Sherwood Forest Hospitals
NHS Foundation Trust

Quality Account and Reports

2019/20

Healthier Communities, Outstanding Care

Contents

Introduction to the Quality Account

This report has been designed to provide assurance to our patients, the public and commissioners the quality of care at Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) meets the expected standard. It provides a review of the Trust's quality improvement activities and achievements during 2019/20 and identifies improvement opportunities the Trust will focus on.

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

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2019/20
- Data Dictionary

Part 1 - Statement of the Quality Account from Richard Mitchell Chief Executive

We want to provide the best care possible to all patients and we want all colleagues at Sherwood to feel they are supported, included and listened to. These aims run through the vision we launched in 2019; “Healthier Communities and Outstanding Care” for all.

I am proud to present our quality account for 2019/20. The report explains how we performed against our priorities during the year and sets out our priorities for the coming year 2020/21. We also provide an overview of our key performance indicators and assurance statements.

The report covers the actions we have taken so far and our plans for 2020/21 to further improve quality in the areas we and our stakeholders have chosen as priorities.

As the Chief Executive at Sherwood, I work with colleagues to improve; quality, culture and access standards (which are an important indicator of quality), to deliver our financial agreements and to strengthen our relationship with partners. Regarding quality, whilst it already feels a long time ago, the Care Quality Commission completed an inspection in January and February 2020. Our overall rating remained Good, we were rated Outstanding for Caring and Good for the remaining four domains. Our acute site Kings Mill Hospital improved its rating to outstanding and Newark Hospital improved to good. All 15 of our services are now rated Good for Safety.

Our staff engagement results in 2019 were the best they have ever been and for the second year running colleagues rated Sherwood the best Acute Trust in the Midlands. I do recognise we still have much more to do though. We still have too many colleagues who do not feel supported at work and who feel their jobs are unmanageable. I will continue to commit personally to focus on this whilst we know one of the biggest determinants of our experience of work is our relationship with our line manager. Happy staff provide safe high quality care and we want to further improve the safety of our services.

Our access standards (waits for emergency, elective, cancer and diagnostic care) have remained strong. I remain worried about the pressure colleagues feel and I do not feel proud about the length of time a minority of patients have waited for their treatment or admission. I am aware of the impact this has on patients and colleagues and we will make further improvements at Sherwood over the next year. For the fourth year in a row, we have delivered on our agreed financial position and we are working even more closely with partners in health and social care through the Mid Nottinghamshire Integrated Care Partnership and the Nottingham and Nottinghamshire Integrated Care System. Sherwood is not an island and we recognise we have a big responsibility to work with partners to transform the services for our patients and public. Whilst we are fortunate to work in buildings, which are very clean and, in general, are modern and spacious, we are also committed to developing these services.

Towards the end of 2019/20 we experienced the impact of COVID-19. I am incredibly proud of how the Sherwood team responded. We continued to focus on providing the best care possible to all patients and we stepped up our efforts to support, include and listen to all Sherwood colleagues. We did pause some of our patient care services as colleagues were redeployed into different roles. We have identified priorities for 2020/21 but as the future currently is so uncertain we may seek to review and reprioritise as the year unfolds.

The quality account has been prepared with our clinical teams and people who are closest to the service being reported upon. Reporting on quality and performance necessarily involves judgment and interpretation. To ensure the report provides an objective review, it has been scrutinised by all stakeholders and by the board including our non-executive directors and governors.

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

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

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

To the best of my knowledge the information contained within this Quality Account is accurate.

Signed: Date:

Richard Mitchell,
Chief Executive

Part 2 - Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

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

2.1.1 Providing high quality, safe care

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

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

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

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

2.1.2 Approach to Quality Improvement

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

The three priorities over 2019/20 were as follows:

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

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

- **Developing a Safety Culture.** The Trust has a 'Human Factors Community of Practice' in place to help shape the organisation's approach to safety, and there is evidence of cohesive and aligned learning from safety, improvement and governance via the shared 'Quarterly Learning Events' that has been established to focus on themes emerging from incidents and feedback.

The Service Improvement strategy has a range of key performance indicators that underpin these priorities, and progress is reported on a monthly basis through to the Trust's Advancing Quality Programme.

In addition to these measures, the Clinical Audit team has merged with the Improvement team, in order to optimise opportunities for clinical staff to learn from, and engage more in evidence based and improvement activities.

Priorities for 2020/21 include the further development of QI capabilities within the Trust, and across the Nottinghamshire Integrated Care System (ICS), using a coaching approach to connect people and to embed improvement skills. We will also raise the visibility of improvement work happening across the Trust, in order to focus activities to support organisational strategic goals. Furthermore, we intend to increase citizen involvement within our improvement work; extending opportunities for people to undergo improvement training, and to actively co-design improvements.

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

2.1.3 Quality Priorities 2018-2021

By 2021 the Trust aspires to be rated as outstanding 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 alignment between quality, activity and financial planning to boost our combined efforts to deliver safe, effective and financially sustainable services in the longer term.

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

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

Three improvement priorities for specific focus in 2020/21 are indicated below:

Specific Indicator	Quality Priority	Success Measure
Patient Safety	Improve in-patient mobility to reduce deconditioning and progress patients functional outcome for a safe discharge	85% of clinically appropriate patients are dressed and out of bed by 12.00
Patient Experience	Service user involvement in recruitment and standing Trust forums	Increase in service user involvement to at least 5 committee or groups
Clinical Effectiveness	Review the pathway for Diabetes to isolate potential crisis points and act on the analysis	Develop a health and well-being package for diabetes patients at SFHFT.

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

Progress against the quality priorities is monitored monthly by the Executive Medical Director and Chief Nurse through the Advancing Quality Oversight Group. A Report is presented to Quality Committee quarterly as part of the agenda who report to the Board of Directors.

2.1.4 Review of Quality Priorities during 2019/20

The following section provides an overview of the Trust's quality priority performance during 2019/20. Three key priorities were selected from each of the four quality campaigns of the 2018/21 Quality Strategy. The table below describes the Trusts '2019/20 Quality Priorities and progress to date.

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

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

As part of the Learning Disability response and ensuring in line with our Learning Disability policy, all patients who attend the Trust are commenced upon the Learning Disability pathway (if they do not have one already in place). All patients are referred to the Learning Disability team when admitted and they ensure that the patients are commenced upon the Learning Disability pathway where needed.

We have seen a 56% increase in the use of the learning disability pathway. Our position for this year and the preceding year are indicated below:

Year	Number of patients admitted who have had a new pathway commenced	Patients seen as outpatient who have had a new pathway commenced	Number of patients commenced upon a Learning Disability Pathway who attend the Trust
2018/2019	467	1742	2209
2019/2020	473	765	1238
Percentage increase			**56%**

Once a patient is commenced upon the pathway they remain on it in and out of hospital to promote multi-agency individualised care provision. Admissions from this patient cohort have fallen significantly this year and this may be a realisation of the benefits of the pathway. We will continue to monitor systematically over the next year.

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

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

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

2019/20	**Q1**	**Q2**	**Q3**	**Q4**
Total Fast Track Discharges	117	133	139	107
Achieved PPC	93	117	112	82
Non-achieved PPC	24	16	27	25
Percentage achieved PPC	**79%**	**88%**	**81%**	**77%**

During 2019/20 significant challenges have remained and these have impacted on the consistency of our performance with this process. The reasons for not achieving PPC include sudden deterioration of the patient, changes in family choice of PPC if patients deteriorate, care home availability & weekend/bank holiday discharges when CHC assessment is not available.

Progress with this priority has been monitored through the Advancing Quality Programme and measures are in place to ensure that factors within the control of the Trust are robustly managed. These have included providing medical teams with better information and resources to improve the identification of suitable patients in a timely manner and preparation of specific applications. Ensuring that the Integrated Discharge Advisory Team (IDAT) are involved with the Fast Track discharge at the earliest opportunity to support staff, patients & their families with the process has also been shown to be a key feature in the quality of the process. In addition, training & support to facilitate a deeper understanding of the process has been delivered by the specialist teams.

