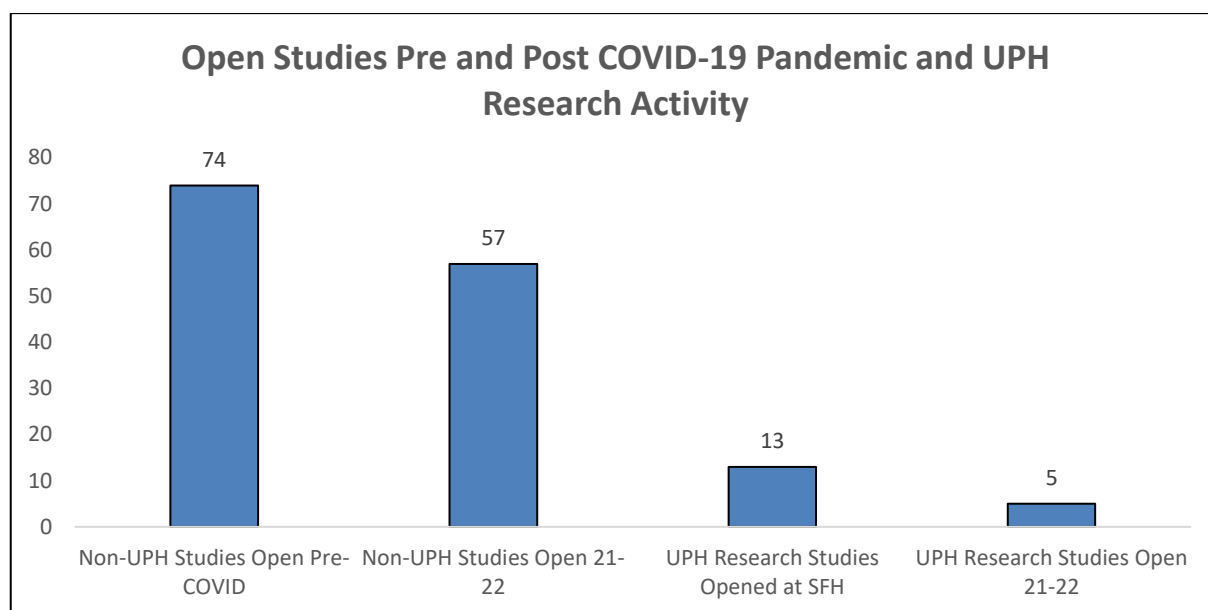
Graph 2



Graph 3



**Graph 4**



The focus for R&I in 2022/23 is to develop a balanced function that can deliver COVID-19 research alongside a healthy portfolio of nUPH studies. R&I have commenced collaborative working with Primary Care to support the development, operation and delivery of clinical research and training across Mansfield and Ashfield. The expected outcome will result in the expansion of the Primary Care portfolio and an increase in patient and staff development opportunities. Due to the pandemic, in 2020/21 and 2021/22, SFHT's commercial research activity has reduced, with 2 studies remaining open and 24 participants recruited across both years. In 2022/23, we plan to rebuild our commercial activity by prioritising the setup of commercial trials, strengthening our reputation for delivery, and attracting more commercial companies to bring clinical trials to SFHT. We have now secured a suitable space for a dedicated clinical research facility. This is the centre of the growth for 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 suitable, 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 SFHF to feedback on their experience so we can make improvements. Our survey found that of those respondents, 91% reported that they would agree or strongly agree that their participation in research has been valued and 93% surveyed would consider taking part in research again.

SFHT is committed to expanding research activities and facilities and has developed strong associations with Universities, other NHS Trust's, and stakeholders. In order to support expanding the to expand the types of research studies available to involve our local population, support workforce capability and, increase capacity to undertake research, we have developed a collaborative partnership with Nottingham University Hospitals NHS Trust (NUH) and Nottingham Trent University (NTU). R&I are 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.

At a local level, SFHT's R&I team is working closely with Divisional teams to support embedding clinical research into frontline care. The department will re-commence research secondments as part of the

SFHT Research Academy and network of Research Champions, in addition to supporting Nursing, Midwifery and Allied Health Professional colleagues to develop capacity and capability to undertake research through collaborations with higher education institutes.

R&I team present a quarterly update to Trust Board and the Quality Cabinet. The research governance committee meets quarterly to oversee and monitor activity. The Trust has an external reporting responsibility to the Department of Health via the Clinical Trials Platform. This is a national key performance indicator for NHS organisations.

#### **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 quality improvement and innovation by linking a proportion of the provider's income to the achievement of local and national improvement goals.

A proportion of SFHT's income in 2021/22 would normally be conditional upon achieving quality improvement and innovation goals agreed between SFHT and any person or body they entered a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In March 2021, NHS England directed both providers and commissioners to suspend delivery of all CQUINs for the year 2021/22 as a result of the COVID-19 pandemic. This directive ensured a block payment was received by providers for the year 2021/22.

As a result of the COVID-19 NHS England directive, CQUIN monitoring was not started or delivered during 2021/22 at the Trust. Some innovation and quality improvement have continued and traditional measures such as the flu vaccination programme have been monitored and reported.

#### **5. Registration with the Care Quality Commission (CQC)**

SFHT is required to register with the Care Quality Commission (CQC) and its current registration status is fully registered without conditions or any restrictions in place. The CQC has not taken any enforcement action against SFHT during 2021/22.

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

The Trust has four locations registered including:

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

During 2021/22, SFHT has continued its support for multiple COVID-19 mass vaccination centres included within its registration

- Kirkby-in-Ashfield Vaccination Centre located at Ashfield Village
- Mansfield Vaccination Centre located at a designated location
- Newark Vaccination Centre located at Newark Showground

- 4 x Nottingham Based Vaccination Centres located at, Forest Receptions Ground, Richard Herrod Centre, Gamston Community Hall and Kings Meadow Campus

During 2021/22 the continuation of the COVID-19 pandemic caused restrictions on external regulators including the CQC. There were no on-site CQC assessments of services during this reporting period, however, SFHT have maintained a positive working virtual relationship with the CQC to maintain ratings from the 2020 visit.

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

### King's Mill Hospital

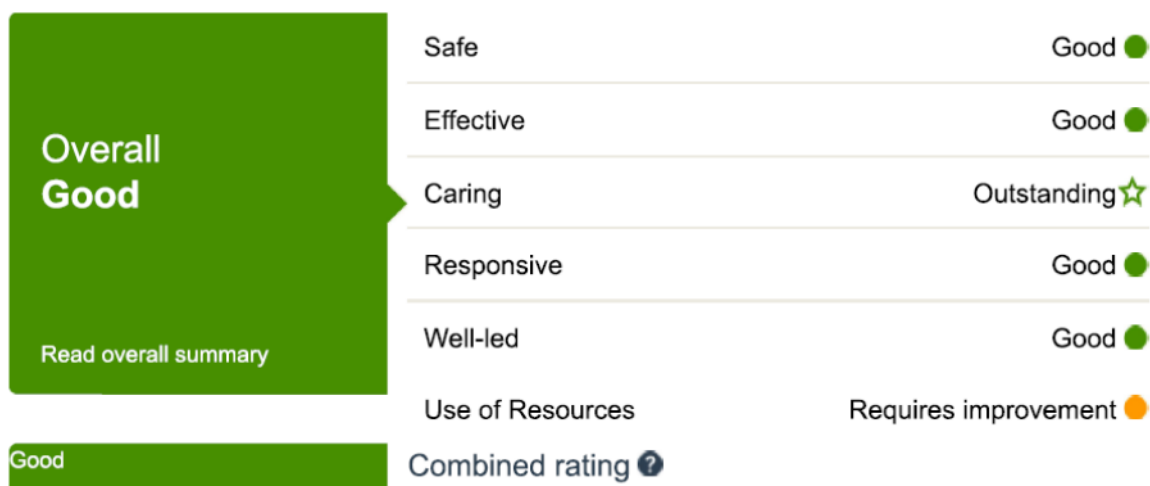
Critical Care  
Children and Young People  
Surgery and Anaesthetics

### 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 2020/21 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:

100% for admitted patient care

100% for outpatient care and

100% 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

99.2% for accident and emergency care

## **7. Information Governance**

SFHT's Data Security Protection Toolkit Assessment Report overall score for 2021/22 graded the Trust as fully compliant. The Data Security and Protection Toolkit for 2021/22 included **111** items: out of **111** mandatory evidence items meet the standards that were required.

### **Data security aims for 2022/23**

The Data Security and Protection Toolkit will encompass Cyber Essentials PLUS certification which is a rigorous test of the Trusts 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 (SFHT 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 2021/22, the Trust reported one data security serious incident, reported on the Data Security Protection Toolkit. The incident involved data integrity being compromised.

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

## **8. Clinical Coding Audit**

SFHT was not subject to the Payment by Results (PbR) Clinical Coding audit during 2021/22 normally undertaken by the Audit Commission.

The Trust has a dedicated team of qualified and trainee clinical coders that are responsible for coding approximately 123,341 inpatient episodes for 2021/22. 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 2021/22**

- 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 Secondary Users Service (SUS) Submission Data Report*

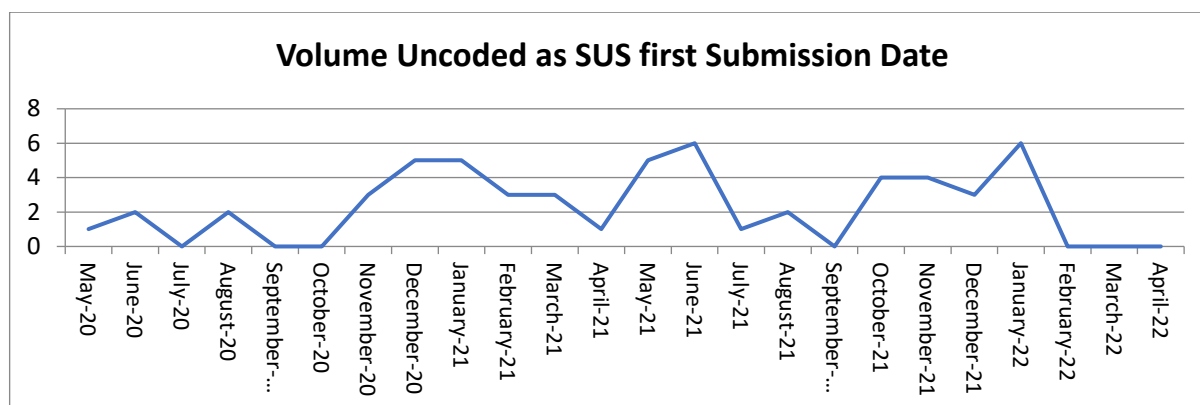
FCE Month	1st SUS Submission date	Total Number of Episodes	Volume Uncoded as SUS first Submission Date Actual & Trajectory	Actual Uncoded %	% Total Uncoded Trajectory	% Coded at 1st Submission
April-19	17/05/2019	9385	2	0.02%	2.0%	100.0%
May-19	17/06/2019	10044	3	0.03%	2.0%	100.0%
June-19	15/07/2019	9326	3	0.03%	2.0%	100.0%
July-19	19/08/2019	10357	2	0.02%	2.0%	100.0%
August-19	27/09/2019	9676	1	0.01%	2.0%	100.0%
September-19	15/10/2019	9761	2	0.02%	2.0%	100.0%
October-19	15/11/2019	10725	1	0.01%	2.0%	100.0%
November-19	13/12/2019	10422	1	0.01%	2.0%	100.0%
December-19	16/01/2020	10124	3	0.03%	2.0%	100.0%
January-20	14/02/2020	11175	3	0.03%	2.0%	100.0%
February-20	19/03/2020	10014	12	0.12%	2.0%	99.9%
March-20	17/04/2020	8796	0	0.00%	2.0%	100.0%
April-20	18/05/2020	4885	0	0.00%	2.0%	100.0%
May-20	15/06/2020	5860	1	0.02%	2.0%	100.0%
June-20	15/07/2020	6929	2	0.03%	2.0%	100.0%
July-20	17/08/2020	8109	0	0.00%	2.0%	100.0%
August-20	16/09/2020	8356	2	0.02%	2.0%	100.0%
September-20	16/10/2020	8860	0	0.00%	2.0%	100.0%

October-20	17/11/2020	8946	0	0.00%	2.0%	100.0%
November-20	17/12/2020	8684	3	0.03%	2.0%	100.0%
December-20	20/01/2021	8469	5	0.06%	2.0%	99.9%
January-21	15/02/2021	8320	5	0.06%	2.0%	99.9%
February-21	12/03/2021	8298	3	0.04%	2.0%	100.0%
March-21	20/04/2021	9416	3	0.03%	2.0%	100.0%
April-21	20/05/2021	9967	1	0.01%	2.0%	100.0%
May-21	17/06/2021	9581	5	0.05%	2.0%	99.9%
June-21	19/07/2021	9134	6	0.07%	2.0%	99.9%
July-21	18/08/2021	9857	1	0.01%	2.0%	100.0%
August-21	17/09/2021	10232	2	0.02%	2.0%	100.0%
September-21	19/10/2021	10335	0	0.00%	2.0%	100.0%
October-21	17/11/2021	9840	4	0.04%	2.0%	100.0%
November-21	16/12/2021	10114	4	0.04%	2.0%	100.0%
December-21	20/01/2022	10117	3	0.03%	2.0%	100.0%
January-22	17/02/2022	10211	6	0.06%	2.0%	99.9%
February-22	17/03/2022	9369	0	0.00%	2.0%	100.0%
March-22	21/04/2022	10373	0	0.00%	2.0%	100.0%
April-22	19/05/2022	9454	0	0.00%	2.0%	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 5) 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 5



## 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 number of experienced staff leaving, the Trust was unable to carry out regular missing comorbidity and individual clinical coder's work audit. However, the limited number audits that were conducted generated an income of **£288,982**. See Table 2 for the details of income generation. Any audit that was conducted in the financial year was followed by 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.

Table 2

Total value by source file												
£	Month											
Source	2	3	4	5	6	7	8	9	10	11	12	Grand Total
Clinical Coding Audit	£22,287	£16,249	£15,189	£37,657	£18,726	£39,203	£9,711	£22,390	(£460)	£2,938	£406	£184,295
Clinician Audit	£16,199	£13,528	£0	£6,911	£19,026	£20,753	£161	£5,246				£81,825
Rules Audit	£5,282	£5,082	(£110)	£1,078	£7,457	£2,052	£8	£2,051				£22,899
Deceased Review				(£37)								(£37)
<b>Grand Total</b>	<b>£43,768</b>	<b>£34,858</b>	<b>£15,079</b>	<b>£45,609</b>	<b>£45,209</b>	<b>£62,008</b>	<b>£9,880</b>	<b>£29,687</b>	<b>(£460)</b>	<b>£2,938</b>	<b>£406</b>	<b>£288,982</b>

## Data security standard One - Data quality:

As part of Data Security and Protection Toolkit, the Trust has undertaken an audit of 200 completed consultant episodes (September 2021-January 2022) to assess the accuracy of clinical coding. The Trust's coding accuracy met the required percentage across all four areas.

The table below (table 3) illustrates the clinical coding audit results compared to the recommended percentage of accuracy scores from the Terminology and Classifications Delivery Service.

Table 3

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct

<b>Standard exceeded</b>	>=95%	>=90%	>=95%	>=90%
<b>Standard met</b>	>=90%	>=80%	>=90%	>=80%
<b>Sherwood Forest Hospitals</b>	90%	91.23%	96.97%	96.95%

## Recruitment and training

The Trust has successfully recruited six trainee clinical coders to replace the six experienced coders who has left SFH due to higher pay band and opportunity for remote working in the surrounding Trust. All the coders are up to date with the mandatory training requirement set by NHS Digital.