The challenges with Fast Track discharges are recognised throughout the system and further Alliance work will focus on supporting a longer-term achievement of PPC for all patients across Mid-Nottinghamshire. This is ambitious but has been set as a priority for the End of Life Care Together Service who are working with Continuing Health Care to understand the scope of what could be achieved through the alignment and coordination of Fast Track referrals and End of life care services

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

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

During 2019/20, 14% (53) of complaints investigated related to discharge concerns; this represents a 4% decrease from 2018/19. The themes identified within these relate to poor communication with families regarding discharge assessments and arrangements, delay in take home medications and inaccurate discharge summaries.
Just over half of the complaints were upheld and actions were implemented by divisions to address these concern.

During 2019/20, there were 232 (1.6%) incidents relating to discharge in comparison to 227 (1.7%) in 2018/19. 2% of these resulted in moderate harm and none in severe or catastrophic harm.

As a result of the complaints and incidents, a triangulation of feedback including, complaints, concerns, incidents and Section 42 (enquiries according to the Care Act (2014) has taken place and a Discharge Task and Finish Group has been established. An action plan has been developed to address the themes and trends and will be monitored by the Advancing Quality Programme. Key deliverables to date include:

- Review of our Discharge Policy focusing on key areas of learning
- The Integrated Discharge Advisory Team continue to work closely with SFHFT's Safeguarding Team in relation to Section 42's to ensure we learn when services feel that the Trust has unsafely discharged a patient.
- The Integrated Discharge Advisory Team work in close partnership with our community colleagues to facilitate early supported safe discharges.
- All patients that are assessed by the Frailty Intervention Team (FIT) in A & E will have a post discharge holistic needs assessment completed within 24 hours of returning home.
- We have a dedicated telephone line for Palliative Referrals to 'Call 4 Care'.
- The Home First leaflet, in conjunction with Social Services Golden Number and 'Call 4 Care' patient line number is at every patient bedside for patients / relatives to for information if required post discharge.
- The Trust sourced local additional capacity at Ashmere Care Homes, along with additional beds at King's Mill Hospital, which are fully supported by Senior Clinicians. This formed part of the Winter Pressure plans for 2019/20.
- We are in the process of trialing "Discharge to Assess" (D2A) to support safe, timely discharge.

2019/20 Additional Quality Priorities

Progress against each of the additional quality priorities can be found in section three.

2.2 Statements of Assurance from the Board

1. General Statement

During 2019/20 the Sherwood Forest Hospitals NHS Foundation Trust provided and/or subcontracted 59 relevant health services.

The Sherwood Forest Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 59 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 80.75% of the total income generated from the provision of relevant health services by the Sherwood Forest Hospitals NHS Foundation Trust for 2019/20.

2. Participation in Clinical Audit

Clinical Audit Submission to Quality Accounts 2019/20

During 2019/20, the relevant health services that Sherwood Forest Hospitals NHS Foundation Trust provides covered 57 national clinical audits and 2 national confidential enquiries.

During that period Sherwood Forest Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential that it was eligible to participate in.

These are as follows:

Project name (A-Z by project name)
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)
British Association of Urological Surgeons Urology Audits - Nephrectomy audit
Care of Children (Care in Emergency Departments)
Case Mix Programme (CMP)
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit Programme (FFFAP) - National Audit Inpatient Falls
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.
Major Trauma Audit
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal morbidity and mortality confidential enquiries (reports alternate years)
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries
Mental Health (Care in Emergency Departments)

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary rehabilitation
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 Dementia (care in general hospitals)
National Audit of Seizure management in Hospitals (NASH) round 3
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
National Cardiac Arrest Audit (NCAA)
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI)
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit
National Diabetes Audit - Adults - National Diabetes Foot Care Audit
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDIA)
National Diabetes Audit - Adults NaDIA-Harms - reporting on diabetic inpatient harms in England
National Diabetes Audit - Adults - National Core Diabetes Audit
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA)
National Oesophago-gastric Cancer (NOGCA)
National Bowel Cancer Audit (NBOCA)
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)

National Ophthalmology Audit (NOD) - Adult Cataract surgery
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit
National Smoking Cessation Audit
Perioperative Quality Improvement Programme
Sentinel Stroke National Audit programme (SSNAP)
Society for Acute Medicine's Benchmarking Audit (SAMBA)
UK Cystic Fibrosis Registry
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)
Endocrine and Thyroid National Audit
Mandatory Surveillance of bloodstream infections and clostridium difficile infection
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Surgical Site Infection Surveillance Service

National Clinical Outcome Review Projects 2019/20

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals NHS Foundation Trust participated in during 2019/20 are as follows:

National Clinical Audit & Enquiry Project Name	Included in NHSE Quality Account List (2019/2020	Part of NCAPOP commissioned by HQIP (Y/N)	% Complete
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	**Y**	**N**	100
BAUS Urology Audits - Nephrectomy audit	**Y**	**N**	100
Care of Children (Care in Emergency Departments)	**Y**	**N**	100

Case Mix Programme (CMP)	**Y**	**N**	100
Elective Surgery (National PROMs Programme)	**Y**	**N**	100
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit Inpatient Falls	**Y**	**Y**	100
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	**Y**	**Y**	100
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	**Y**	**N**	50
Major Trauma Audit	**Y**	**N**	39
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	**Y**	**Y**	100
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal morbidity and mortality confidential enquiries	**Y**	**Y**	100
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries	**Y**	**Y**	100
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	**Y**	**Y**	100
Mental Health (Care in Emergency Departments)	**Y**	**N**	100
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	**Y**	**Y**	100
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	**Y**	**Y**	100
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	**Y**	**Y**	100
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary rehabilitation	**Y**	**Y**	100
National Audit of Breast Cancer in Older People (NABCOP)	**Y**	**Y**	100
National Audit of Cardiac Rehabilitation	**Y**	**N**	100
National Audit of Care at the End of Life (NACEL)	**Y**	**Y**	100
National Audit of Dementia (care in general hospitals)	**Y**	**Y**	100
National Audit of Seizure management in Hospitals (NASH) round 3	**Y**	**N**	100
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	**Y**	**N**	100
National Cardiac Arrest Audit (NCAA)	**Y**	**N**	100

National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	**Y**	**Y**	100
National Cardiac Audit Programme (NCAP) - Myocardial Ischemia National Audit Project (MINAP)	**Y**	**Y**	100
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI)	**Y**	**Y**	100
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	**Y**	**Y**	100
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	**Y**	**Y**	100
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDIA)	**Y**	**Y**	100
National Diabetes Audit - Adults NaDIA-Harms - reporting on diabetic inpatient harms in England	**Y**	**Y**	100
National Diabetes Audit - Adults - National Core Diabetes Audit	**Y**	**Y**	100
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	**Y**	**Y**	100
National Early Inflammatory Arthritis Audit (NEIAA)	**Y**	**Y**	100
National Emergency Laparotomy Audit (NELA)	**Y**	**Y**	100
National Oesophago-gastric Cancer (NOGCA)	**Y**	**Y**	100
National Bowel Cancer Audit (NBOCA)	**Y**	**Y**	100
National Joint Registry (NJR)	**Y**	**N**	100
National Lung Cancer Audit (NLCA)	**Y**	**Y**	100
National Maternity and Perinatal Audit (NMPA)	**Y**	**Y**	100
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	**Y**	**Y**	100
National Ophthalmology Audit (NOD) - Adult Cataract surgery	**Y**	**N**	100
National Paediatric Diabetes Audit (NPDA)	**Y**	**Y**	100
National Prostate Cancer Audit	**Y**	**Y**	100
National Smoking Cessation Audit	**Y**	**N**	100
Perioperative Quality Improvement Programme	**Y**	**N**	100
Sentinel Stroke National Audit Programme (SSNAP)	**Y**	**Y**	100
Society for Acute Medicine's Benchmarking Audit (SAMBA)	**Y**	**N**	100
UK Cystic Fibrosis Registry	**Y**	**N**	100
UK Parkinson’s Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	**Y**	**N**	100