## 9. Data quality strategy for 2020-21

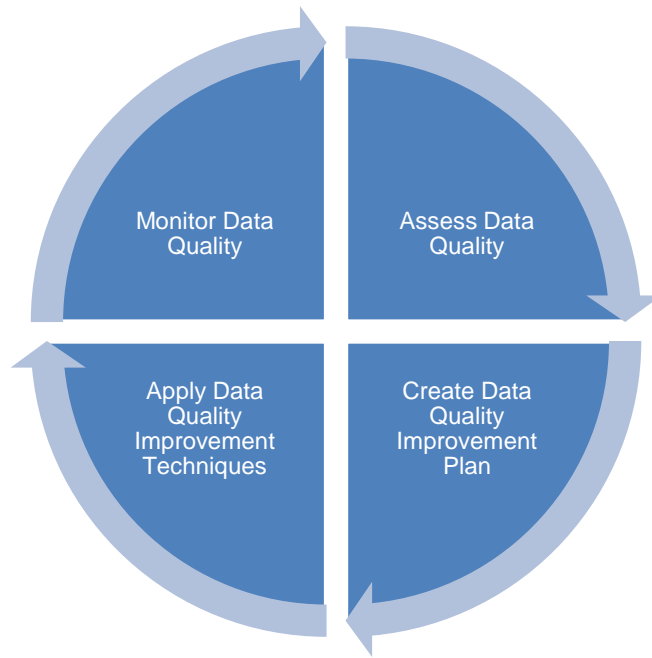
SFHT's Data Quality Strategy aims to influence and drive improvements in outcomes for patients through effective decision making by clinical, operational, and managerial staff by ensuring timely availability of accurate and high-quality information.

Shared decision making is part of the NHS Long Term Plan's commitment to make personalised care business as usual across the health and care system. Personalised care requires a whole system approach, integrating all services around the patient and recognises a positive shift to empowering patients and care professionals to make informed decisions, based on robust and trusted information. Information collected and used to enable this process must therefore support the patient care pathway.

To ensure good quality data underpins the assessment of SFHT's quality performance, we adhere to the six dimensions of data quality, each of which is fundamental in providing fit for purpose information and include: accuracy, validity, reliability, timeliness, relevance and completeness.

Through our strategy, we will promote a sense of accountability and commitment to the on-going improvement of the quality of the data amongst all staff handling and using data, and for which they are responsible for. This strategy will help to create a culture of 'getting it right first time' regardless of job role whether this be clinical, technical or administrative. This will in turn release staff time from correcting data and ensuring that patients outcomes are based on accurate information.

Our approach to improvement relies on a continual process as described below:



SFHT maintains three key behaviours in our approach to providing data quality. These are: Responsiveness, Proactivity and Continuous improvement.

SFHT will be taking the following actions to improve data quality:

### **Responsiveness**

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

- Actively validate data sets to ensure decision making is based upon accurate information
- Work with operational/clinical teams to quantify the relative risk and priorities, thus allowing informed choices on the necessary action and timescales for the Divisional Teams supported by the data quality (DQ) team to remedy identified issues.

**Addressing errors** – where data errors are identified, in addition to informing operational and clinical teams, and, 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 and that an action plan implemented.
- Obtain assurance that the appropriate actions have been taken by the Divisions to reduce or prevent repetition of the issue and that all associated actions have been closed.

### **Proactivity**

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

- Monitor levels of DQ
- Identify improvements or deterioration in DQ
- 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 DQ 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 DQ training programmes for all members of staff in line with the Elective Care Training Strategy. In addition, we will provide targeted training in response to themes or repeated errors, as identified through audit, reporting or 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 in line with the action plan

### **Data Quality training**

The Trust continues to review all system based and operational DQ training materials, including 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.

Careflow is the Patient Administration System (PAS) used by SFHT. Training is delivered by Nottinghamshire Health Informatics Service (NHIS) trainers and is a prerequisite to obtaining access to SFHT PAS system. SFHT continue to deliver a comprehensive training plan for both DQ and elective care.

SFHT will be taking the following actions to improve DQ training:

- Further develop a suite of non-face-to-face electronic solutions to support the delivery of the Elective Care Training Plan, considering social distancing constraints, both during and post the COVID-19 pandemic and to support home and distanced working.

### **Data Quality improvement KPIs**

SFHT 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
- Careflow PAS maintenance and generic DQ

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

### **Data quality internal audit programme**

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

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

- Continuing to keep SFHT 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 2022

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

The Trusts' average total DQMI score is 89.2%.

The percentage of records in the published data which included the patient's valid NHS number (as at Dec 2021)		
Admitted Patient Care	Outpatient Activity	Accident and Emergency Care
99.9%	100%	98.%

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%	98.9%

The Trust submitted records during 2021/22 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%

## 10. Improving Care and Learning from Deaths

During 2020/21 1,782 of SFHT patients 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 31<sup>st</sup> March 2021, 1,145 case record reviews and 25 investigations had been carried out in relation to 1,782 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 a review of the structured case reports during the Covid waves, we have begun to instigate a data and quality improvement process, aimed at strengthening a consistent 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, in 2019, SFHT implemented the national ReSPECT Tool, and this has now been rolled out across all providers within Notts Integrated Care system (ICS). Clinical teams have been trained in the appropriate usage and 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. Utilisation of the ReSPECT form and the appropriateness of the decision-making has been audited throughout 2020/21 in order to identify areas of good practice and where any further support and training may be required.

SFHT has continued to support and develop the Medical Examiner (ME) Service. The ME provides independent scrutiny of 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 days prior to death may have identified as failing and whether this contributed to the death or not. The ME also provides support, advice and guidance to the trainee medical staff to ensure accurate completion of the Medical Certificate on the cause of death. As SFHT moves into 2022/23, there have been further actions developed to improve the learning from deaths process. They include:

- Increasing the number of ME's recruited by SFHT and Notts ICS to support roll out of the community ME service
- Wider Structured Judgment Review (SJR) training and process development to enhance consistency and quality of learning outputs

## **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 and acuity 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 from SFHT. 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 4) illustrates SFHT's SHMI banding as being consistently recorded as a two, indicating 'as expected' levels of mortality.

*Table 4*

Year	SFHT SHMI Value	SFHT SHMI Banding	National Average	Highest Performer	Lowest Performer	SHMI banding - Worst	SHMI banding - Best
<b>Oct 16 – Sep 17</b>	101.62	2	100.5	72.7	124.73	1	3
<b>Jul 17 – Jun 18</b>	97.72	2	100.35	68.92	125.72	1	3
<b>Oct 17 – Sep 18</b>	96.72	2	100.3	69.17	126.81	1	3
<b>Jul 18 – Jun 19</b>	93.80	2	100	69.89	119.11	1	3
<b>Oct 18 – Sep 19</b>	94.7	2	100	69.79	118.77	1	3
<b>Jul 19 – Jun 20</b>	96.75	2	100	67.64	120.74	1	3
<b>Oct 19 – Sep 20</b>	97.72	2	100	68.69	117.95	1	3
<b>Sep 20 - Aug 21</b>	98.09	2	100	79.30	119.10	1	3

### Percentage of Patient Deaths Coded as Palliative Care

SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care 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 5) 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 5*

Trend (financial year)	Non-elective spells	Palliative care	Rate	National Rate
2017/2018	36,286	441	1.22%	2.00%
2018/2019	51,008	523	1.03%	2.07%

2019/2020	55,008	345	0.63%	2.18%
2020/2021	49,814	371	0.74%	2.60%
2021/2022	29,286	237	0.81%	2.12%

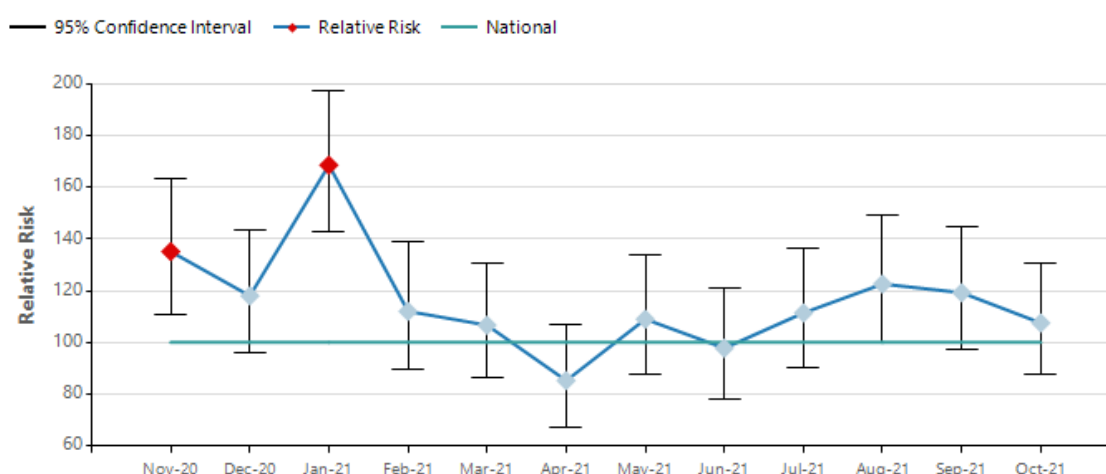
## Hospital standardised mortality rate (HSMR)

HSMR uses risk modelling to compare the number of expected deaths per month against actual deaths within SFHT. HSMR's are calculated using Hospital Episode Statistics provided by SFHT with analysis in the Healthcare Intelligence Portal tool, SFHT HSMR score is produced by Dr Foster Intelligence.

Graph 6 displays SFHT's HSMR for all inpatient admissions for 12 months from November 2020 to October 2021.

Graph 6

Diagnoses - HSMR | Mortality (in-hospital) | Nov 2020 - Oct 2021 | Trend (month)



SFHT HSMR is elevated though decreasing from January 2021. 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)

SFHT considers that this data is as described for the following reasons.

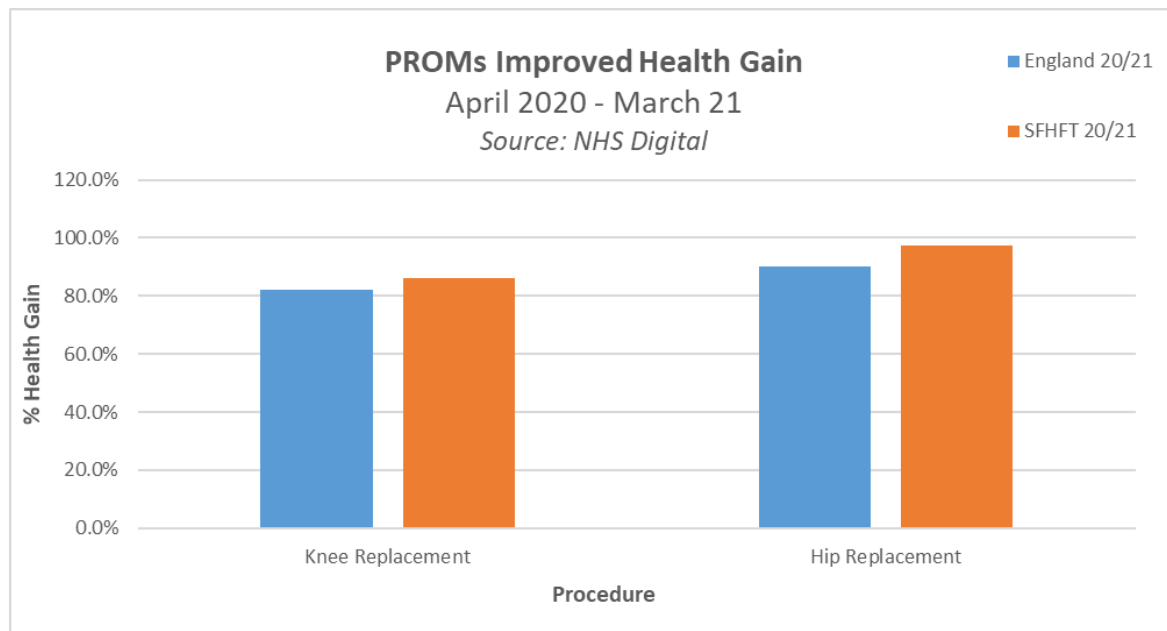
PROMs (data made available by NHS Digital), measures health gain in patients undergoing hip and knee replacement surgery in England, based on responses to questionnaires before and after surgery. This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected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

Graph 7 shows how SFHT compares to the England average for measuring generic health status. This is one of the most commonly used generic health status measurements and has high levels of validity and reliability reported in a variety of health conditions.

## Improved health gains – April 2020 – March 2021

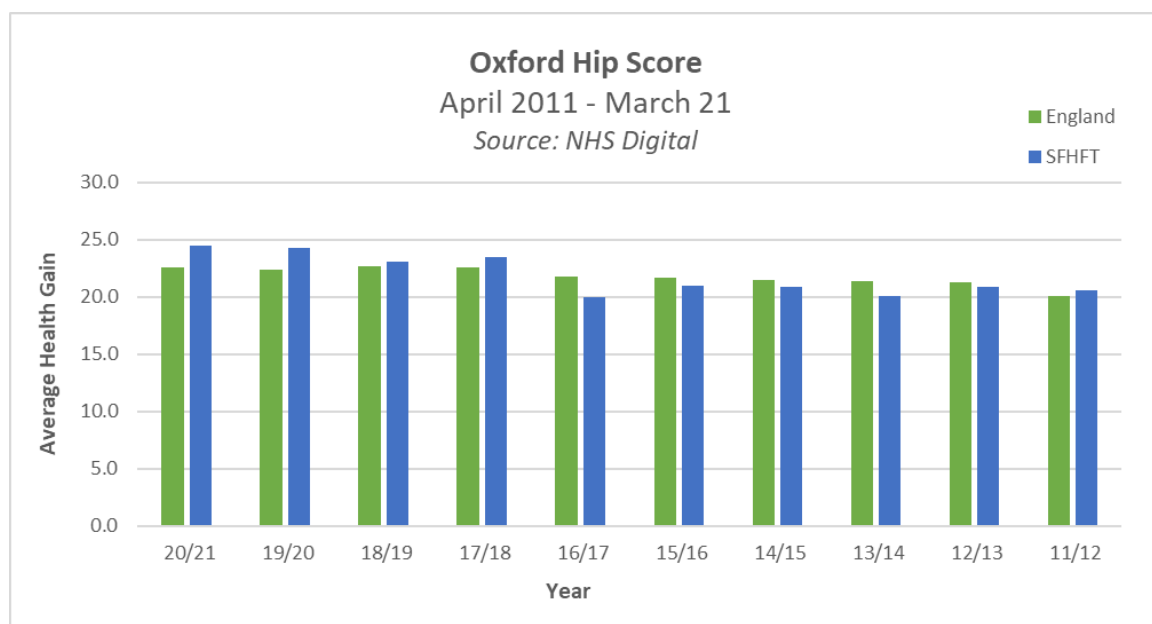
In response to the 2021/22 results, SFHT's pre-operative assessment department are currently working with local councils to develop strategies to ensure patients are optimised and in their best health prior to surgery. This includes programmes to improve our patients' general health prior to undergoing surgery, through smoking cessation and gym memberships.

Graph 7

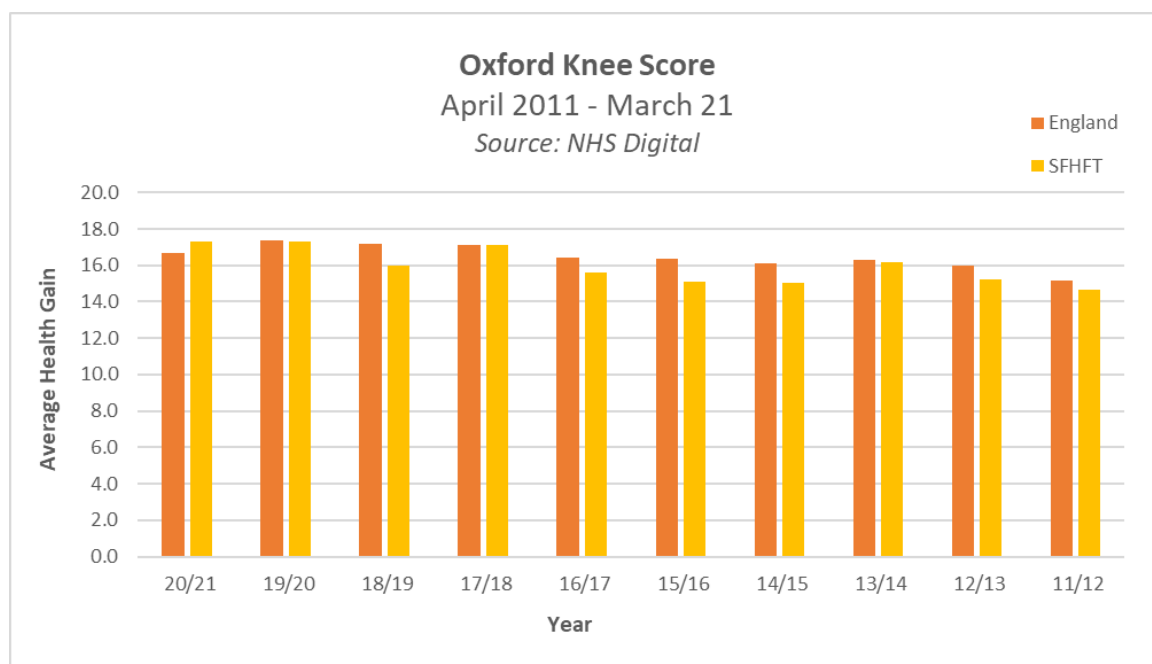


The graphs below (graph 8 and graph 9 ) show the Oxford Scores for hip and knee replacements. The Oxford score is a patient-reported outcome instrument. It includes questions on activities of daily living that assess function and residual pain in patients' specifically undergoing total hip or total knee replacements.