Endocrine and Thyroid National Audit	**Y**	**N**	100
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	**Y**	**N**	100
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption	**Y**	**N**	100
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship	**Y**	**N**	100
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	**N**	**N**	100
Surgical Site Infection Surveillance Service	**Y**	**N**	100

Study Title	**Participation**	**Project Status**	**% Complete**
Dysphagia in Parkinson's Disease	Yes	Patients Submitted to study	100
In-hospital management of out-of-hospital cardiac arrest	Yes	Patients Submitted to study	100

Non-Participation/Exceptions

Inflammatory Bowel Disease (IBD) programme
Approximately 50% of the data has been inputted for 2019/20.
Historically, data has been collected and submitted manually for this audit. Whilst a new Trust data collection tool has recently been commissioned which should rectify this going forward, the trust has not been able to submit a full set of data for this year. It should be noted that the data entry going forwards will contain a full data set therefore making compliance of participation at 100%.

Major Trauma Audit
39% of data has been submitted due to a vacancy within the administration post; this post is a joint appointment with NUH which is the lead employer. Mitigation actions were put into place at SFHFT (including freeing up an administrator to continue the audit) but it is a complex audit and this has shown us that experience and knowledge of the process is key. Action has been taken to increase the frequency that patient data is made available to the administrator; this will result in increased data being submitted in future. Potentially due to the fact that we have utilised an 'in house 'administrator who understands the process, the compliance with the audit standards has increased.

Outcomes and Learning from Clinical Audits Undertaken During 2019/20
The number of clinical audits, both national and local, which formed part of the 2019/20 Audit Plan, is as follows:

Total Number of Audits in the 2019/20 Plan: **265**
Number of Local / Other Audits: **206**
Number of National Audits, Inc NCEPOD: **59**
Number of Audits completed: **95 (36%)**

The COVID-19 pandemic has significantly affected the audit programme in 2019/20. We have many further audits in progress and are developing a recovery plan for the programme in 2020/21.

Whilst we benchmark well nationally, there is opportunity to improve the care provided to patients through audit. The alignment of clinical audit and quality improvement will enable us to do this systematically in the future.

The National Audit of Breast Cancer in Older People
The results demonstrate that 100% of patients received the Triple Assessment, which is seen as the gold standard approach to diagnosis. This is in comparison to the national figure of 67%.

The Chronic Obstructive Pulmonary Disease (COPD) Audit
The results demonstrate that the Trust has seen a significant increase in the number of current smokers accepting advice and interventions, rising from 48% in March 2018 to 85% in March 2019.

The National Heart Failure Audit
The results show that the proportion of patients who have received intervention from a Heart Failure Specialist has increased to 81.2% and more patients have Heart Failure Specialist Nurse input.

The British Thoracic Societies National Audit of Smoking Cessation
The audit sees the trust continuing to achieve excellent results with 96% of patients being screened for their smoking status compared to the national average of 76.8%.

The Sentinel Stroke National Audit
The Trust achieved an 'A 'rated service for the treatment of patients experiencing a Stroke. This is highlighted 97.5% of patients had their swallowing screened within 72 hours of being admitted; higher than the national average of 88.6%.

The National Hip Fracture Database (NHFD)
The results indicate that patients undergoing a Delirium assessment at pre-operative stage have increased for a second year to 93.8% reviewed prior to them undergoing an operation at the Trust. The results also indicate that the number of patients who are discharged to their original residence improved to 77.5% higher than the national average of 70.6%.

The Royal College of Emergency Medicines audit relating to Vital Signs In Adults
The results of the audit demonstrate that SFHFT achieved 75% for measuring and recording the 'six vital signs 'of respiratory rate, oxygen saturation, pulse, blood pressure, GCS or AVPU score and temperature within 15 minutes of a patient's arrival or triage; this is above the national average of 50%. These are imperative in ensuring that patients are triaged in a timely manner and that their care needs are established at an early opportunity

The National Emergency Laparotomy Audit
The results of this audit highlight that there is both a Consultant Anaesthetist and Consultant Surgeon present in 100% of cases where the risk of patient death in surgery is calculated at being equal to or greater than 5%, 16% higher than the national average. The Trusts average post-operative stay is recorded at 11 days which is 5 days lower than the national level, and 4 days lower than the local Academic Health Science Network region

The National Audit of Adult Asthma
The audit demonstrates that 85% of patients requiring systemic steroids have these administered within four hours of arrival at the hospital, higher than the national average of 65%

The National Paediatric Diabetes Audit
The audit demonstrates that the percentage of children with a Hba1c measurement below 58mmol (which is an indicator of positive glucose control) is 43.3%, 14% higher than the national average, and continues to improve year on year.

Below are some examples of the local audits completed in 2019-2020 with the outcomes captured and actions to aid improvement:

19-20-3315: An Audit of the Haematology Nurse Specialist (HNS) Role in the Care of Patients with a Cancer Diagnosis
The standards were derived from the Haematological Cancers – Improving Outcomes, Implementing the Care Taskforce Recommendations and the Manual for Cancer Services – Haemato-Oncology Cancer Measures. The sample consisted of 49 patients diagnosed with a Haematological Cancer from January to June 2019.

- Results showed that 71% of patients were aware of who their key worker was, 85% were seen by a Haematology Nurse Specialist at the time of diagnosis and treatment planning and 71% of patients were given information prescription about the diagnosis and condition.

- Outcomes from Multi-Disciplinary Team (MDT) meetings were recorded in the majority of cases within the medical record or within the patients nursing documentation.

- Based on audit outcomes, a Standard Operating Procedure has been developed and shared that outline expectations of the Haematology Nurses (NHNS) team across SFHFT sites. Recruitment of further Haematology Nurse Specialist is being undertaken, with additional training being given to current staff on electronic health needs assessment (e-HNA). The Key Worker leaflet has also been updated. All HNS receive a copy of all patients referred via a 2 week wait pathway. This aids planning and arrangement of patient appointments and clinics.

19-20-3311: Routine Enquiry in to Maternity Services (NICE PH50) (Re-audit)
This audit cycle examines national guidelines stating Maternity Services are best placed to support pregnant women who may be at risk of domestic abuse. It is repeated every two years and was last conducted in March 2017. Changes introduced following the previous cycle include Pregnancy Day Care, the Triage Unit on the Sherwood Birthing Unit and Antenatal Clinic. The audit also examined occasions where domestic abuse was disclosed. It assessed if a Domestic Abuse, Stalking and Harassment (DASH) risk assessment was completed, or if Social Care or the Independent Violence Advocate Service (IDCA) Service were involved.

- 82.5% of patients were asked about domestic abuse

- 99 patients (64.4% of cases) confirmed that they had been asked about domestic abuse by the Community Midwife at least once, and in 34% of cases, over four times.

- There were low numbers of positive disclosures, totaling four (3.3%) disclosures.

- Collaborative work has been undertaken with Women's Aid to deliver training around domestic violence and abuse, and further to the audit, a half day training in how to complete the DASH risk assessment is also available. All members of staff are to attend both training events.

- Actions following this audit cycle include signposting people to Women's Aid Information Services (WAIS) using "rip off" telephone number sheets in male and female patient toilets.