Graph 8



Graph 9



SFHT continue to show improvements in these scores and are working in collaboration with our Clinical Commissioning Group to enhance and further develop our Musculoskeletal (MSK) pathways. In September 2020, SFHT 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 operations being cancelled. 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 hip replacements at SFHT have seen the greatest improvement in daily living when benchmarked against other acute sector providers within the Midlands.

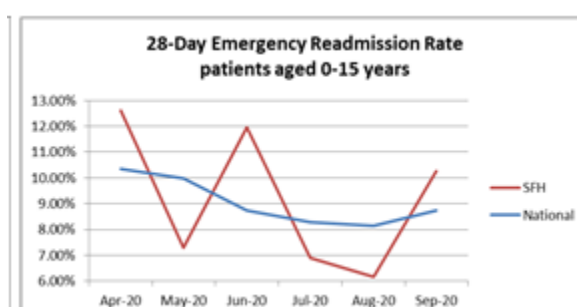
### 3. Percentage of patients readmitted to hospital within 28 days

In April 2020 – September 2020 (graph 10):

- 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 10

Data Source: Dr Foster



#### 4. Trust Responsiveness to the Personal Needs of Patients

SFHT 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.

SFHT 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.

The formal complaint management process was paused during January 2022 in recognition of the unprecedented pressure on the Trust in terms of capacity and staffing issues caused by the Omicron Covid variant. This allowed clinical 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 on 1<sup>st</sup> February 2022.

During 2021/22 we received 325 complaints, demonstrating a 27% increase compared to 2020/21. Of these, 37% were completed within 25 working days or locally agreed timescales with the complainant.

While performance against the 25-working day standard was reduced, all complainants were kept updated on the progress of their complaint and a personal written apology was provided to all complainants. The Complaints Team have been through a challenging time recently. This is making it increasingly difficult to meet the current 25-day complaint response timeframe set by SFH.

It has been recognised that the blanket 25-day timescale for completion for all complaint responses, regardless of complexity, is no longer achievable with the current resource available. A new 'menu' of timescales has just been approved by the Trust Executive team which will allow the Complaints Team to triage the complaints and allocate a more realistic completion timescale. It also means that complainants will be advised of a more realistic expected response date and so reducing the frustration often felt by complainants when responses are overdue.

The table below (table 6) shows the revised complaint timescales according to the severity of the concerns raised.

*Table 6: Complaint timescales according to the severity of the concerns raised:*

Category & PET Timescale	Criteria – Severity of concerns raised/cross division concerns	Division Timescale
Complex/ Multiple Divisions and Specialties/legal involvement.  <b>60 working Days</b>	Complaint involves numerous issues across multiple Specialties/ Divisions/Organisations or is significantly complex involving multiple issues/treatment pathways. May be legal involvement and or	<b>30 working days</b>

	incident/safeguarding involvement	
Complicated/Cross two Divisions/more than one specialty in Divisions  <b>40 working days</b>	More than one Division and multiple specialties involved. Multiple clinicians required to provide responses.	<b>20 working days</b>
Moderately complex/More than one specialty involvement  <b>30 working days</b>	The issues raised relate to more than one specialty however minimal concerns/generally straight forward	<b>15 working days</b>
Standard – Only a few concerns relating to one division/specialty  <b>25 working days</b>	The complaint involves issues contained within one specialty/Division and is considered straight forward with minimal concerns	<b>10 working days</b>

The divisions receiving the highest number of complaints were Emergency Medicine (68), Covid Vaccination Programme (31) Trauma and Orthopaedics (29), Acute Medicine (22), Geriatrics (22). The Covid Vaccination Programme and Geriatrics had not previously featured in the top five reported specialties (graph 11)

There are no patterns to receipt of the complaints, most related to episodes of care provided during 2021/22.

The top five themes of complaints for 2021/22 remained largely the same as the previous year with complaints about the attitude of doctors replacing complaints about communication by doctors (table 7):

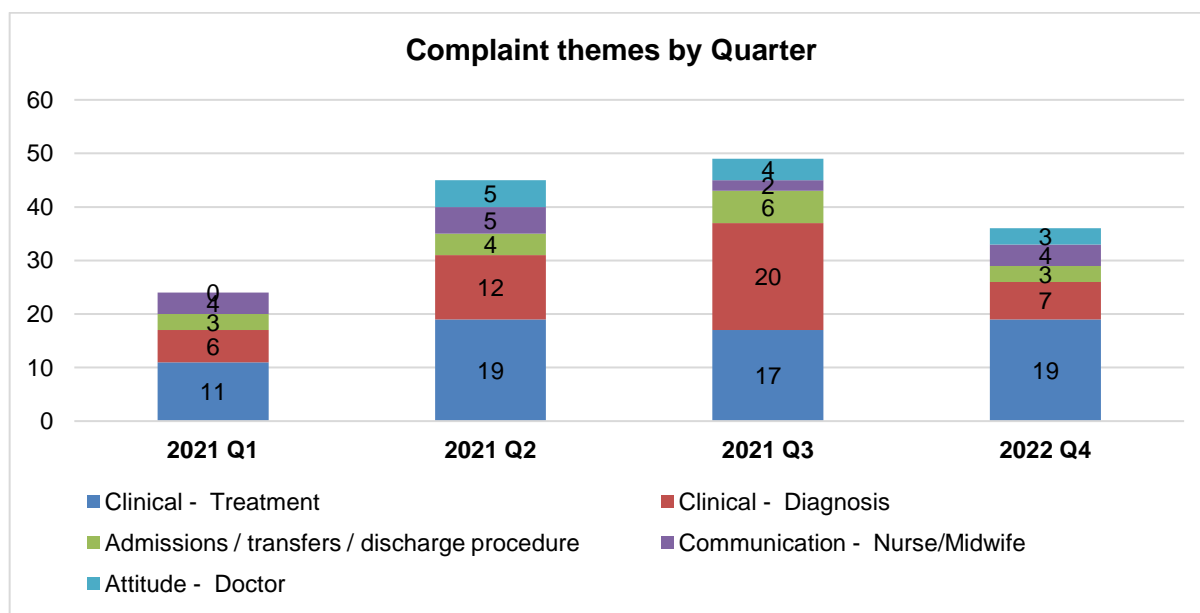
*Table 7: Top five themes for complaints 2020/21 and 2021/22*

	2020/21	2021/22
<b>1</b>	Clinical Diagnosis	Clinical Treatment
<b>2</b>	Clinical Treatment	Clinical Diagnosis
<b>3</b>	Communication – Nurse/Midwife	Admissions / transfers / discharge procedure
<b>4</b>	Admissions / transfers / discharge procedure	Communication – Nurse/Midwife
<b>5</b>	Communication – Doctor	Attitude – Doctor

Clinical treatment and clinical diagnosis continue to be the most frequently reported subjects of dissatisfaction. Themes relating to poor communication from nursing remain within the top five this year, along with admissions/transfers/discharge procedures. Complaints about communication by doctors has been replaced in the top five themes by complaints about the attitude of doctors during this reporting

period. These complaints have been triangulated, to ensure safeguarding and patient safety issues and concerns are escalated and managed via the appropriate routes, and to further analyse for themes and trends for escalation to the relevant divisions.

*Graph 11: Top 5 Themes – Complaints by Division*



Of the complaints responded to within 2021/22, 53% were upheld/partially upheld, which shows a slight decrease of 2% with previous year. This has provided an opportunity for learning and service improvements. One complainant withdrew their complaint following initial investigation and discussions with the patient; a local resolution was achieved.

A total of 45 complaints were re-opened in 2021/22 as it was identified the complainant had raised new concerns. This demonstrates a 221% increase of reopened complaints from 2020/21. All requests are formally responded to, reiterating the options relating to the next steps, which include Public Health Service Ombudsman (PHSO), independent advocate and access to medical records procedure. Upon reviewing the reopened complaints, no common themes to indicate why complainants remain dissatisfied have been identified. There have been no changes to the complaints process or the format in which we respond to complainants that would account for the increase.

The PHSO decided to investigate two new complaints between 2021/22, with a total of 5 cases under on-going investigation.

The Patient Experience Team pre-empt that there will be a significant increase in correspondence from the PHSO during 2022/23 as a result of their own backlog due to suspending their investigations in 2020/21 as a result of the COVID-19 pandemic.

The PHSO have also clarified more recently that in the instance a complainant escalates their concerns for review, they are now encouraging as part of the pilot for the 'NHS Complaints Standards' that even in instances where the complaint is not upheld, that the Divisional Patient Experience Leads from the Trust, along with the support of the PHSO, facilitate an opportunity for the patient and/or family to have a face to face discussion with the clinical teams, where previous responses from the Trust have not been successful in providing resolution/clarification of concerns.

The table below (table 8) provides details of the cases investigated by the PHSO.

*Table 8: Cases decided by the PHSO which were upheld or partially upheld*

ID	Division/ Specialty	Subject	PHSO Open Date	PHSO Outcome	Date PHSO Closed	Learning from PHSO
34641	Medicine – Cardiology / Stroke /Geriatrics	Clinical – Treatment	27.02.20	Partially Upheld	09.06.21	Following investigation, the PHSO have concluded that the complaint was not thoroughly addressed. A written apology has been sent to the patient acknowledging the additional distress caused.
28699	Medicine – Ward 42	Communication	31.03.19	Partially Upheld	28.05.21	The PHSO found failings in the complaint handling detailing that the family were not afforded adequate time to prepare for an LRM after raising their concerns and felt the Trust should have made further efforts to achieve local resolution. A written apology has been sent to the patient for the upset this caused.

## 5. Staff Friends and Family responses and recommendation rates

### The NHS Staff Survey

In 2021 the Trust engaged staff in its annual staff survey through a mixed mode approach of electronic and paper surveys. The response rate to the 2021 survey was 66.4% compared to 61.1% in 2020. National results demonstrate a deterioration in the comparator group. This is thought to be a result of staff experience in the COVID-19.

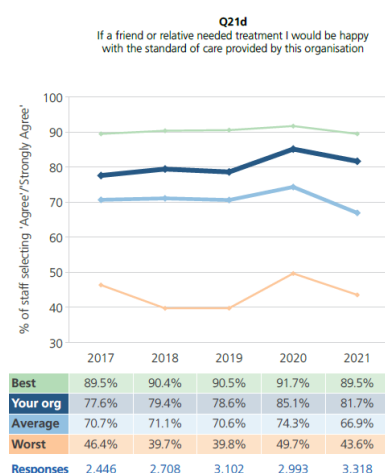
For the fourth year SFHT scored the highest for engagement in the Midlands and is reported to be the best acute trust to work at in the Midlands. Nationally it is rated the third best acute or acute/community Trust in England. Our Equality Diversity Inclusivity (EDI) analysis is trending higher than comparators.

SFHT sits very favourably against other comparator organisations but has itself declined in 42 scores out of 65 comparable questions from last year (there have been a number of changes to questions in 2021 and therefore not all questions can be compared). A strong people recovery plan is required alongside service recovery in 2022/23.

- Despite the challenges of the past year, 74.8% of colleagues would strongly recommend the organisation as a place to work (59.4% national comparator)
- Colleagues feel more valued than the national average for our peer group. Our National Staff Survey score was nearly 10% above national average
- Colleagues want to stay at this Trust reporting being supported and have opportunity to develop (10% higher than the national comparator)

The graphs below (graphs 12 a,b,c) summarise SFHT 2021 staff survey results.

Graph 12a



Graph 12b



Graph 12c



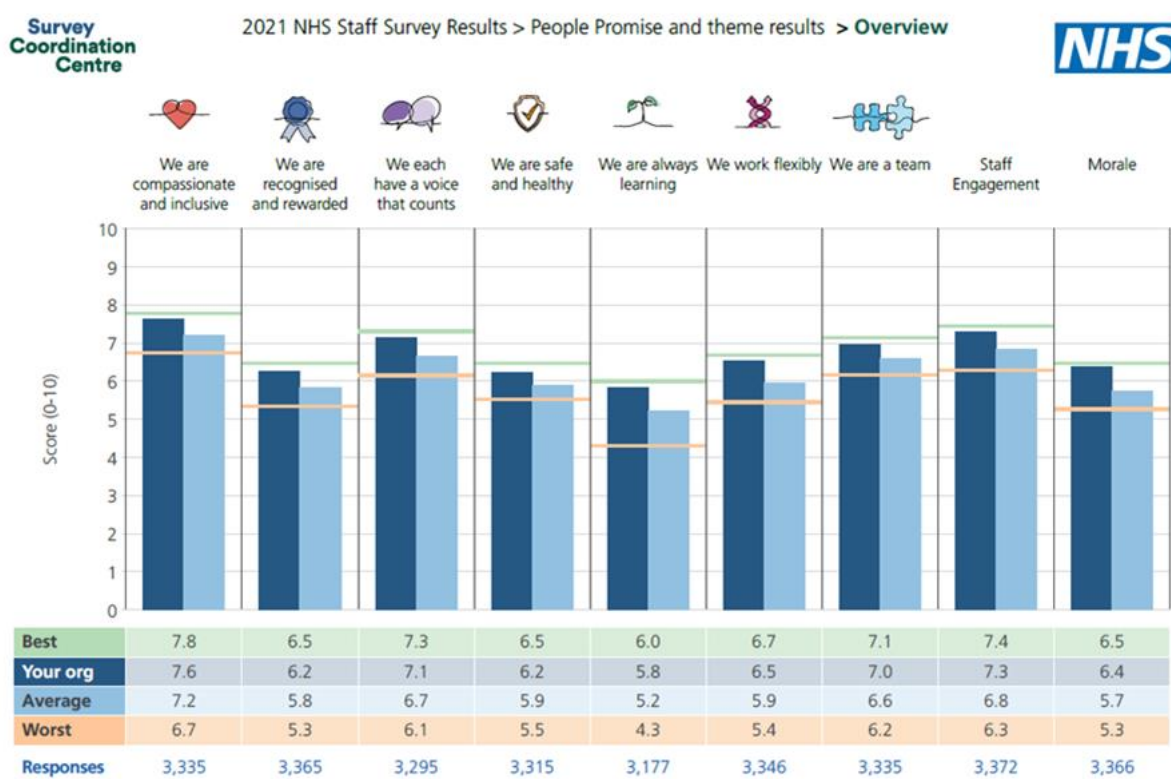
The table below (table 9) gives an overview of the key staff survey themes at a Midlands and national level against the national people promise elements, showing how SFHT has been ranked. SFHT scored in the top two trusts in the Midlands region for all domains and in the top quartile nationally.

Table 9

Indicators ('People Promise' elements and themes)	Trust Score	Benchmarking Group Score		
People Promise	Score	Score	Regional Position	National Position
We are compassionate and inclusive	7.6	7.2	2 <sup>nd</sup>	4 <sup>th</sup>
We are recognised and rewarded	6.2	5.8	2 <sup>nd</sup>	4 <sup>th</sup>
We each have a voice that counts	7.1	6.7	Joint 1 <sup>st</sup>	3 <sup>rd</sup>
We are safe and healthy	6.2	5.9	Joint 1 <sup>st</sup>	3 <sup>rd</sup>
We are always learning	5.8	5.2	2 <sup>nd</sup>	3 <sup>rd</sup>
We work flexibly	6.5	5.9	Joint 1 <sup>st</sup>	3 <sup>rd</sup>
We are a team	7.0	6.6	Joint 1 <sup>st</sup>	4 <sup>th</sup>
Staff Engagement	7.3	6.8	1 <sup>st</sup>	4 <sup>th</sup>
Morale	6.4	5.7	1 <sup>st</sup>	2 <sup>nd</sup>

Below (graph 13) are the nine key indicator themes from the 2021 Trust Staff Survey aligned to the national NHS People Promise. SFHT sit above national average for their comparator peer group in all 9 themes and are within 0.2 points off the highest achieving organisation in 7 out of these 9 themes.

Graph 13



## National Staff Survey actions and monitoring

The results are to be communicated to colleagues in a variety of formats including electronic and face-to-face briefings. The positive results will feature in our recruitment campaigns.

The reports were analysed including scrutiny of comments captured as free text as these provide further context. Analysis was undertaken by staff groups, divisions, departments, and across all hospital locations. Our Culture and Improvement Cabinet will maintain oversight of SFHT action plans, with regular updates to the Trust, People, Culture and Improvement Committee. Results are triangulated with other data sources such as the quarterly pulse surveys, workforce KPIs and freedom to speak up concerns.

All divisions receive copies of their results and the free text comments. Engagement sessions with triumvirate leadership teams allow them to identify any support they feel would help improve culture. This will allow them to develop action plans pertinent to local circumstance.

The EDI elements will be scrutinised by our staff networks and overarching and reported through the People and Inclusion Committee. They will monitor the performance programme. Performance and activity is reviewed and aligned with key priorities and requirements under the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Equality Delivery System (EDS).

There will be SFHT wide initiatives for incorporation into the People, Culture and Improvement Strategy 2022/23 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.

### **Areas for development for 2022/23**

- Build on what has been achieved and continue to support the post COVID-19 recovery
- Reduce variation of colleague experience and closer partnership working through our staff networks
- Better understanding of the experiences of colleagues who identify as having a protected characteristic with dedicated actions in place to improve their experience at SFHFT.
- Focus on further improvements in how we treat each other
- Reduce staff experience of bullying and harassment from managers, peers, patients, and the public.
- Targeted staff engagement to understand experiences of those reporting physical violence
- Better understand why colleagues need to 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 from our executive and senior leadership teams, particularly across the Newark and Mansfield sites of the Trust
- Further develop our talent management to support succession planning.
- Specific programmes to be developed around fairness and equity in the recruitment process
- Better inform staff about cultural improvements made at a local level through the development of a new active staff engagement 'Culture Collaborative' model, and our 'You Said, Together We Did' campaign
- Focus and develop our people and improvement coaches to better support colleagues in an inclusive and compassionate manner.
- Continually evaluate and improve the wellbeing and resilience offer for colleagues

## **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.

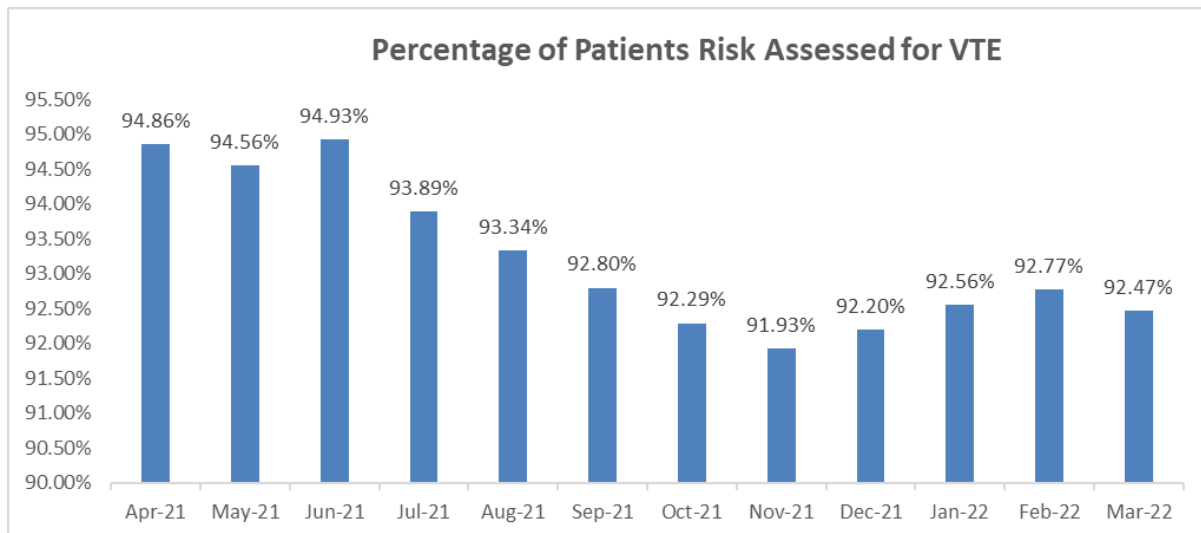
The Trust considers that this data is as described for the following reasons:

- 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 and has not yet re-started. However, SFHT 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. Despite the manual process reverting back to pre-Covid practice in April 2021, it can be seen that 95% compliance has not been achieved. Data is not yet

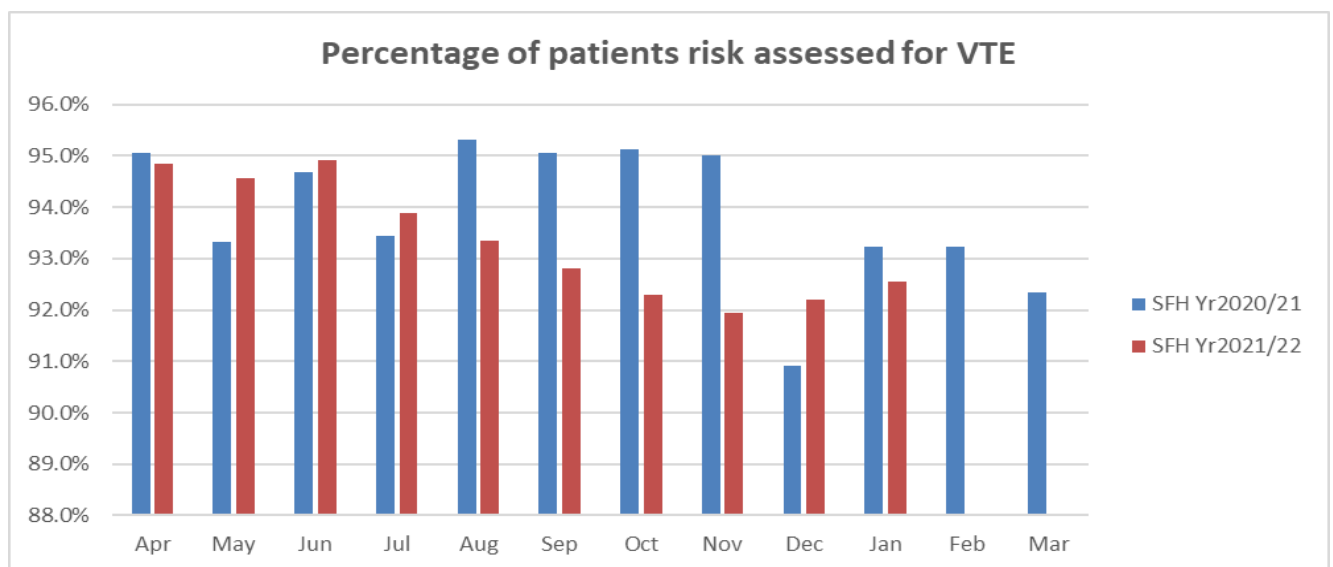
available for February and March 2022. The roll out of an electronic, mandatory VTE screening tool is anticipated from April 2022 alongside the roll out of electronic prescribing.

- The Trust can report there has been one hospital acquired deep vein thrombosis incident identified during this period. The investigation is on-going. There are 20 investigations ongoing pertaining to this time period.

Graph 14



Graph 15



National performance figures are no longer collected.

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

- The implementation and roll out of Electronic Prescribing and Medicine Administration (EPMA) and electronic VTE screening commenced April 2022 in Urgent and Emergency Care and Medicine divisions. Roll out in Surgery Division is planned for autumn 2022. Until electronic

VTE screening roll out is complete across all inpatient areas in the Trust, a manual check of patient notes for completed VTE risk assessments will continue in applicable areas.

- 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.

## 7. Clostridium Difficile infections

Clostridioides Difficile infection (CDiff) is acknowledged as an issue that impacts upon the whole health economy. There continues to be partnership approach to this across the Health Economy. The definition of an SFHT acquired case changed in 2019/20 and SFHT is now responsible for any case identified more than 2 days after admission and any case where the patient has been an inpatient at SFHT within the preceding four weeks, known as Community Onset Hospital Associated (COHA). 2022 trajectory has been set at 57.

The Trust aims for 2021/22 are outlined below:

To conduct root cause analysis on each case to identify common themes across the organisation and within the whole healthcare economy.

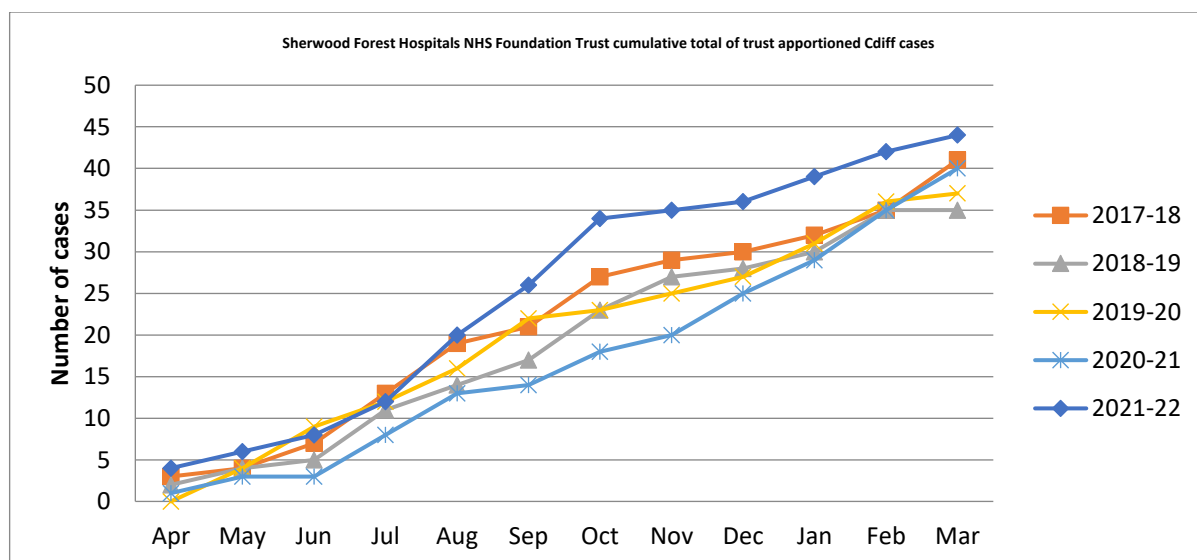
To share relevant learning between divisions in the Trust and with the local infection prevention teams.

To ensure that the Trust attributable cases in the reporting period remain below 57.

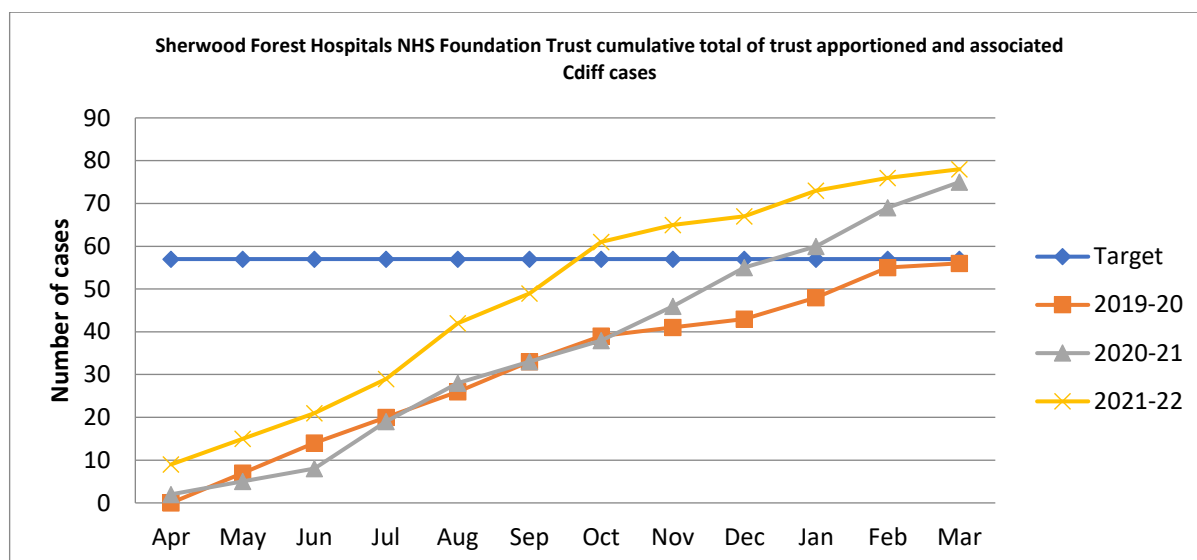
### How was this achieved?

In 2021/22 the numbers of cases identified as post two days of admission were 44, this does not include the COHAs. The total number of cases identified including the COHAs is 78. A rise in numbers was identified during April and is displayed in the graphs (graphs 16 and 17) below.

Graph 16



Graph 17



A root cause analysis of all cases was performed to establish any common themes, but no link could be established to identify any cross transmission. Lapses of care were monitored for all cases and these included delays in obtaining samples and a small number of antibiotic 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 and is closely monitored by the Infection Prevention & Control Team (IPCT).

SFHT have taken the following action to reduce the number of *CDiff* cases and improve the quality of its services by focusing further on *CDiff* management and implementing the interventions outlined below:

- 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 have been developed to share learning across the organization
- The trust invited NHSE/I, UKHSA and CCG colleagues to come and conduct a peer review.
- Re-introduction of the deep clean program, without the ward move.
- Introduction of a bed decontamination services
- Introduction of an Executive led *CDiff* meeting
- Introduction of regular UV cleaning of toilets
- Introduction of a system wide *CDiff* meeting

#### **Education and training:**

- All educational programmes highlight the importance of preventing primary infections to avoid increased use of unnecessary antibiotics.
- Regular information is provided to all divisional, specialty governance forums.
- Information is given to staff, patients, and visitors as part of an infection prevention and control campaign

- Ensuring all patients receive information leaflets with regards to their infection.
- A CDiff action plan has been generated and is monitored at the Infection Prevention and Control Committee.

#### **Peer review outcome:**

Following the peer review, there were no identified areas of major concern. Some issues were identified with PPE usage, storage and cleaning, these were things as an organisation we were aware of and have put actions in place. The peer review team will repeat the visit in May 2022.

#### **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 organisation, ensuring all staff are aware of their responsibilities. We are currently working on implement the new National Standards of Cleanliness.

#### **Auditing**

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

#### **Monitoring and reporting**

All cases of *CDiff* infections within the Trust are reported to United Kingdom Health Security Agency (UKHSA). These have been reported within both internal 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 2022/23 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 an annual report which provides information on the quantity and types of reported incidents, comparing the organisation with other non-specialist acute trusts.

During the reporting period the design and frequency of NRLS reports has changed from bi-annual to annual in preparation for the launch of Learning from Patient Safety Events (LFPSE). When launched this will replace NRLS. There is no longer any analysis to indicate how well a Trust is reporting. The data is delayed and the most up to date data is detailed in the table below.

The table below (table 10) shows the comparative level of patient safety incident reporting within the Trust compared with other non-specialist acute providers.