19-20-4161: MRI in Cauda Equina Syndrome Re-audit

Prompt diagnosis is important in Cauda Equina Syndrome as delays could result in complications; diagnosis is undertaken through an MRI scan. The purpose of this re-audit was to improve patient outcomes, and to reduce time for the MRI scan to be requested to Radiology and subsequently a Radiologist report being issued. This audit was undertaken with the East Midlands Spinal Network (EMSN). This re-audit was undertaken in March-April 2019 followed introduction of a Network Urgent Radiology Policy agreed in 2018/2019. King's Mill Hospital does not have 24 hour access to MRI scanning, so a Standard Operating Procedure (SOP) was also introduced. This allowed Radiographers to authorise and scan the MRI Spine requests without consultation with a Radiologists using agreed criteria. The actions from the original audit at the time of this re-audit ensured urgent MRI spines are identified quicker, are scanned and reported within 12 hours. Early inpatient appointments were allocated for urgent spinal referrals.

- The Standardised Operating Procedure increased the number of patients whose tests, (from initial request to MRI reporting), were completed in 12 hours from 50% to 86.5%.
- This process has improved access to MRI for patients with suspected Cauda Equina, and standardised working practices across the network standards.

19-20-3310: Re-audit Screening for Early Onset Sepsis in Neonates

This local re-audit assessed whether septic screens are undertaken in accordance with National Institute for Health and Care Excellence and local guidance:

- The results demonstrated all babies had C-RP (C-Reactive Proteins), full blood counts and blood cultures performed. All babies were started on the correct antibiotics as per local guidelines and 86% of babies were reassessed after 36 hours.
- There was a reduction in the number of avoidable Sepsis screens from 10% in the first audit to 1.8% in the re-audit.
- There was some improvement in communication with the parents, from 71.21% to 74%.
- In 57% cases it was documented that babies were screened within one hour of the decision to treatment.

18-19-3264: Need for Ultrasound of Kidney in Acute Kidney Injury (AKI) Stage 1

An audit into the number of kidney ultrasounds performed in Stage 1 AKI patients, and how many of these scans were indicated according to NICE AKI guidelines (2013 – CG169). This states routine ultrasound of the urinary tract is not indicated when the cause the AKI has been identified.

- 84% of the stage 1 AKI's resolved within 72 hours, yet 82% of ultrasounds were performed within 48 hours.
- 28% ultrasounds were performed after the AKI was resolved so did not need to be undertaken.
- 42% of ultrasounds requests were undertaken as per the AKI bundle. The audit recommended that an alteration to the AKI bundle and changes in clinical practice in requesting ultrasound in stage 1 AKI.
- This change to the bundle will reduce unnecessary scans and identify better practice. This has been enacted and will be re-audited in 2020.

Review of 2019/20

1. Clinical Audit and Quality Improvement Teams merged in July 2019, highlighting the shared agenda of outcomes, improvement and learning.

2. There has been a review of the Clinical Audit and Effectiveness Group, following feedback from key stakeholders, resulting in a name change to the 'Improvement and Clinical Audit Group 'and a refined focus to work collectively on improving the audit process and strengthening the link to improvement and learning.
3. The Specialty Audits leads meetings took place in early 2019, with productive discussions around the expectation of the role and the support on offer from the Audit and Improvement team.
4. The Clinical Audit Policy was updated and ratified in October 2019, to focus more on improvement and learning
5. The Clinical Audit team celebrated Clinical Audit Awareness Week 2019 (25-29 November 2019). There were drop-in sessions, stands, communication events, additional training and a poster competition for the best project. As a result, the SFHFT Clinical Audit and Improvement team chase been nominated for a national HQIP Team award.
6. The clinical audit registration form has been updated to incorporate Specialty approval before the project is registered, in order to add value, and to ensure best use of resources.
7. The current and historic audit plan is now accessible via the Intranet, sharing all of the registered local audits in the Trust.
8. An updated Clinical Audit outcomes template is available to users, in accordance with feedback from an internal audit and Care Quality Commission (CQC) requirements. This aims to help staff to capture learning and improvement in a robust way, and encourages staff to undertake Service Improvement training as part of the process.
9. Consultation is underway with all Specialty Audit Leads and Divisions, to see whether the current Trust-wide audits reflect the work of the Specialty and Division, and whether they are truly meaningful indicators of quality. Divisions are currently planning their annual audit priorities for 2020/21.

Looking Forward to 2020/21

1. The Clinical Audit strategy actions to be implemented over next 12 months include; building closer working relations with the Governance Support Unit, Legal and Risk teams and Research and Innovation in order to triangulate information and outputs in a more defined way.
2. To increase awareness of clinical audit as a QI tool amongst staff, and to encourage and train leads to undertake QI training to support positive and sustainable change.
3. To re-connect staff to the purpose of audits by introducing the new approach to the Trust-wide audits programme.
4. To introduce and implement a new Clinical Audit system which will incorporate the registration of projects, data collection and analysis, monitoring of both the progress and action plans. This will combine improvement projects and audits into one visible area for staff.
5. Further development of the Clinical Audit intranet page in sharing learning, outcomes of audits and the in-house support available to progress these effectively.

3. Participation in Clinical Research and Innovation

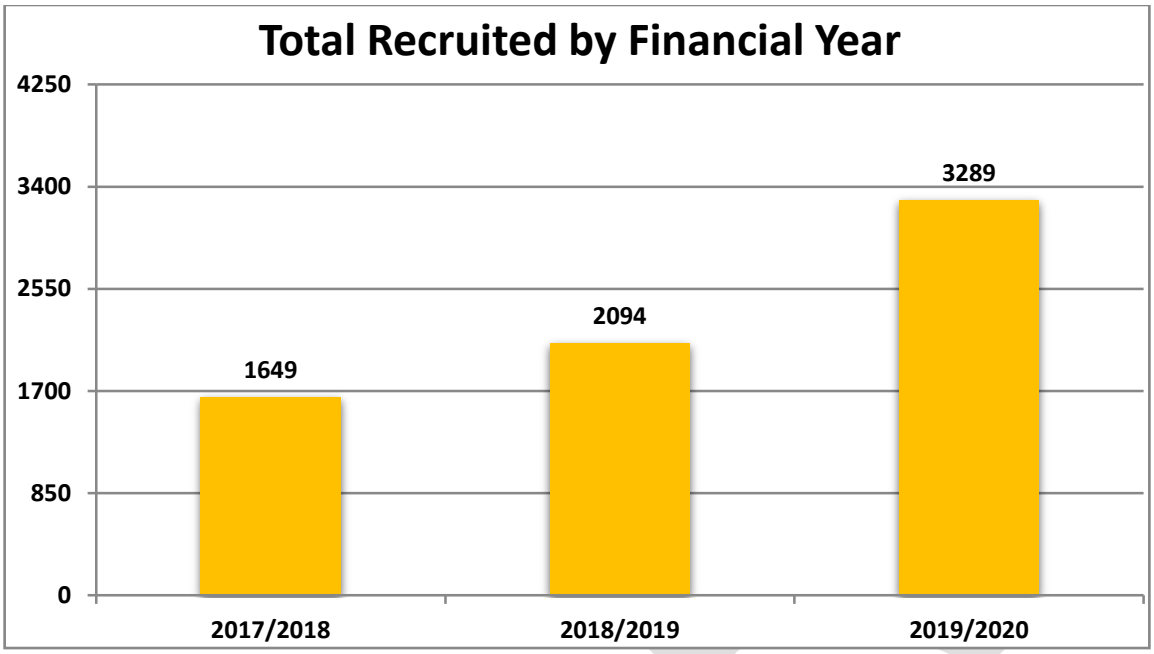
The number SFHFT patients receiving healthcare in 2019/20 recruited during the period to participate in research approved by the Research Ethics Committee was 3,433. This figure includes patient's data and tissue samples.

The Trust is actively involved in clinical research and has a dedicated Research and Innovation department (R&I). The R&I team is responsible for developing and supporting a varied research portfolio that creates better opportunities for patients and staff to participate in research activity, whilst informing the provision of high quality, evidence based health care. Patient participation in research is

mainly through studies adopted by the National Institute for Health Research (NIHR). The Trust is involved in a small number of non-adopted studies which are typically undertaken for educational purposes.