Table 10

	Sherwood Forest Hospital Trust			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
1 <sup>st</sup> Oct 2015 – 31 <sup>st</sup> March 2016	3,687	3,657	34.63	39.31
1 <sup>st</sup> April 2016– 30 <sup>th</sup> Sept 2016	3,397	3,339	32.82	40.02
1 <sup>st</sup> Oct 2016 – 31 <sup>st</sup> March 2017	3,581	3,507	33.51	40.14
1 <sup>st</sup> April 2017 – 30 <sup>th</sup> Sept 2017	3,277	3,180	34.09	Report indicates 'No evidence for potential under reporting'
1 <sup>st</sup> Oct 2017 – 31 <sup>st</sup> March 2018	3,563	3,406	32.64	Report indicates 'No evidence for potential under reporting'
1 <sup>st</sup> April 2018– 30 <sup>th</sup> Sept 2018	3,904	3,739	37.76	Report indicates 'No evidence for potential under reporting'
1 <sup>st</sup> Oct 2018 – 30 <sup>th</sup> March 2019	4,160	4,068	39.8	Report indicates 'No evidence for potential under reporting'
1 <sup>st</sup> April 2019 – 30 <sup>th</sup> Sept 2019	4,190	4,083	40.82	Report indicates 'No evidence for potential under reporting'
1 <sup>st</sup> Oct 2019 – 31 <sup>st</sup> March 2020	4,457	4,388	44.58	Report indicates 'No evidence for potential under reporting'

	<b>Sherwood Forest Hospital Trust</b>			<b>All non-specialist acute providers</b>
<b>Period</b>	<b>Number of incidents uploaded to NRLS from the Trust</b>	<b>Number of incidents reported by NRLS</b>	<b>Rate per 1,000 bed days, reported by NRLS</b>	<b>Median average rate per 1,000 bed days</b>
<b>1<sup>st</sup> April 2020 – 31<sup>st</sup> March 2021</b>	8,040	7,387	47.2	Data extracted from NRLS organisational data workbook

### Level of patient safety reporting

From the 1 April 2021 to 31 March 2022 the Trust declared a total of 30 Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the 28 incidents, five 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 13 in 2020/21 to 28 in 2021/22. This increase is in large part due to the requirement from March 2021 to report and investigate all Nosocomial COVID-19 deaths as Serious Incidents. During this reporting periods there have been 10 such incidents reported on StEIS.

Excluding the Nosocomial Covid Deaths the most commonly reported categories are 'delay in diagnosis' and 'suboptimal care'. Of the 30 investigations for 2020/21, 13 have been submitted to the CCG within agreed timeframes with extensions where required and 17 are still under investigation.

Identifying and disseminating the learning arising from incidents in order to improve patient safety remains a key priority. During this reporting period, in response to the number of wrong blood in tube incidents, phlebotomy style trollies have been rolled out across the wards and fitted with computers and label printers to enable bedside printing and labelling. Staff were consulted and the trollies have been named ICE trollies and the messaging around them extended to include all sampling and not just bloods. The number of wrong blood in tube incidents demonstrates a steady downward trend. A Trust learning event was delivered in September 2021 with a theme of positive patient identification. Work is now underway to convert this to an e-learning module to widen the access. The Medical Director has introduced regular Sherwood Interactive Multi-Professional Learning Event (SIMPLE) events to promote Trust wide MDT learning from incident investigations.

The Trust is currently working towards the roll out of the new DATIX DCIQ 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. The roll out has been delayed slightly due to the impact of the Covid -19 pandemic, the associated capacity issues and focus on patient care.

### 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. The table below (table 11) details the number of duty of candour qualifying incidents:

Table 11

Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total for 2021/22
1. Number of Qualifying Incidents	1	3	3	2	7	4	2	2	5	5			34
2. Confirmation of Notification complete	1	3	2	2	6	4	2	2	4	5			31 (91%)

During this reporting period it has been identified that three formal duty of candour letters were sent to patients/families outside of the expected ten-day time frame. This delay occurred in the Women's & Children's, Urgent and Emergency Care and Surgery Divisions being eight, one and ten days late respectively. In all these cases verbal duty of candour had been given in a timely manner, it was the follow up letter that had been delayed.

## 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 SFHT, patient safety culture has been identified as an organisational priority, and work continues to support and progress this agenda. This is demonstrated by continued investment in 2022 to fund an evidence-based safety attitude questionnaire to build on the work highlighted within this section.

### PASCAL patient safety culture surveys undertaken 2016 - 2022

PASCAL are a global leader in developing evidence-based safety attitude questionnaires that measure performance against key indicators of safety culture. These have been used at SFHT since 2016.

To date, over 2,000 clinical and non-clinical staff have had the opportunity to complete a survey involving evidence-based domains that directly 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. These have previously been delivered via 'kitchen table' events delivered in local areas, however, there has been limited opportunities to share outputs directly at service level during 2020-2022 due to Covid challenges and the restriction on ward visits. Nevertheless, all outputs from the programme have been shared with colleagues who can influence decisions and 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.

As an output of this work, the following illustrations demonstrate the results of the patient safety culture surveys from 2016, when the survey was first deployed, to 2020 (when the contract with PASCAL ended):

Over the 4 years, key finding/themes have been identified:

- Support staff in administrative roles, on average, score less well than clinical colleagues. This is being taken forward by the Trust in 2022 with its 'Proud2bAdmin' programme of work.
- There are more positive perceptions of Senior Leaders across all staff groups over the four-year period.
- Overall, colleague's '*perceptions of patient safety*', have remained positive and unchanged over the four-year period, as demonstrated across all staff groups despite pandemic challenges. The 2020 survey indicates a difference between staff group scores in the '*safety culture*' domain, with medical colleagues scoring more positively, and registered and administrative colleagues scoring less positively. This will be monitored as part of further surveys, and questionably, reflects the impact of the pandemic over 2020.

SFHT is currently in the process of re-commissioning a platform to deliver further safety attitude questionnaires, to continue beyond 2022.

### **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 'what have we been most proud of during COVID-19?'. Face to face Schwartz Rounds were not able to be held due to social distancing but are expected to re-commence in 2022.

The following is a quote from a nursing colleagues, following presenting her experience of re-deployment into ICCU at a Schwartz Round:

*'On the day of the Schwartz round, I was nervous, speaking and sharing my experience, I worried how I would hold it together, would people think I was dramatic? I manage to share my story and found it very cathartic. Feedback from attendees was very supportive, I had an overwhelming sense that attendees saw me as being brave, whereas I saw it as my duty. I walked away with a sense of pride - I made a difference to so many people's lives, during the darkest moments of their lives'.*

Joint Schwartz Rounds with primary care colleagues in Mid Nottinghamshire ICP have been explored in 2021.

### **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.

SFHT has an active, and nationally acclaimed Civility offer and continues to hold national webinars on this topic, as well as in-house training and awareness.

### **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. Compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver against the current framework.

The national aim that Trusts would be ready to implement PSIRF by April 2022 has been significantly delayed by the pandemic and organisations continue to respond to ongoing challenges associated with COVID-19, and those associated with the restoration of services. NHSE now expect preparation for implementation to be a gradual process that will commence in Spring 2022 with further details about the approach to be shared with Trusts in due course.

Whilst we continue to work to the existing SI framework, reductions in time for clinical staff to conduct investigations due to frontline clinical duties has also stretched our capacity to conduct investigations. There is very little dedicated time for these activities in job plans. A number of proposals have been made to centralise these investigations, but executives are keen that they remain within Divisions. We continue to work on a resolution to this.

The first two modules of the Patient Safety Syllabus have been published by NHSE. Key components of these are the importance of Human Factors and Systems Thinking. Level 1 is intended to be appropriate for all staff (although not mandatory at this stage). Higher levels of training will be more targeted, and we have recommended level 2 training is undertaken by current members of the Patient Safety Committee initially. We anticipate that level 3 training will be appropriate for these colleagues, when it becomes available, as they form the majority of those roles previously identified as the Patient Safety Academy. We may also recommend that those with a wider range of roles should receive this training examples including Governance leads and Clinical chairs. However, this may be limited by availability at the national level. We have included this in our return of the learning needs survey to NHSE.

Locally, redeployment of key Governance staff has delayed development of our local Investigation Training Programme which incorporates Human Factors and Systems Thinking approaches. However, a further 30 members of staff have undertaken our investigation training. We are also able to report that a member of staff have signed up for the HSIB Investigation Training. It is likely that in the future all training of this sort will have to be provided by an accredited supplier and the local Patient Safety Specialists Steering group has begun preliminary discussion about standardising this across the Nottinghamshire ICS.

A stand-alone Human Factors training package was developed in 2021 and is offered as part of the Quality Improvement training. The Human Factors training is evaluated in terms of number of attendees, increase in knowledge and understanding of the topic, and further work in 2022 will extend this into the application of this learning.

SFHT has been selected to contribute to a national working group supporting, the introduction of Patient Safety Partners as part of involving patients in their own safety. This is a significant component of the Patient Safety Policy. This will formalise previous patient involvement roles used to recruit Improvement Partners to inform our work in the context of existing Public/ Patient involvement arrangements (e.g., Patient Representatives, Patient Governors)

### **Aims for 2022/23**

- To re-commission a Trust-wide Safety Attitudes Questionnaire and build on the baseline established by PASCAL
- To optimise colleague psychological safety by developing a standardised platform and approach for any colleague to access psychological support following human-facing incidents at work
- Continue preparations for PSIRF implementation, including patient safety syllabus education and Human factors training. Strong links between Governance and Service Improvement are essential to this work.
- To ensure that service users are actively engaged within all key safety meetings at SFHT

## **3.2 Safety – reducing harm from falls**

### **Aims for 2020/21**

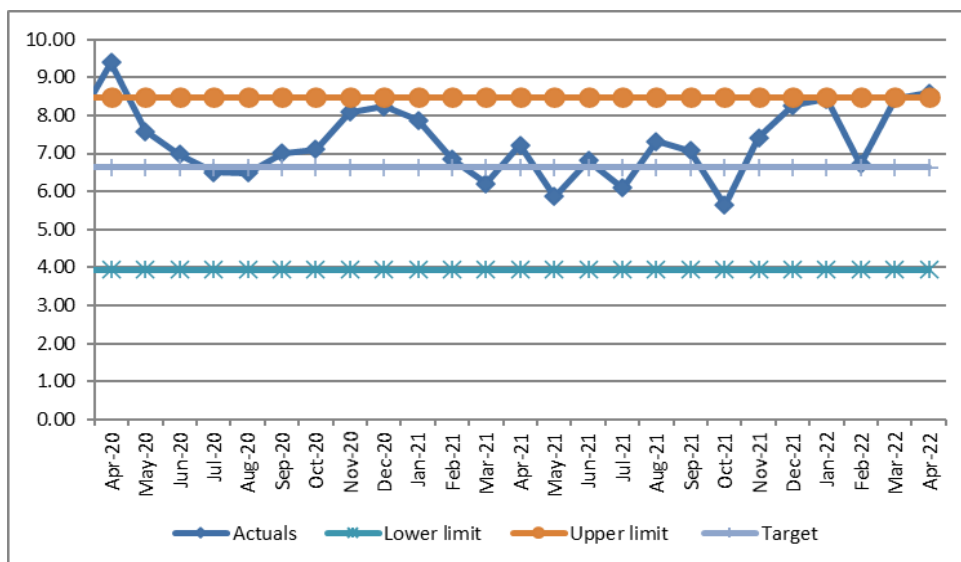
- Month on month decrease of in-patient falls in line with RCP ambition of 6.63 per 1,000 bed days
- Reduce deconditioning and mitigate risk of falls and harm from falls
- Increase community involvement and networking

Performance against this target

Reducing harm from falls is identified as a quality priority in line with the Quality Strategy. Our ambition as a Trust is to be below the Royal College of Physicians ambition for falls per 1,000 Occupied Bed Days (OBDs).

The graph below (graph 18) demonstrates the percentage of falls calculated by 1,000 Occupied Bed Days (OBDs) as per the National Audit of Inpatient Falls (2015) criteria. Currently, the Trust performance for the end of March 2022 indicates falls / per 1,000 OBDs exceeds the published standard. Whilst the Trust has been below this for a period of months, this increased during each wave of COVID-19. This is reflected in national data reported via networking with neighboring Trusts.

*Graph 18*



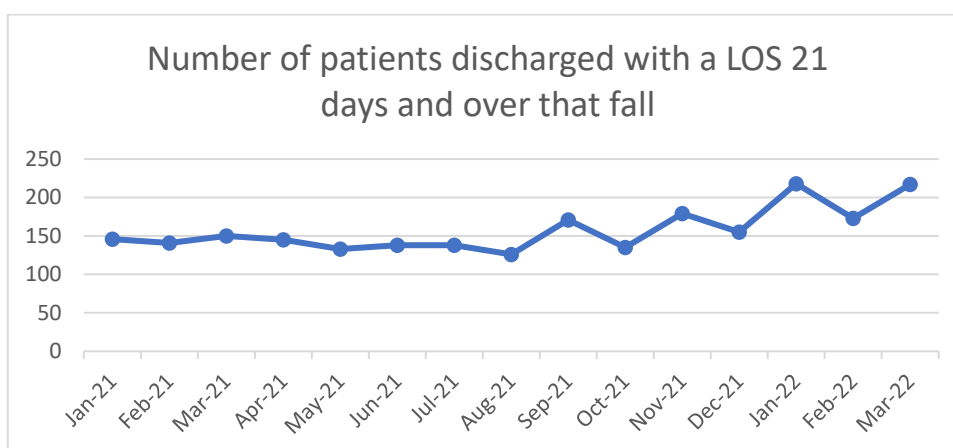
### How was this achieved?

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 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 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 and a further increase in the risk of falling.

We have seen an increase in the complexity of acute admissions. People attend with acquired deconditioning due to reduce mobility during the pandemic. If during admission mobility is further reduced, the combined effect is an increased length of stay and during this time, increased risk of falling (graph 19).

Graph 19



Whilst we have not seen the desired falling trend, we have seen improvements in mobility. We have developed a community of practice internally with colleagues focused on enhanced patient observation and people living with dementia. Externally we have introduced a wider community of practice which involves colleagues working in social care, community practice primary care and other acute providers. This work is attempting to connect care of people at increased risk of falling to mitigate risks across the whole health community does not address issues in acute services in isolation.

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

- Completion of chief nurse clinical fellow project
- 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 all Health and Allied Health Professionals within partner organisations and the Trust

### Continue to reduce falls with harm

- Adjustment in monitoring process allows in month interventions
- Clinical focus of falls prevention team brings provide support closer to areas of care delivery and bespoke education
- Revision of post falls data collection to support accessing learning faster
- Falls team contribution to scoping meetings and actions Where there may be learning identified
- Monthly falls analysis, reports and feedback as to themes and trends provided by the falls (table 12)

**Table 9**

In-patient Falls by severity of harm	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Grade 1- No harm	88	70	81	88	95	105	89	112	128	132	91	131
Grade 2 - Low harm	26	30	32	16	32	18	14	20	23	25	22	31
Grade 3 - Moderate harm	0	0	0	0	0	0	0	0	0	2	0	0
Grade 4 - Severe harm	0	0	1	2	1	2	0	2	0	2	0	1
Grade 5 - Catastrophic harm	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>114</b>	<b>100</b>	<b>114</b>	<b>106</b>	<b>128</b>	<b>125</b>	<b>103</b>	<b>134</b>	<b>151</b>	<b>161</b>	<b>113</b>	<b>163</b>

- 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
- Monthly networking and sharing of COVID-19 related themes with local health care providers
- Develop response to COVID-19 across the local system examples include awareness and staff education of patients requiring enhanced observation, patients with delirium and reduced cognition.
- Partnership working in the Trust to consolidate the implementation of the Carers Passport
- Connected care group development linking enhanced care and dementia care with falls prevention
- Continued education to address the importance of regular mobility to prevent deconditioning and awareness of patients admitted already deconditioned.
- Inclusion of COVID-19 and further understanding of complications reading to increased risk of falls

## **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 2021/22**

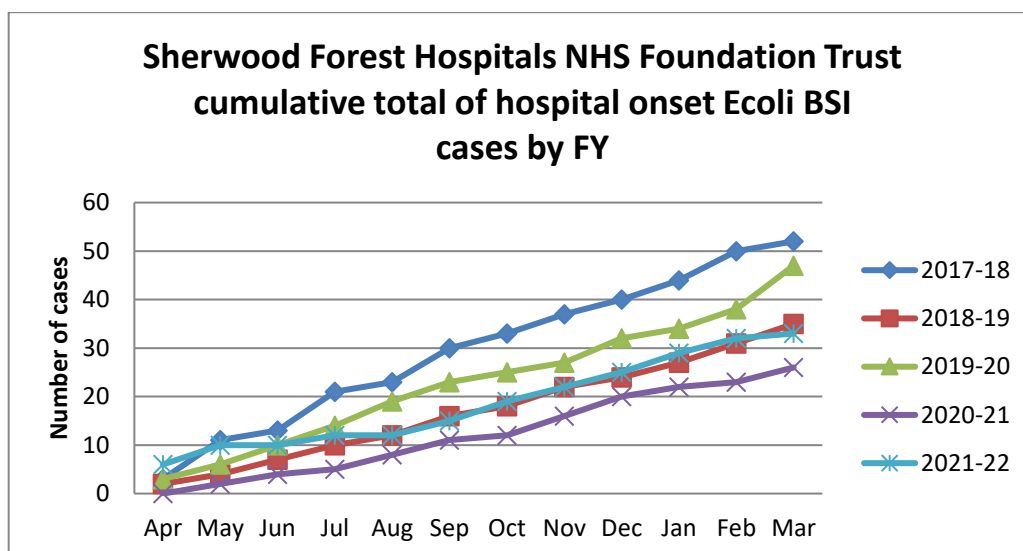
- To work to reduce SFHT Escherichia Coliform (E-Coli) in line with national targets.
- To work to reduce SFHT surgical site infection rates in line with national target.

#### **Performance against this target**

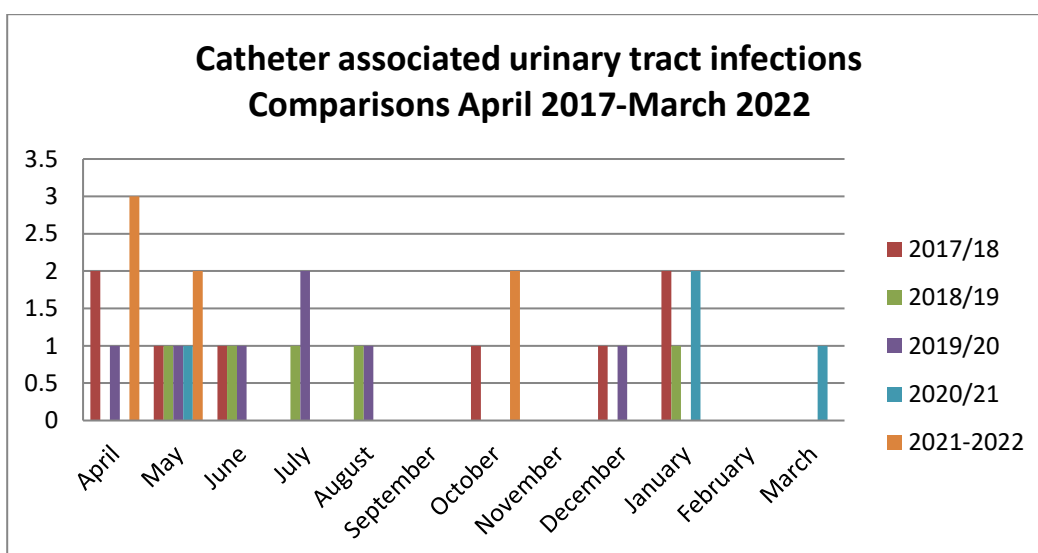
Below is a summary of the performance against the two aims outlined above:

- 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 E. Coli. In 2021/22 there has been an increase in the number of SFHT acquired cases compared with 2020/21, although we have had a lower number of cases compared to the 3 years prior to that (Graph 20). This increase has corresponded with an increase in the number of Catheter-Associated Urinary Tract Blood Stream Infections (CAUTI) (Graph 21).

*Graph 20*



Graph 21



The report from UKHSA for October – December 2021 (table 13) indicates that for the last four periods, SFHT continues to perform in line and slightly better than national benchmarking. The table indicates the summary result that suggests in all three fields, SFHT has a rate lower than the amalgamated average.

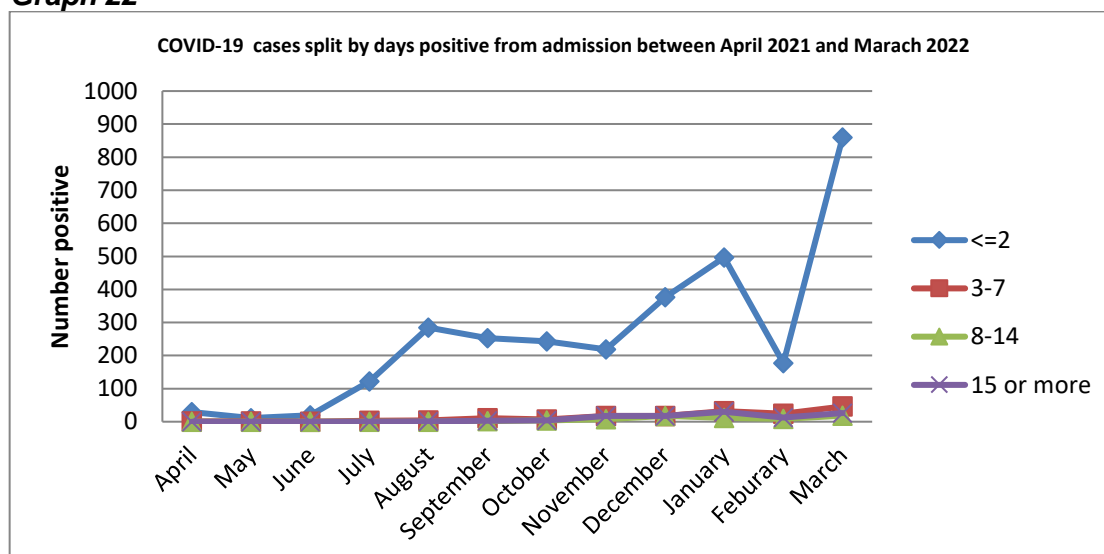
Table 13

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	0.0	3.6

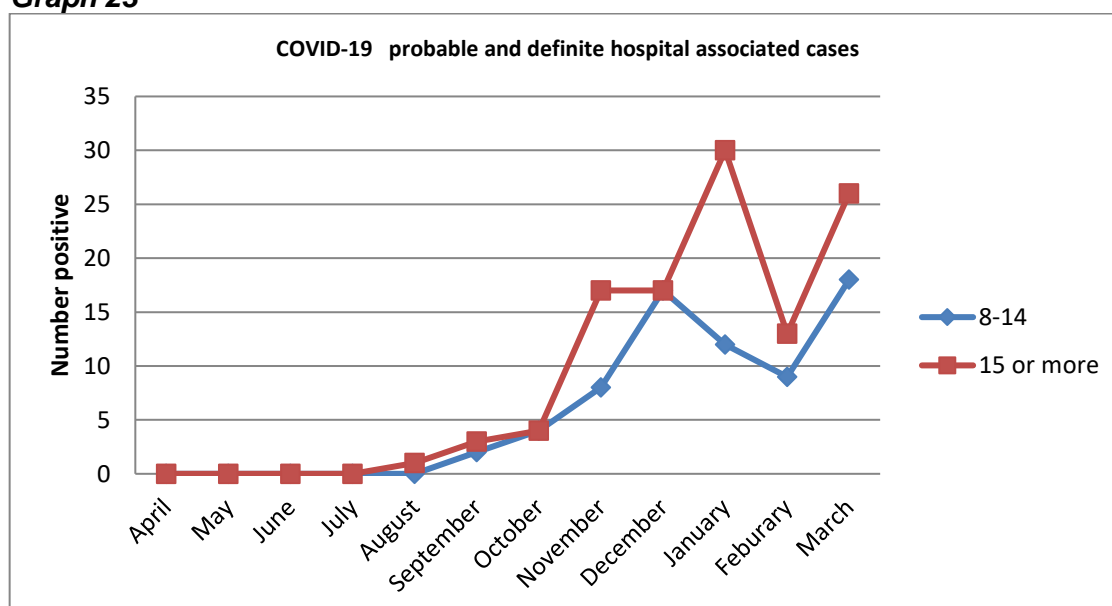
## COVID-19

During 2021/22, whilst SFHT has been dealing with the COVID-19 pandemic we have been monitoring our cases closely. We have seen varying numbers of probable and definite hospital associated cases as shown in Graphs 22 and 23. The definitions are displayed in Table 14.

**Graph 22**



**Graph 23**



**Table 14**  
**Definitions of hospital onset COVID-19**

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

### **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
- SFHT is moving to the new National Standards of Cleanliness, which will increase cleaning in clinical areas.
- 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 UKHSA to monitor outbreak progress
- Regular monitoring of screening compliance

### **Monitoring and reporting for sustained improvement**

- All elements identified above are monitored and reported externally by UKHSA and NHS England.
- Internally these are scrutinised and challenged via the SFHT governance processes
- Information on infection rates is available publicly via UKHSA 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 2022/23?**

- To improve practice standards in use of invasive device including urinary catheters and cannula
- To achieve the new Clostridium Difficile Infection (CDI) target
- To reduce the number of all hospital associated infection cases

## **3.4 Effectiveness – Improving the Effectiveness of Discharge Planning**

### **Aims for 2021/22**

- For the next stage of Nervecentre (a software application linking aspects of healthcare across SFHT including observations, escalations and key discharge information) development, it is intended to give full access to the community partners. This allows them to review and input onto Nervecentre which will allow real time updates for the wards.
- To implement a true Discharge to Assess (D2A) pathway where patients can be discharged within 4-24 hours of them being MSFT.
- To offer an integrated workforce that 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 in 2022.

### **Performance against this Target**

- Nervecentre - Through the development a read only access, has been achieved for Social care services and Nottinghamshire Healthcare Trust. Full access has not been completed at this time.
- This has not been achieved in its entirety due to lack of domiciliary care in the community. COVID-19 has been a contributing factor to this.
- A workforce change has now been completed and we are working towards a fully integrated discharge model
- Criteria Led Discharge policy has been reviewed.

### **How was this achieved**

- Though collective partnership with Social care services and Nottinghamshire Healthcare Trust.
- A comprehensive dashboard was developed which allowed the referrals to come directly through to IDAT from all areas.
- Nervecentre has allowed a full audit trail of referrals and metrics regarding all pathways and Length of stay (LOS).

## **Monitoring and Reporting for Sustained Improvement**

### **Aims for 2022/23**

- Full system access to Nervecentre for all partners
- To reduce the separate platforms used such as Orion and System One with the potential of using one IT platform. This will give a real time account of the patients journey throughout SFHT.
- To ensure or aim towards a 95% daily discharge rate from the trust of patients that become safe for transfer.
- To reshape the daily hub, call to focus away from discussing the same patients and refocusing on new patients and complex patients.
- For the Frailty intervention team to focus on admission avoidance. To ensure that the frailty score (Rockwood clinical frailty scale) is completed on Nervecentre and with a raised score would indicate the need for further assessment.
- To progress from admission avoidance to hospital at home/virtual wards.

## **3.5 Effectiveness – Improve our Care and Learning from Mortality Review**

SFHT 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 SFHT. SFHT 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, if indicated 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 2022/23**

As described in the 2020/21 Quality Account, the Trust planned to focus on mortality within specific services and continue to develop the SJR methodology. After work in 2021/22 to improve the methodology and increase engagement within the Trust, it is the aim of

- the LFD group aim to complete more robust SJR's, resulting in more widespread learning and as a result, improving patient care.

## **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 will this be 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 SFHT as an area for improvement. The 2021/22 reporting period did see a small improvement but due to COVID-19, this was lower than expected. In 2022/23 the expectation is that we will achieve a significant improvement and resolutions of the challenges faced in some specialties.

## **Monitoring and reporting for sustained improvement**

The Learning From Deaths group (LFD) has continued to work closely with each division to support the overall mortality review process. SFHT received regular intelligence from 'Dr Foster' – who provide the external view of the Trust mortality position.

The LFD group 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 2022/23**

- 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, supporting them to understand where the mortality agenda fits into the care they deliver.

Since 1 April 2022, it is now statutory for the medical examiner (ME) service to review community deaths alongside Trust deaths. This had been delayed from 1<sup>st</sup> April 2021. The ME service is developing plans to meet this requirement with the aim of liaising with the key community stakeholders, working towards achieving compliance by the end of the 2022/23 reporting period.

## **3.6 Effectiveness – 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. SFHT 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; updated in May 2021 for 2021 – 2026 by the National Palliative and End of Life Care Partnership).

## **Aims for 2022/23**

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 SFHT are:

- Launch the new Trust 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' experience
- 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.

### **Launch the new Trust EoLC Strategy for 2020-2025**

The COVID-19 pandemic paused further developments of national and local EoLC strategies in 2020. This activity has resumed and the emerging work with regards to the National Ambitions for Palliative & EoLC, the Notts ICS EoLC strategy, and the SFH Nursing, Midwifery & Allied Health Professionals' strategy will all form the Trust's future EoLC Strategy.

Closer working across the Macmillan EoLC Team and the Specialist Palliative Care Team (SPC) (employed by Nottinghamshire Healthcare NHS Trust and based at John Eastwood Hospice) has also been developed by the Teams throughout 2021 to date.

As SFHT is within the Notts ICS system, it is envisaged that a separate SFHT EoLC Strategy will not be developed. An Action Plan and associated work plan will be developed during 2022/23, to set out how SFHT will support delivery of the National Ambitions for Palliative and EoLC, the Notts ICS EoLC priorities and SFHT EoLC priorities.

### **Participate in the next cycle of National Audit for Care at End of Life (NACEL)**

SFHT fully participated in Round 3 (2021/22) of the NACEL Audit, as follows:

- Submitting a Trust site / Board overview, in relation to EoLC provision
- Review of 40 x case notes during the audit qualifying period (2 weeks in April and 2 weeks in May 2021)
- Sending letters to relatives/those important to patients who died within the Trust between 1<sup>st</sup> April and 31<sup>st</sup> August 2021 (as agreed by the relatives/those important to the patients), inviting them to submit their thoughts and feedback through the NACEL Quality Survey
- Seeking feedback from staff within the Trust who provided care and support to adult patients in their last days of life.

Participation in the Audit, e.g. case note reviews and data collection, was led and undertaken by the EoLC Team and Dr Ben Lobo (Trust Medical Lead – EoLC). All data was received and submitted ahead of the Audit deadline.

The draft outcomes/output report of the NACEL Audit collection received and presented and discussed at General palliative and EoLC committee. Actions included in EoLC work plan

Following receipt, the report will be reviewed, actions required by SFHT identified and a corresponding Action Plan will be created.

SFHT has recently signed up to fully participate in Round 4 (2022/23) of the NACEL Audit. Details are awaited from the National audit Team around the Audit process and timescales.

### **Enhanced measures to capture patients and their relatives' experience**

The Macmillan EoLC Team will be developing a patients' and relatives' experience leaflet during 2022/23. It is anticipated that it will support earlier recognition of the last year of life and encourage patients/relatives to engage in Advance Care Planning discussions.

### **EoLC Butterfly Volunteers Scheme**

The Macmillan EoLC Team, in partnership with SFHT Community Involvement Hub Team, have developed an EoLC Butterfly Volunteers scheme which is currently being piloted across several Wards/areas in SFHT.

The EoLC Butterfly volunteers enhance the experience of patients identified as being in the last days of life, by having volunteers sitting for a short time with patients (as appropriate). Depending on the patient, the volunteers will talk to patients and/or read to them, and sometimes just sit with them to provide company for them. The EoLC Butterfly Volunteers also work as part of the Ward Team, supporting non-clinical activities.