Research activity in the organisation is increasing year on year with a total of 3289 participants recruited in to NIHR studies in 2019/20. This demonstrates a 57% increase on 2018/19 recruitment figures with a 99% increase over the last 3 financial years (see graph 1) All data is based on local recruitment figures from the research management database EDGE.

Graph 1



In 2020/21 the Trust aims to increase the number of patients who have access to research studies as part of their care pathway; with a target of 2000. This is less than we recruited last year as we had a large spike in recruitment in October from 1 specific study and the impending pandemic means it is not realistic to set a target higher than last year's recruitment. We also acknowledge despite year on year increases it is important to balance quality of studies and patient benefit with achieving high numbers.

In 2019/20 SFHFT continued to increase its commercial research activity with 6 commercial trials opened and recruiting in year; 100% of those were interventional studies and all recruited to time and target. In 2019/20 we set to build on commercial activity by strengthening our reputation for delivery and attracting more commercial companies to bring clinical trials to SFHFT. This was realised and the Trust now deliver clinical trials for 7 different commercial companies. The plan is to open a dedicated Clinical Research Facility later this year. This will be at the centre of the growth of commercial research locally and will expand the access to clinical trials for patients in the region, enabling the uptake of more complex trials in a comfortable and relaxed environment

Research is a partnership between participant and researcher. Every year, as part of the NIHR research participant experience survey we ask people who have volunteered for health research at SFHFT to feedback on their experience so we can make improvements. Our survey focused on two main questions and we found that of those respondents, 87% reported that they would agree or

strongly agree that they had a good experience of taking part in research and 33% surveyed reported that one of the main reasons they took part in research was to help future generations.

The Trust is committed to expanding research activities and facilities and has developed strong associations with Universities, other NHS Trusts and stakeholders. To expand the types of research studies available to the local population the Trust has developed collaborative relationships with Nottingham University Hospitals NHS Trust and Nottingham Biomedical Research Centre and University College London Hospitals NHS Foundation Trust. 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.
SFHFT has recently joined the NIHR Research Champion scheme and is recruiting volunteers to help promote health and care research to patients and the public. There is particular focus on those groups who are considered less likely to take part in studies. They also help research and healthcare staff to understand more about the experiences of those who take part in research.

SFHFT is working closely with the East Midlands Academic Health Science Network (EMAHSN) and the life sciences industry expertise at BioCity Nottingham to deliver a unique, fully funded programme for staff with novel ideas that could benefit patients and the NHS. The programme will help to support staff and the organisation to progress a great idea to become a great innovation which could be commercially developed.

At a local level, the Trust R&I team is working closely with Nursing and Allied Health Professional teams to begin to embed clinical research into frontline care. A joint initiative with the Critical Care team at SFHFT to create research opportunities for staff and uptake trials for patient benefit has been successful, resulting in a portfolio of 6 trials in this area. The department continues to support research secondments and dedicated research time within new posts, as part of the SFHFT Research Academy and network of Research Champions.

Research and Innovation have presented a quarterly update to Trust Board, and a performance update is provided quarterly to the Trusts Patient Safety and Quality Group. Also, 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 KPI (Key Performance Indicator) for NHS Trusts; “Performance in Initiation and Delivery of Clinical Research” in which SFHFT continue to retain its sustained performance improvement.

4. Commissioning for Quality and Innovations (CQUIN) Indicators

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

A proportion of Sherwood Forest Hospitals NHS Foundation Trust income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Sherwood Forest Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at http://www.sfh-tr.nhs.uk/index.php/board-of-directors/board-of-directors-meeting-papers -2019

During 2019/20 the Trust engaged in all eligible national CQuINS and specifically identified specialised CQuINS and has received positive endorsement for all work undertaken by our commissioners (Clinical Commissioning Group and NHS England).

The following section provides an overview of the 2019/20 CQUIN year-end position.
A – Achieved
PA – Partially Achieved
NA – Not achieved

Summary of Acute Schemes for 2019/20

CQUIN scheme	Indicator name	Description	Q1	Q2	Q3	Q4
National	CCG1a AMR – Lower Urinary Tract Infections in Older people. Prevention of Ill Health	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting the NICE guidelines for lower UTI and PHE diagnosis of UTI guidance in terms of diagnosis and treatment.	NA	NA	A	
National	CCG 2 Staff Flu Vaccinations Prevention of Ill Health	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	A	A	A	
National	CCG3a Alcohol and tobacco - screening Prevention of Ill Health	Achieving 80% of inpatients admitted to an inpatient ward for at least one night that are screened for both smoking and alcohol use.	A	A	A	

Summary of Acute Schemes for 2019/20

National	CCG3b Alcohol and tobacco – Tobacco brief advice Prevention of Ill Health	Achieving 90% of identified smokers given brief advice.	A	A	A	
National	CCG3c Alcohol and tobacco - Alcohol Brief Advice Prevention of Ill Health	Achieving 90% of identified as drinking above low risk levels, given brief advice or offered a specialist referral.	A	A	A	
National	CCG 7 Three high impact actions to prevent hospital falls Patient safety	Achieving 80% of older inpatients receiving key falls prevention actions.	A	A	A	
National	CCG 11a SDEC – Pulmonary Embolus Best Practice Pathways	Achieving 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate.	NA	NA	A	
National	CCG 11b SDEC – Atrial Fibrillation Best Practice Pathways	Achieving 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.	NA	NA	A	

Summary of Acute Schemes for 2019/20

National	CCG 11c SDEC – Community Acquired Pneumonia Best Practice Pathways	Patients with or confirmed community acquired pneumonia should be managed in a same day setting where clinically appropriate.	NA	NA	A	

During 2018/19 the Trust negotiated a block payment with the commissioner to allow the focus of CQuIN objectives on quality improvement rather than financial drivers. The national CQuIN office suspended the CQuIN process in quarter 4 to allow Trusts to concentrate on preparation and care delivery in this period as a result of the pending COVID19 pandemic.

5. Registration with the Care Quality Commission (CQC)

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) is required to register with the Care Quality Commission (CQC) and its current registration is fully registered without conditions. Sherwood Forest Hospitals NHS Foundation Trust currently has no restrictions on registration. The Care Quality Commission has not taken enforcement action against Sherwood Forest Hospitals NHS Foundation Trust during 2019/20.

Sherwood Forest Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has four locations registered;

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

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

King's Mill Hospital

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

Newark Hospital

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

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

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

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

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

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

99.9% for admitted patient care
100% for outpatient care and
98.5% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;
100% for outpatient care; and
98.7% for accident and emergency care

7. Information Governance

Sherwood Forest Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2019/20 was all standards met and was graded fully compliant.

The SFHFT Information Governance Data Security and Protection Toolkit for 2019/20 included **116** items out of **116** mandatory evidence items complete **no** improvement plan to meet the standards was required.

Information Governance Aims for 2020/21
The Data Security and Protection Toolkit encompass the National Data Guardian Review, the Trust will aim to be fully compliant when the new Toolkit is released, and this is perceived to be released after 30th September 2020.

How Was This Achieved

The Trust participated in an audit review pilot in conjunction with 360 assurance (internal audit) and NHS Digital. The audit facilitated a better understanding of data security and protection risk themes across the health and care system

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 2019/20, the Trust reported 5 information governance serious incidents, reported on the Toolkit. The incidents ranged from information being disclosed inappropriately via email, letter and or verbally. No incident remains open for investigation by the ICO moving into the new financial year.

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

8. Clinical Coding Audit

Sherwood Forest Hospitals NHS Foundation Trust was not subject to the Payment by Results (PbR) Clinical Coding audit during 2019/20 by the Audit Commission.