Volunteers who are interested in becoming an EoLC Butterfly Volunteer attend a 1-day training session (led by the Macmillan EoLC Team along with other key clinical colleagues from the Trust), before joining the scheme. Several key topics are covered during the training day, including:

- The process of dying
- Boundaries and safe working
- What to expect on a ward
- Communication skills, including talking to relatives/those important to the patient
- Self-care for the volunteers
- Being prepared that patients may die while the volunteers are with them.

Feedback received in relation to the EoLC Butterfly Volunteer initiatives has been very positive. A review of the pilot scheme will be undertaken shortly, with a view to rolling out the initiative further across SFHT during 2022/23.

### **Develop the Business Case for dedicated EoLC Beds to support choice and enhance experiences of patients and their loved ones**

The EoLC Clinical Nurse Specialist (CNS) Team continues to undertake daily ward visits to patients in the last days of life across the Trust, providing support to staff caring for these patients. In addition, providing information and support to the patients and their relatives/those important to them. (This support is provided over 5 days, Monday to Friday, between 8.00am and 5.00pm). The Macmillan EoLC Team also provides ad-hoc education to staff as required, during the patient visits.

Between 1<sup>st</sup> April 2021 and 28<sup>th</sup> February 2022, the EoLC CNS Team made a total of 1,519 ward visits to patients across the Trust.

On 1<sup>st</sup> January 2022, 8 x EoLC Beds were opened on Ward 36 (Short Stay Unit), (the number of beds reduced to 6 substantive beds in February 2022). During January and February 2022, the EoLC CNS Team visited 183 patients identified at EoLC on Nervecentre. The Team undertake frequent visits to all Wards/areas with patients on the EoLC model, to support the care of these patients. The EoLC CNS Team made a total of 337 contact visits with patients during January and February 2022 to these 183 EoLC patients (some patients were visited on multiple occasions). Of these 183 patients, 70 patients (38%) were being cared for on Ward 36/SSU (46% in January 2022 and 29% in February 2022).

### **Ensure sustainability of the Macmillan EoLC Team Resource**

The Macmillan EoLC team was previously 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.

Due to various staffing changes, the Macmillan EoLC CNS staffing reduced from 2.0 Whole Time Equivalents (WTE) in May 2020 to 1.6 WTE (still supported by 1.0 WTE Project Support Officer). The current CNS and Project Support Officer secondment roles were extended to 31<sup>st</sup> March 2022. A

Business Case has since been written and submitted, to seek to sustain the core Macmillan Team on a substantive basis from 1<sup>st</sup> April 2022.

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

During 2021/22, the EoLC Champions Network meetings were reconvened, and the Network meets every 2 months, led by the EoLC CNS Team.

The membership of the Network was reviewed, to ensure that members of each ward/area that supports patients at the end of life are invited to join the meetings. The membership comprises of:

- Ward Leaders
- Nurses
- Health Care Assistants / Health Care Support Workers
- Occupational Therapists (OT)
- Front Door Discharge Team
- IDAT Team.

Each meeting also has a theme or topic, with guest speakers invited from Teams across SFHT to present updates to the EoLC Champions.

### **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 continues to work towards maximising the potential of our workforce, by continuously learning, choosing to adopt evidence-based practice, utilising information, and advancements in digital technology, being innovative and improving for the benefit of the local community.

#### **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 2022/23 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. SFHT has achieved this as part of their induction programme, the group of staff that currently do not receive any training are the Healthcare Support Workers. There were plans pre COVID-19 to deliver on their induction but as the pandemic began these were put on hold. In 2022/23 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. 2021/22 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.

### **Performance against this Target**

2021/22's achievements have again been hampered by the on-going COVID-19 pandemic, face masks continue to be used in all health care environments which significantly impacts on the ability to effectively communicate, patients having visitors has fluctuated reducing the opportunity to interact and group activities for patients and their carers remains unworkable.

- Prior to nursing staff being permitted to complete the dementia assessments the percentage achieved would be 30% or less, following a change to the system and allowing registered nurses access to complete, the percentage rate achieved has been in the mid 80's for the past four months.
- The number of patients with an identified diagnosis of dementia and a corresponding tag on our electronic systems continues to increase, and this will remain on the aims list for future years.
- The consultation and planning for the post diagnosis plan has been completed, there are Webinar's available about part of the new support provision, that has been commissioned to be delivered by the Alzheimer's society while recruitment is underway to two Admiral Nurse posts that have been commissioned and are supported by Dementia UK. The aim of both services will be to support the person diagnosed and their carer/family, both will provide an individual needs approach, with the Registered Admiral Nurses having the ability to support with nursing needs and advice.
- All staff recruited by the Trust undergo an orientation day prior to commencing their role, the session has been adapted to ensure that it covers all elements required to achieve Tier 1. The organisations that provide the ancillary services to the organisation have agreed to provide this training to their newly appointed staff, a film to deliver this is in development.
- Unfortunately, the Alzheimer's Society has yet to restart the Champions training for dementia friends, they have recently updated everyone who has expressed an interest to inform them that an online option is being developed. Two groups of volunteers have undertaken training to supporting activities across the organisation, they have begun to provide support to several wards and feedback from both volunteers, patients, carers and ward staff has been of a positive outcome.
- Delirium is now discussed as part of the monthly harms free group, data is provided on the numbers of patients who have delirium during their stay, unfortunately there is currently no way to determine if the episode was pre or peri admission. Covid has again impacted on this aim as it has been noted as part of the presentation of the virus that delirium has been present in many of the post ITU patients. Further work is underway to understand how SFHT can reduce the occurrence, the training proposed last year has been prepared to be rolled out once the pressures of the pandemic have subsided.
- The dementia champions are perhaps the most successful achievement from this year's list of aims, in collaboration with falls and manual handling, 3 sessions were successfully completed, and dates and venues are arranged for the forthcoming year. Feedback from the sessions was positive and the dementia champions were the greatest number represented in each of the 3 days.

### **How was this achieved**

- The previously formulated gap analysis which identified the deficits in the service and formulated a three-year work plan, in line with the Dementia Strategy, has supported the creation of the yearly work plan. 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.

The challenge associated with the pandemic restrictions will continue to affect the achievements and enforce different approaches some of which are due to the nature of the illness.

Moving from the safeguarding team has facilitated an increased focus on the service provided and the employment of a substantive band 3 HCSW has begun to enable further development.

### **Monitoring and Reporting for Sustained Improvement**

The service would previously have been required to report nationally on the percentage of dementia assessments completed. This was initially suspended during the pandemic and has since been discontinued. SFHT 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. The champion days generated some additional information that could support these findings.

The figures related to delirium are now produced and added to the harms free report monthly, this is chaired by the deputy chief nurse who shares the learning at the Patient safety group meetings.

### **Aims for 2022/23**

- Shared governance has been introduced to the organisation, the aim this year is to recruit and commence work with a dementia focused council. This will be made up from a variety of individuals at the Trust aiming to offer a diverse viewpoint and encourage cross-organisation working.
- In an approach to increasing the quality of interactions on the wards, especially with patients who are requiring Enhanced Patient Observations, activity boxes are to be developed for each of the wards and departments. Initially this will be part of a pilot exercise which is to be supported by the Trusts Charity.
- Having been involved in discussing and evaluating the ICS dementia pathway, the Dementia Nurse Specialist will promote the new options available for support. These include a referral to the Alzheimers society for patients, carers, family and friends, and health and social care employees, plus a nursing element of support provided by the newly appointed Admiral nurses. The intention will be to support the service by making referrals and liaising with the providers to understand how SFHFT can enhance the service provision.
- There will be a continued 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.
- The Integrated Care Partnership's shared aim is to continue with the process of ensuring that all partner organisations provide Tier 1 dementia training for all employees. SFHT has achieved this as part of their induction, the groups of staff that currently do not receive any training are the Skanska and Medirest teams. There were plans in place pre COVID-19 to deliver on their induction but as the pandemic began these were put on hold. In 2022/23 we will revisit this and look to achieve the target set by the ICP, utilising an online video style training process
- Delirium continues to have a significant impact on our patients, as dementia is one of the predisposing factors associated with this. 2022/23 will see the introduction of online delirium training for medical, nursing and healthcare assistants. Following an in depth focus on the potential causes of hospital acquired delirium.

- Dementia, falls and manual handling champion days will be coordinated and presented on four occasions throughout the year. Champions are an essential component of these services, they allow a larger resource of both knowledgeable and skilled staff to enhance the care delivery whilst assisting their colleagues with same endeavour.
- The Dementia Team will continue to support and promote the carers passport, including adding the information to the internet pages on dementia and as part of the information sharing with the individuals supporting the new Dementia Pathway.

### 3.8 Patient Experience – Using feedback from patients and their carers

#### Friends and Family Test (FFT) themes and trends

The Friends and family test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Every patient receiving treatment within SFHT can give feedback about the quality of care they received. This enables the views of patients and their families to be heard and helps us to continuously improve our services. We are very pleased with our results as most patients rate their experience highly. However, we also want to know where we have not met expectations so that we can make improvements. Feedback is our best way of knowing where we are doing well or where we could do better.

We use FFT feedback along with other methods of feedback that include compliments, concerns, and complaints, to understand what matters most to our patients and family members. There are several ways to provide FFT feedback:

- Online questionnaire via the SFH website
- Text message
- QR Code
- Paper survey

SFHT have continued to collect FFT feedback during the pandemic, complying with IPC guidance, by increasing services using the SMS text messaging service due to the increase in virtual clinics.

Results have shown a fluctuation in response rates during 2021/22 (table 15) and the Patient Experience Team, led by the matron for Patient Experience, have worked closely with divisions to develop and support action plans to increase response rates, providing an increase in qualitative data to help shape future services.

*Table 15 - FFT data October 2021 – March 2022*

	Recommendation Rate %					
	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
<b>Diagnostics and Outpatients</b>	96.90%	97.11%	96.93%	96.85%	96.39%	95.90%
<b>Emergency / Urgent Care</b>	88.84%	89.95%	92.06%	92.08%	93.43%	90.90%
<b>Medicine</b>	97.14%	95.95%	96.85%	96.37%	96.55%	95.69%
<b>Surgery</b>	94.19%	95.96%	95.74%	96.16%	95.04%	95.92%
<b>Women's, Childrens and Maternity</b>	94.87%	94.16%	94.59%	91.15%	94.10%	91.91%

\*FFT reporting nationally paused during 2021/2022 therefore FFT data from Oct 2021-March 2022

The FFT feedback is shared with all divisions for learning and reflection to focus on areas of improvement, the following themes, trends and responses have been highlighted during 2021/22:

- Lack of communication reported in ED regarding waiting times – screen introduced to update patients.
- Difficulty experienced contacting administrative teams in surgery departments relating to patient enquiries – Patient experience team continue to support patient/carers to access services to address queries.
- Concerns regarding catering staff and food on Ward 43 – escalated to ward leader for further investigation with ward hostess and team. This has resulted in positive feedback.
- Challenges to speak to wards during waves of pandemic – reintroduction of Family liaison service to support communications between patients, family and medical and nursing teams.
- Lost property and family members reporting issues accessing information regarding the policy. A Patient Property Task and Finish Group was re-introduced with updated policy and processes agreed and circulated to staff and available for patients/family members.

#### **Actions taken to support increased response and recommendation rates:**

- Introduction of QR codes in Maternity and the ED to support increased accessibility to provide feedback real-time.
- Expansion of SMS messaging in all areas throughout SFHT which has resulted in increase in response rates.
- Training sessions provided to teams to increase FFT awareness and engagement. Training delivered to support accessing FFT data form dashboard to empower leaders to review and action FFT feedback.
- SFHT has successfully undertaken a competitive procurement process to award the FFT contract to a new provider from April 2022, providing opportunity to relaunch FFT post COVID-19 and explore additional methods of collection. User friendly system provides easy access to reporting to identify trends and themes.

#### **Aims for 2022/23**

- Development of engagement plan to continue to refresh FFT and support divisional teams to deliver FFT locally resulting in increased recommendation rates.
- Reintroduction of volunteers supporting FFT completion in ward and outpatient areas, post COVID-19 restrictions being lifted.
- Relaunch of FFT in 2022 to raise awareness and engagement, resulting in an improvement of quantitative and qualitative data.

### **3.9 Patient experience – Safeguarding vulnerable people**

#### **Aims for 2021/22 were:**

The impact of COVID-19 raised concern both nationally and locally of safeguarding and domestic abuse incidents, significantly increasing for both adults and children. The key aims of SFHT for 2021/22 were to ensure safeguarding remained a top priority within our care and service delivery, working to ensure systemic safety nets were in place and recovery plans were implemented within different patterns of working.

To review key elements of the safeguarding assurance processes whilst continuing to collaborate with external partners, regarding SFHT's response to the safeguarding agenda. Further promotion and embedding of the Hospital Independent Domestic Violence Advocate (IDVA) service, review and development of the domestic abuse work plan, and consideration of the new Domestic Abuse Bill. Remaining focussed and committed to supporting the health and well-being of our workforce, particularly in relation to domestic abuse and mental health.

To further develop our work around the Mental Capacity Act (MCA) training, supporting the development and implementation of our legislative responsibilities to Liberty Protection Safeguards (LPS). To continue to learn from local and national safeguarding issues ensuring they are reflected within the service aims.

### **Performance against this Target**

Safeguarding has remained a key focus of the Trust throughout the COVID-19 pandemic with the safeguarding service remaining a top priority. Recovery plans are currently underway.

The Hospital IDVA role 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 into 2022/23.

SFHT has continued to work with external partners through representation at safeguarding board and partnership events, in addition, providing additional assurances in light of the challenges of the pandemic.

The Trust has maintained its representation as part of local and national safeguarding reviews with learning being embedded into mandatory training and where urgent change is required; it is cascaded and reflected within the service.

Staff have received ongoing support with domestic abuse issues and mental health through the hospital independent domestic violence advocate (IDVA) and Mental Health Specialist Nurse.

Work has been undertaken to further embed MCA training along with ongoing representation at LPS working groups and development of action plans to support delivery.

### **How was this achieved**

- The safeguarding team has remained an essential service during the pandemic with no staff being re deployed to other areas.
- The safeguarding team has supported colleagues to provide focused interventions, providing an enhanced service around safeguarding referrals, escalations and follow ups.
- 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. Recovery plans have been developed for safeguarding training at all levels.
- Attendances to the Emergency Department have been monitored to ensure direct support can be provided to patients presented with potential domestic abuse.
- Hospital IDVA has provided bespoke training sessions, direct support to patients and staff, after actions reviews and follow up to complex cases.
- A Domestic Abuse workplan has been reviewed to reflect the changes in the Domestic Abuse Bill.
- Work has been completed with HR teams around domestic abuse and how to support staff.
- The Hospital IDVA and Named Nurses continue to provide support to managers and HR advisors in relation to staff cases where domestic abuse and mental health are a feature.
- Links have been made with the Trust well-being leads to review how further support can be offered to staff in relation to domestic abuse and mental health concerns.

- Mental Capacity Act (MCA) audits have continued, and action plans developed.
- SFHT have been represented at external LPS working groups and analysis is under way.
- 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 to provide assurance that SFHT are meeting its statutory responsibilities.
- Input into divisional governance meetings will continue
- Workplans are under review to ensure these reflect the needs of the service
- An updated audit programme will be identified for key issues relating to the safeguarding and vulnerabilities agenda
- 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 2022/23**

Lockdown and self-isolation during the COVID-19 pandemic has been a catalyst for safeguarding risk to both vulnerable adults and children. For many, the home was not be a safe place, with routes to support and safety being shut down or limited. However, with lock down restrictions coming to an end this has created further concerns as what was potentially hidden abuse is now coming to the forefront as people now have the opportunity to be seen and disclose. This along with the impact upon people's mental health, families experience, poverty due to loss of employment and the rise in the cost of living is raising concern both locally and nationally. SFHT recognises safeguarding remains a priority within our care and service delivery. We will work to maintain that system safety processes are in place and introduce recovery plans where appropriate. We will build on established work and strengthen our approach to 2021/22 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 Partner Assurance Tool (PAT) and be responsive to the priorities as set out by the NSAB and NSCP.
- Work to further embed the Mental Capacity Act principles across the organisation.
- Continue to develop and implement the organisational legislative responsibilities to Liberty Protection Safeguards (LPS).
- To agree and embed delivery of the Mental Health Strategic Plan

#### **To Promote and support health and wellbeing**

- Safeguarding priorities during 2022/23 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 enhance the personalisation of care to patients with a Learning Disability

#### **To maximise the potential of our workforce**

- Focus during 2022/23 will continue to be around supporting the health and wellbeing of SFHFT 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 2020/21	Yr 2021/22
*Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	69.2%	70.0% - Apr-21 to Jan-22
*A&E : maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	94.1%	86.2% - Apr-21 to Feb-22
Cancer 2 week wait: all cancers	93%	96.0%	90.8% - Apr-21 to Jan-22
Cancer 2 week wait: breast symptomatic	93%	99.7%	93.3% - Apr-21 to Jan-22
Cancer 31 day wait: from diagnosis to first treatment	96%	93.5%	92.3% - Apr-21 to Jan-22
Cancer 31 day wait: for subsequent treatment – surgery	94%	81.8%	85.0% - Apr-21 to Jan-22
Cancer 31 day wait: for subsequent treatment –drugs	98%	91.8%	91.7% - Apr-21 to Jan-22
Cancer 62 day wait: urgent GP referral to treatment for suspected cancer	85%	68.0%	65.6% - Apr-21 to Jan-22

Cancer 62 day wait: for first treatment – NHS cancer screening service referral	90%	72.0%	74.2% - Apr-21 to Jan-22
Maximum 6- Week wait for diagnostic procedures	99%	61.5%	76.7% - Apr-21 to Jan-22
Clostridium difficile variance from plan	56	74	Target 57 Actual 76
**Summary Hospital-level Mortality Indicator (SHMI)	100	97.57	97.25
VTE Risk assessment	95%	93.9%	93.3% - Apr-21 to Jan-22

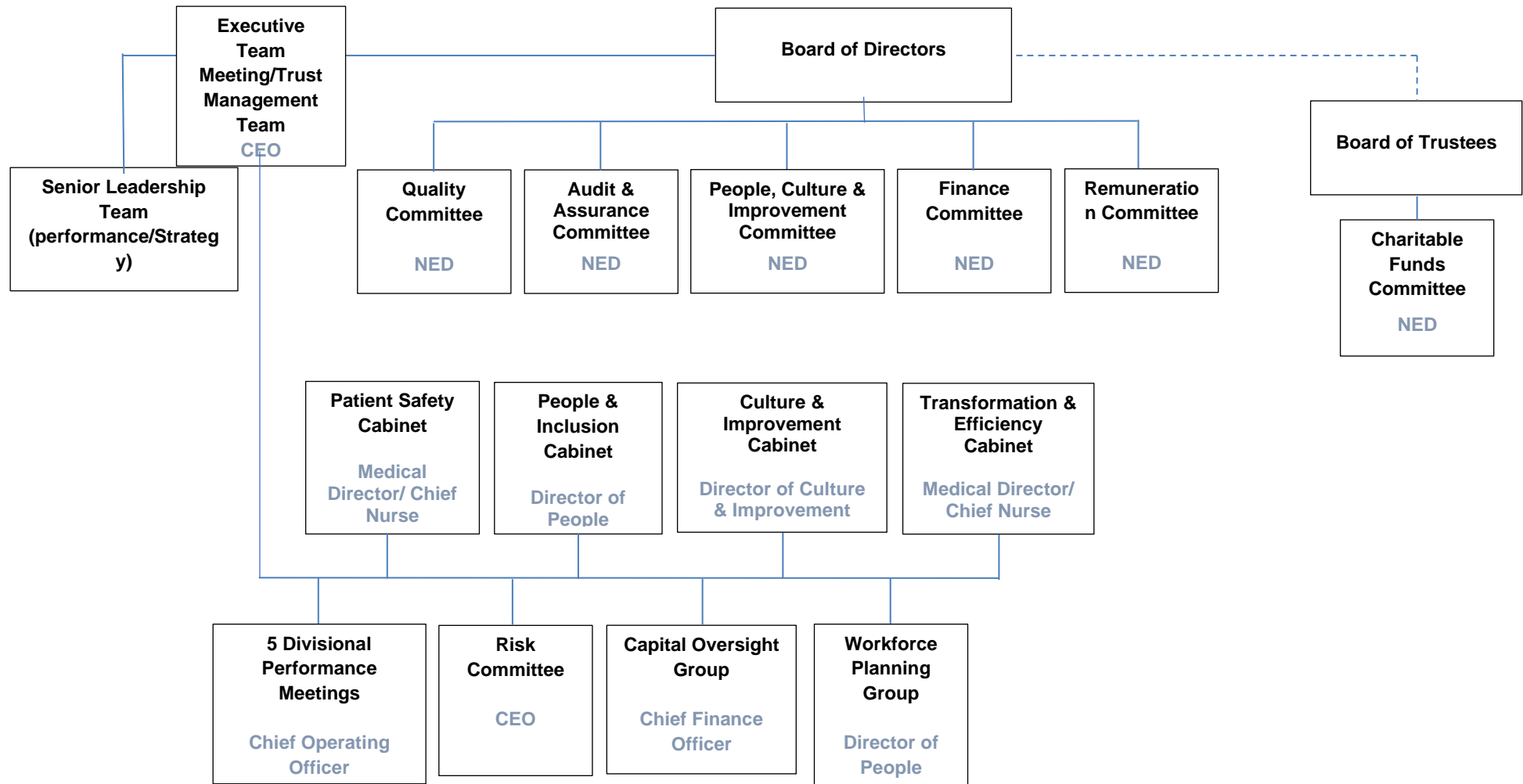
\*Further detail of assurance over mandated and selected local indicators can be found in Appendix 3.

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

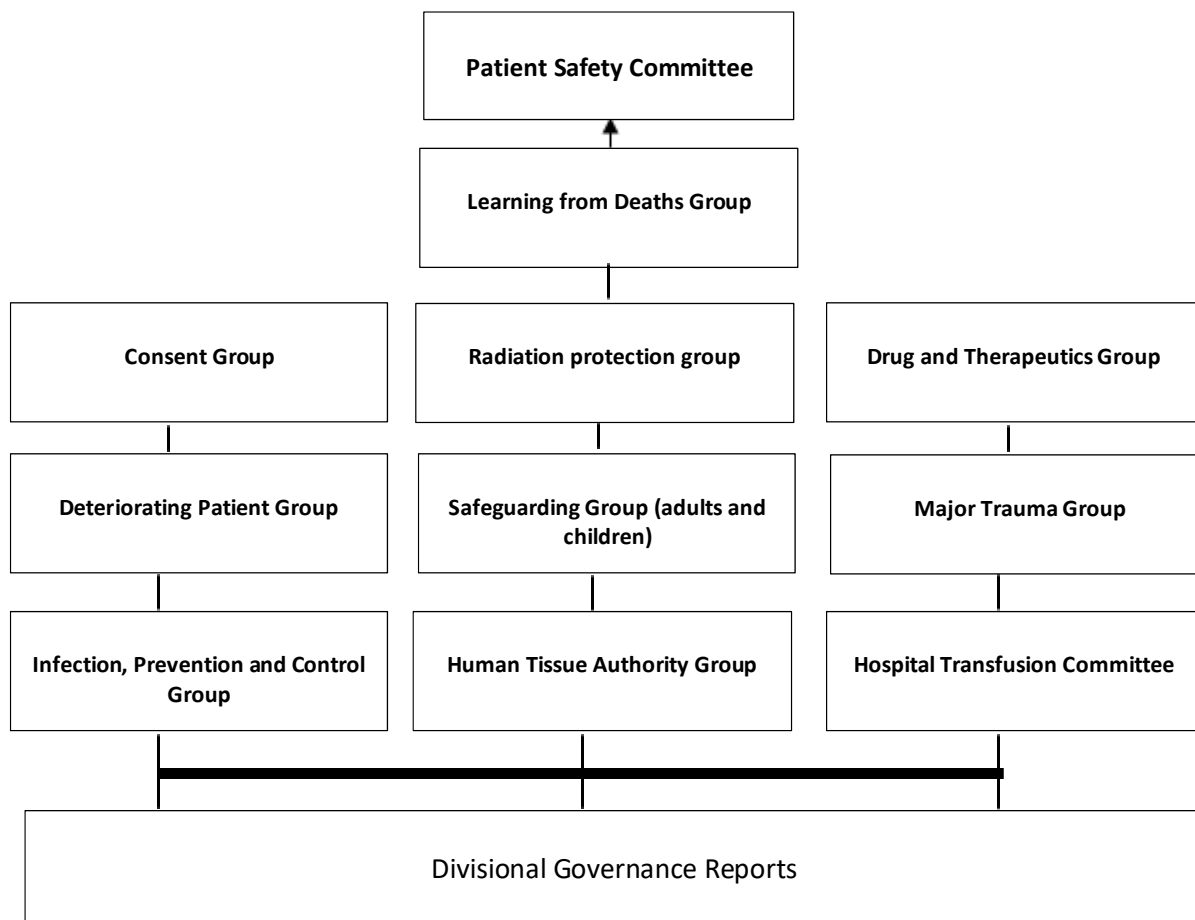
97.57 August 2019 – July 2020

97.25 August 2020 – July 2021

# Sherwood Forest NHS Foundation Trust Committee Structure – June 2022







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.

## **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 2021/2022 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 throughout the continued system pressures of the last year. 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.

### **Quality Oversight**

Throughout 2021/2022 the CCG has continued to work with the Trust to monitor the quality and continuous improvement of services delivered through reviews of information on safety, patient and staff experience, outcomes, and performance. The Trust's quality priorities are embedded within the Quality Strategy (2018-21; 2022-24 strategy in draft) with executive oversight by the Medical Director and Chief Nurse and reporting via the Advancing Quality Programme.

The CCG has worked with SFHT 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 pressures resulting from the COVID-19 pandemic have continued to impact the clinical audit programme in 2021/2022. However, the Trust has fully participated in National Audits and Confidential Enquiries as well as local clinical audit. The Account demonstrates some good examples of work to improve care with a commitment to clinical effectiveness, and a focus and ambition to strengthen the assurance and visibility of clinical audit through 2022/23.

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 2021/22.

### **Achievements**

#### **Wider Organisational Achievements**

Key successes include the accreditation of SFH as a Schwartz Round site, providing an evidence-based forum for staff 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 stories and offer support. This has been evaluated positively by clinical and non-clinical staff. The development and roll out of the PASCAL questionnaire also provided the views on safety in services from over 2000 front line staff

The Quality Account shows that the Trust remains the best acute Trust in the Midlands for staff engagement and ranks highest for staff morale and teamworking. The staff survey for 2021 clearly shows a focus on quality of care and safety culture, again ranking highest in the midlands in these areas of feedback.

The Friends and Family Test (FFT) was formally reported from October 2021 – March 2022 and shows a high recommendation rate across divisions with scores mainly above 90%. As a result of patient feedback. The Quality Account shows improvements made in communication, including the reintroduction of a family liaison service to support communications between patients, family, and medical and nursing teams.

### **Quality Improvements**

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

- Introduced a QIP club, engaging trainee doctors to lead on an audit and improvement projects
- Developed an e-learning package for audit
- Supported wards involved in pathway to excellence from the QI and Audit Team to help achieve ward accreditation as an exemplar ward.
- Introduced a new governance route via the Advancing Quality Group to strengthen the clinical effectiveness agenda and assurance processes.
- Shown a high level of compliance and favourable results against comparators in National audits

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 Deaths 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). The number of serious incidents reported has increased compared to 2020/21 this is due in part to the requirement to report and investigate all nosocomial COVID-19 deaths as serious incidents from March 2021. All Serious Incidents are investigated, and action plans are developed to mitigate the risk of recurrence.

Identifying and disseminating the learning arising from incidents to improve patient safety remains a key priority for the Trust and the Account shows practice improvement introduced as a result of learning from incidents to improve patient safety and quality of care. The Trust continues to promote openness and

honesty at all levels and continues to show a high level of compliance with the duty of candour requirement.

The Trust is committed to the national Patient Safety Strategy and fully engaged with the system through the ICS Patient Safety Specialists Steering Group.

## **Challenges**

The Trust has been affected by the wider system pressures of increased demand within the context of recovery and restoration post-Covid. There has been a focus on the number of patients readmitted to a hospital within 28 days of being discharged with the intention of taking action to improve quality: and a collaborative system approach to the safe admission and discharge of patients via appropriate routes.

The process for collecting the data for Venous Thromboembolism (VTE) risk assessments was re-introduced in April 2021 and the Account acknowledges that the Trust has not achieved the required 95% compliance. To address this the Trust are planning to launch a mandatory electronic screening tool in conjunction with the implementation and roll out of Electronic Prescribing and Medicine Administration (EPMA).

There continues to be a partnership approach to the management of clostridium difficile (CDiff) across the health economy. The Account acknowledges the rise in CDiff cases from April 2021 and continue to closely monitor, conducting root cause analysis of all cases and taking appropriate action, sharing learning across the Trust. NHSE/I and CCG colleagues were invited to conduct a peer review which provided assurance that the Trust had implemented appropriate actions and no new actions were identified. Monitoring continues through the IPC and patient safety committees that are attended by a CCG representative.

Reducing harm from falls was identified as a quality priority for 2020/21, and whilst the desired trend has not been achieved, there has been an increase in patient mobility, and the Trust continue to promote mobility to reduce deconditioning. A community of practice has been developed involving social care and community colleagues as well as other acute providers to connect the care of people at risk of falls and mitigate risks across the whole community.

## **2021/2022 Priorities**

### **Achievement against 2020/2021 Priorities**

Quality improvement activities were maintained during 21/22 and 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.

Quality priorities included improving inpatient mobility to reduce functional decline and maximising discharge potential; improving the use of personalised care and support plans (PCSP) for women using maternity services; and reviewing diabetes pathways to isolate and act on crisis points.

During the year data relating to patients who are sitting out of bed at lunchtime has been collated and supported by falls prevention practitioners who have celebrated the successes reported across inpatient areas. The PCSP has not progressed as predicted due to continued COVID-19 pressures but the workstream has recommenced and SFHT continue to be active participants.

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. SFHT has also helped establish the priorities and roadmap for the Mid Notts ICP working with system partners outside of the hospital.

## **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 2022-2023 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**

**Not received on date of submission**

## 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 2021- 22 Quality Account report.

The report includes a comprehensive section on complaints. Whilst it is concerning that the number of complaints received by the Trust increased by 27% in 2021 -22, the report demonstrates an honest and transparent approach by sharing the main themes and specialties involved. There are reported concerns with the pressure on the Complaints Team and a new set of timescales for responding to complaints is outlined.

The staff survey reports positive results, with the Trust achieving the highest score in the Midlands and the accolade of the “best acute Trust to work in”. Staff engagement and satisfaction are important indicators for the delivery of excellent patient care.

We welcome the additional Quality Priorities around patient experience: improving the experience of care for Dementia patients and their carers; using feedback from patients and their carers (using the Families and Friends Test); and safeguarding vulnerable people. The Trust has shared feedback from the Families and Friends Test with divisions for learning and reflection, and the report documents some of the changes that have been made as a result of this feedback.

Improvement priorities for 2022-23 include ‘Excellent patient experience for users and the wider community’. This will be measured by increased service user/citizen engagement at key SFH meetings. Whilst this priority is welcomed, the Trust needs to pay attention to the metric which focusses on engagement at meetings. This will exclude some service users/citizens for whom other engagement approaches are needed.

## 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 2021/22 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 2021 to March 2022
  2. Papers relating to quality reported to board over the period April 2021 to March 2022
  3. Feedback from commissioners dated 27/05/2022
  4. Feedback from local Healthwatch organisation dated 28/06/2022
  5. Feedback from Overview and Scrutiny Committee not received on date of submission
  6. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009,
  7. The 2021 survey was published in March 2022
  8. The 2021 national staff survey dated 30 March 2022
  9. The Head of Internal Audit's annual opinion of the trust's control environment dated xxx
  10. 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



30/06/2022 .....Chair