The Trust has a dedicated team of qualified and trainee clinical coders that are responsible for coding approximately 102,923 inpatient activities for 2019/20. 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 2019/20

- Deadline and Targets: Achieve 100% coding target by the 5th working day after the month end.
- Audits: Improving coding accuracy by conducting monthly audits of coded data before the final submission.
- Recruitment and Training: Recruit and train trainee clinical coders
- Clinical engagement – to 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 5th working day after the month end.

Table 1

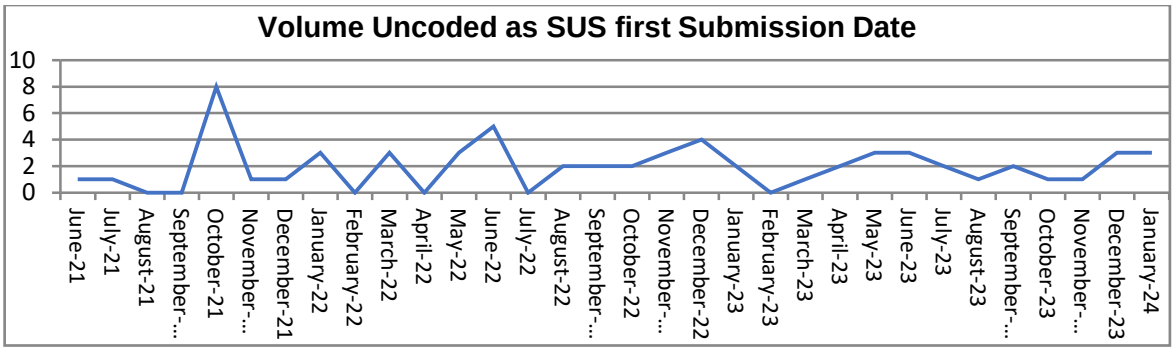
		Spell Discharges				
FCE Month	**1st SUS Submission date**	**Total Number of Episodes**	**Volume Uncoded as SUS first Submission Date Actual & Trajectory**	**Actual Uncoded %**	**% Total Uncoded Trajectory**	**% Coded at 1st Submission**
June-17	19/07/2017	8898	1	0.01%	2.0%	100.0%
July-17	17/08/2017	9024	1	0.01%	2.0%	100.0%
August-17	19/09/2017	9082	0	0.00%	2.0%	100.0%
September-17	18/10/2017	8859	0	0.00%	2.0%	100.0%
October-17	17/11/2017	9297	8	0.09%	2.0%	99.9%

November-17	15/12/2017	9315	1	0.01%	2.0%	100.0%
December-17	17/01/2018	8447	1	0.01%	2.0%	100.0%
January-18	19/02/2018	9003	3	0.03%	2.0%	100.0%
February-18	16/03/2018	7899	0	0.00%	2.0%	100.0%
March-18	19/04/2018	8840	3	0.03%	2.0%	100.0%
April-18	21/05/2018	8196	0	0.00%	2.0%	100.0%
May-18	18/06/2018	8907	3	0.03%	2.0%	100.0%
June-18	18/07/2018	8558	5	0.06%	2.0%	99.9%
July-18	16/08/2018	8741	0	0.00%	2.0%	100.0%
August-18	18/09/2018	8783	2	0.02%	2.0%	100.0%
September-18	17/10/2018	8504	2	0.02%	2.0%	100.0%
October-18	16/11/2018	9411	2	0.02%	2.0%	100.0%
November-18	17/12/2018	9117	3	0.03%	2.0%	100.0%
December-18	17/01/2019	8614	4	0.05%	2.0%	100.0%
January-19	15/02/2019	10062	2	0.02%	2.0%	100.0%
February-19	22/03/2019	9292	0	0.00%	2.0%	100.0%
March-19	17/04/2019	9747	1	0.01%	2.0%	100.0%
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%

Notes:
The table above provides an indication of the volume of un-coded episodes for discharged hospital spells within each month. The 1st Submission date and % un-coded 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 2



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.

2019 / 2020 Gross Savings or Income (£'000)													
Area:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Clinical Coding Audit	£55,965	£70,019	£47,369	£24,326	£65,437	£96,327	£99,999	£54,170	£91,846	£45,069			£650,527
Clinician & Coding Audit	£23,362	£28,538	£16,134	£13,382	£0	£0	£0	£0	£0	£27,135			£108,550
Total	**£79,327**	**£98,557**	**£63,503**	**£37,707**	**£65,437**	**£96,327**	**£99,999**	**£54,170**	**£91,846**	**£72,204**	**£0**	**£0**	**£759,077**
Investments (invoice dated)													
Area:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Data	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Auditors	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Net Savings													
Total	**£79,327**	**£98,557**	**£63,503**	**£37,707**	**£65,437**	**£96,327**	**£99,999**	**£54,170**	**£91,846**	**£72,204**	**£0**	**£0**	**£759,077**

Data Security Standard 1 Data Quality:

As part of Data Security and Protection Toolkit, the Trust has undertaken an audit of 200 finished consultant episodes (April - December 2019) to assess the accuracy of clinical coding. The Trust's coding accuracy meet the required percentage across all four areas.

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

Table 2

	Primary diagnosis correct	**Secondary diagnosis correct**	**Primary procedure correct**	**Secondary procedure correct**
Standard Exceeded	>=95%	>=90%	>=95%	>=90%

Standard Met	>=90%	>=80%	>=90%	>=80%
SFHFT	*90.5%*	*95.6%*	*90%*	*90.4%*

Recruitment and Training

The Trust has appointed a dedicated Clinical Coding Trainer, Clinical Coding Auditor and 2 Senior Clinical Coders, and also successfully recruited four trainee clinical coders.

Clinical Coding Awareness

Clinical coders conducted Bite-size Learning events to raise coding awareness to administrative and clerical staff. Clinical coders also conduct specialty-coding presentations to doctors at Clinical Governance meetings.

Clinical Engagement

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

How Was This Achieved

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

Monitoring and reporting for sustained improvement

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

Sherwood Forest Hospitals will be taking the following actions to improve data quality:

- Ensure that both operational and clinical staff are made aware of the importance of data quality and validation of their data. This will be achieved through addressing training and educational needs, awareness sessions and regular communication.

- Improve engagement between clinical and administrative staff.
- Consider all challenges to the accuracy of data and where necessary update processes to reflect these constraints.
- Praise excellent performance and highlight good practice and share amongst other staff.
- Seek to understand where data accuracy is under achieving and will engage with administrative staff to improve.
- Develop local performance reporting tools that demonstrate, following audit, the accuracy of data.
- Empower line managers of administrative staff to engage with data accuracy and quality.
- Provide accurate complete and timely information to support commissioning.
- Ensure that data items are valid and adhere to data standards set out in the NHS Data Dictionary and any locally developed standards are consistent with the NHS Data Dictionary.

9. Data Quality Strategy for 2019 - 20

The Trust's Data Quality Strategy describes our approach to optimising the quality of our information, to enhance and improve our decision making and services to patients.

We continue to strive to embed Data Quality into the values, cultures, and ethos of the organisation such that 'right first time 'is the only accepted outcome.

The Trust is invested in ensuring that the recommended six data quality dimensions (Figure 1) are adhered to, thus providing assurance that all information reported is as robust as possible.

Fig 1 Dimensions of Good Quality Data

Trust Data Quality Oversight Group (DQOG)

The Data Quality Oversight Group acts as a point of escalation for emerging data quality concerns and oversees the management and resolution of existing data quality issues. The group is well established, attended and continues to support data quality improvement across the organisation the overarching aim is to improve the quality, accuracy and timeliness of data capture, reporting and use within the Trust.

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

- Responsiveness
- Proactivity
- Continuous Improvement.

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

- Provide consistent feedback to the Board of Directors to highlight issues identified through the Data Quality Oversight Group;
- Review current Data Quality risks, outcomes and lessons learnt.

Data Quality Training

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

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

The Trust has an established on-going review of Standard Operating Procedures, PAS process guides and role based user guides (acknowledging that this is a continuous process in the light of system upgrades);

Sherwood Forest Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Further roll out of Elective Care Training Plan for both existing and newly appointed staff, to include clinicians.
- Ensure user competency via mandatory training and the appraisal process;
- Develop a system for non-elective training programme for admitted patient care.

Data Quality Improvement KPI's

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

- Outpatient Referral Management
- Outpatient Activity
- Inpatient Activity
- Elective Waiting List Management
- Referral to Treatment (RTT)
- Maternity
- Medway PAS Maintenance Generic DQ

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

Data Quality Internal Audit Programme

The Data Quality team have an agreed schedule of targeted audits that are undertaken throughout the year to systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback at Divisional and Governance meetings and the Data Quality Oversight Group.

The Data Quality team have undertaken ad-hoc audits in response to suspected Data Quality weaknesses and observational audits in response to emerging themes and issues.

Internal audits completed include;

- Referral to Treatment
- Outpatient Activity
- Admitted Patient Care
- Emergency Activity

Robust Communication Channels

The Data Quality Team coordinates communication through the following channels:

- Trust articles and bulletins
- Dedicated Data Quality web page
- training sessions E-learning tools
- Awareness sessions
- Progress reports to the Board of Directors and Risk Committee
- Dedicated Data Quality and Clinical Coding support provided to all Divisions (and Service Lines as appropriate)

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

- To continue to keep the Trust informed of emerging data quality issues through our regular communication channels
- To maintain the process of continuous evaluation of documentation designed to support system users to maintain data quality standards e.g. Standard Operating Procedures
- Where system upgrades take place documentation is amended in response and appropriate user awareness sessions are delivered

SFHFT Data Quality Position March 2020

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

Sherwood Forest Hospitals average total DQMI score is 98.1%.

The percentage of records in the published data which included the patient's valid NHS number (as at Nov 2019)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
99.9%	**100%**	**98.6%**

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%**	**99%**

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 > 99%

The Trust has:

- Further explored and seeks to improve accurate and real-time data capture within admitted patient care (APC)
- An established suite of Operational Data Quality reports with the aim of addressing process issues, resulting in potential failures to manage patients 'care pathways following outpatient attendance and compounding referral management issues

The Trust has been subject to a Data Quality Framework Audit, reported in November 2019.

Significant Assurance was given to the areas examined. The risk management activities and controls are suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review.

10. Improving Care and Learning from Deaths

During 2019/20 1,538 of Sherwood Forest Hospitals NHS Foundation Trust patients died in hospital. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 358 deaths in the first quarter;
- 352 deaths in the second quarter;
- 420 deaths in the third quarter;
- 408 deaths in the fourth quarter.

By 31 March 2020, 1,116 case record reviews and 938 investigations have been carried out in relation to the 1,538 deaths included above.

In 938 cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 310 cases in the first quarter
- 302 cases in the second quarter
- 326 cases in the third quarter
- 0 cases in the fourth quarter

41 cases, representing 2.6% of the 1538 patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. There are clear plans in place to ensure we learn from this and improve care for patients going forward.

In relation to each quarter, this consisted of:

- 7 deaths representing 1.9% for the first quarter
- 17 deaths representing 4.9% for the second quarter
- 17 deaths representing 4.0% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the Royal College of Physicians Structured Judgment Review (SJR) methodology. It should be noted that due to the Covid-19 pandemic the quarter 4 and annual summary learning from Deaths reports to the Board of Directors have been deferred to October 2020. It is therefore not possible to provide accurate data for Q4 or complete the annual figures.

It should also be noted that a separate review of all deaths where Covid-19 appeared on the Medical Certificate on the Cause of Death (MCCD) has been undertaken between 23/03/2020 and 30/06/2020

to determine whether patients received the appropriate care and treatment regardless of their Covid-19 status. The outcome of these reviews was presented monthly to the Trust Quality and safety Assurance Cabinet. No concerns have been identified.

Clinical teams have continued to improve their mortality processes presenting a consistent and comprehensive report to the Trust Mortality Surveillance Group each month. As a consequence the Trust has consistently performed within the expected Hospital Standardised Mortality Ratio (HSMR) range since April 2016, despite continuing increased crude mortality through the winter period.

The Royal College of Physicians Structured Judgment Review Methodology (SJR) is now well established across the organisation. The adoption of this review methodology has built firmly on the electronic Mortality Review Tool (MRT) providing a comprehensive, standardised review methodology that is well understood by clinical teams and facilitates the multidisciplinary and where required multispecialty review of care delivery and improvement opportunities.

A significant proportion of SJR/Avoidability assessments presented to the Trust Mortality Surveillance Group identify a failure to apply appropriate, well-documented, well-explained and timely ceilings of care. This often leads to distress and confusion for the patient and relatives and on occasion's inappropriate treatment or intervention.

To support these difficult conversations the Trust implemented the national ReSPECT Tool (Recommended Summary Plan for Emergency Care and Treatment) in April 2019. The ReSPECT form facilitates an early discussion with the patient and family about their wishes towards the end of life or at the time of a significant medical event. Clinical teams have been trained in the appropriate application of the ReSPECT form with ongoing support provided by the End of Life team. This information remains with the patient with a copy retained in the notes. Use of the ReSPECT form and the appropriateness of the decision-making has been audited through the last quarter of 2019/20 to identify areas of good practice and where further support and training may be required.

- A flag is applied to Nervecentre (electronic record keeping system) which is re populated if someone is readmitted and the MCA form remains in the notes (we are not photocopying the form). We are working with ICS partners to look at how we can standardise the dynamic communication re the ReSPECT form.
- The monthly & quarterly audits commenced in May 2020

As the mortality review system has matured across specialties, teams are becoming more competent at identifying those cases where a more in-depth review is required. This has led to some complex, but extremely productive multidisciplinary and multispecialty interactions and enhanced the opportunities for teams to learn together. The Trust has implemented the Medical Examiner Service. The Medical examiner provides independent scrutiny for any death where initial concerns have been raised, not just in relation to the cause of death but where the care provided to the patient in the day prior to death may have identified a failing whether it contributed to the death or not. The Medical examiner also provides support, advice and guidance to the junior doctor to ensure an accurate completion of the MCCD.

The Trust recognises that learning from the care given to patients in their final days is about understanding how that care met their needs and those of their relatives and carers. It is about understanding the right decisions are made in conjunction with them and that they are fully informed at all times.

We have made good progress throughout the year and have a firm basis on which to improve even further. The learning themes from our mortality reviews have helped shape some of the Quality Strategy and improvement requirements for the coming year and it is hoped we will continue to optimise our learning opportunities, sharing good practice across the organisation and wider health system.

Zero case record reviews and zero investigations have been completed after 1 April 2019, which related to deaths, which took place before the start of the reporting period.

Zero cases representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using Royal College of Physicians structured judgment review methodology.

2.3 Reporting Against Core Indicators

1. Summary Hospital Level Mortality Indicator (SHMI) Banding

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

The table below illustrates the Trusts SHMI banding as being consistently recorded as a two, which indicates ‘as expected ’level of mortality.

Table 3

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

Percentage of Patient Deaths Coded as Palliative Care

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

Table 4

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

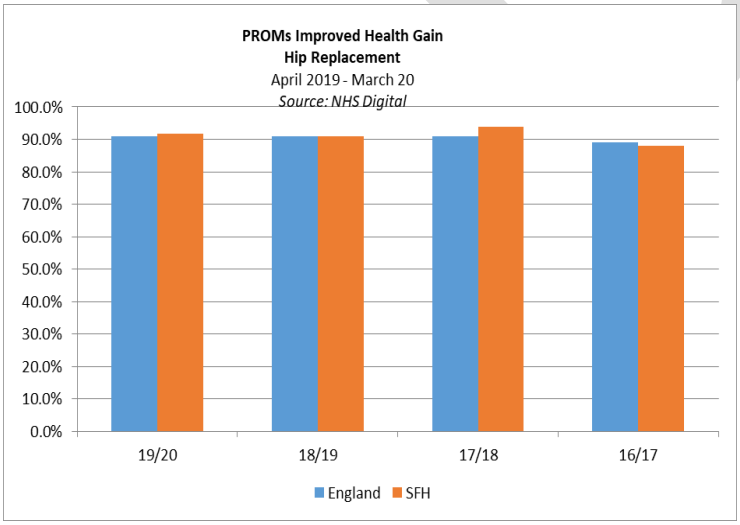
2. Patient Reported Outcome Measures (PROM's)

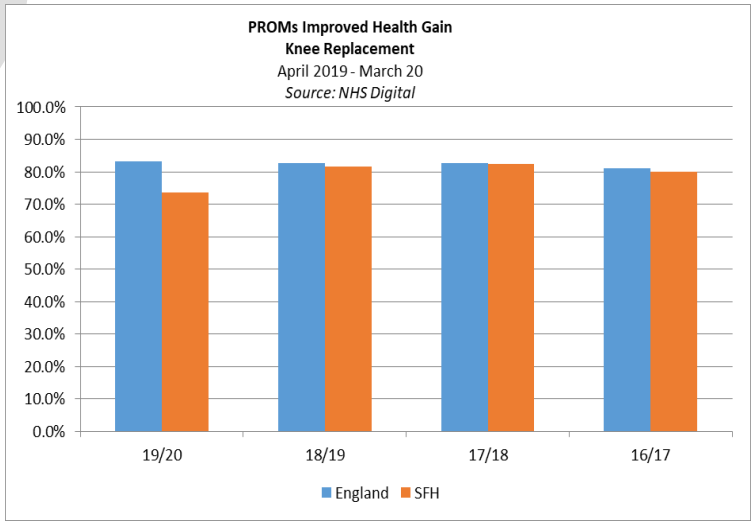
The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; it is made available to the Trust through NHS Digital.

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

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

Graph 3





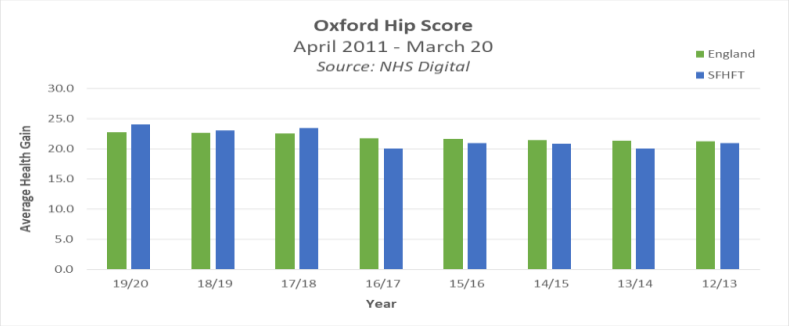
Improved Health Gains – April 2018 – March 2019

In response to the 2019/20 results the Trust has undertaken an audit and review of cases to ascertain how to improve the scores to above the national average.

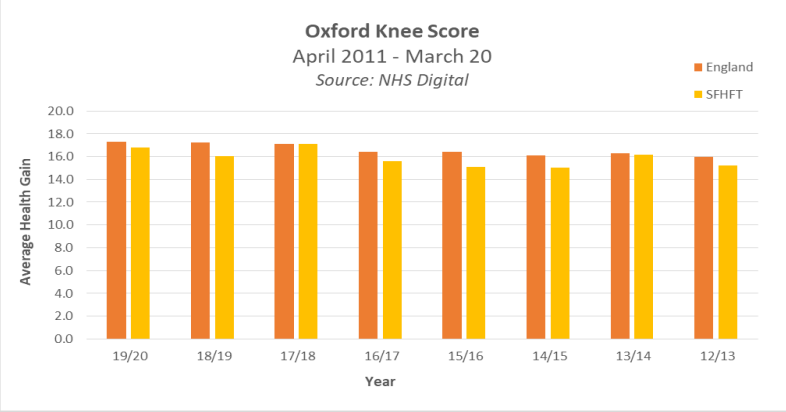
The Trusts pre-operative assessment department are working with local councils to develop strategies to ensure patients are optimised and in the best health prior to surgery and we have implemented strategies to improve patients 'general health prior to undergoing surgery through smoking cessation and gym memberships.

The graphs below show the Oxford Scores for Hip and Knee replacements. The Oxford score is a patient-reported outcome instrument, which contains questions on activities of daily living that assess function and residual pain in patients specifically for undergoing Total Hip or Total Knee replacements.

Graph 4
Oxford Hip Score – April 2011 – March 2020



Graph 5
Oxford Knee score April 2011 – March 2020



Sherwood Forest Hospitals NHS Foundation Trust has continued to show improvement in these scores and work in collaboration with our Clinical Commissioning Group to enhance and further develop our MSK pathways. In September 2020 the Trust implemented our service offering at Newark Hospital as a cold elective joint replacement site following Getting It Right First Time (GIRFT) review. Sites that offer purely elective services have a significantly lower risk of cancellation which we envisage, will result in greater patient satisfaction, improved clinical outcomes, fewer infection, shorter length of stay, reduced re-admission rates and a reduction in waiting times.

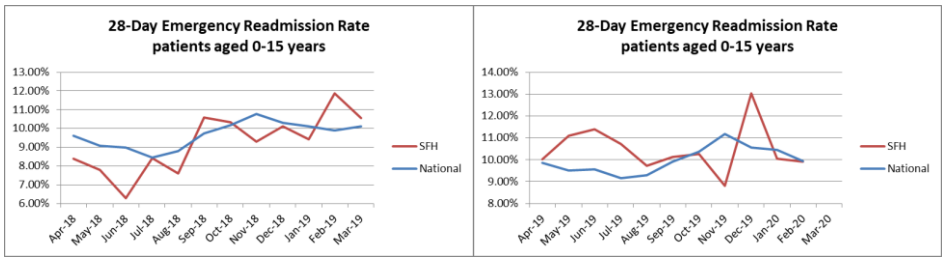
3. Percentage of patients readmitted to hospital within 28 Days

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; in 2019/20:

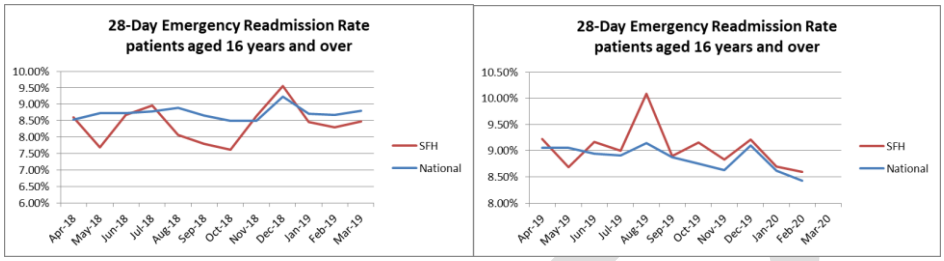
- 10.49% of patients aged 0 to 15 were readmitted to a hospital within 28 days of being discharged during the reporting period.

- 9.04% of patients aged 16 or over were readmitted to a hospital within 28 days of being discharged during the reporting period.

Graph 6
Emergency Readmission Rate % (28 Days) by Month of Discharge (0-15 years)
Data Source: Dr Foster



Graph 7
Emergency Readmission Rate % (28 Days) by Month of Discharge (16 years and over)
Data Source: Dr Foster



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

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

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

4. Trust Responsiveness to the Personal Needs of Patients

The Trust is committed to resolving any complaints or concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the Patient Experience Team (PET). The PET provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department/ward directly, or where they have done so but their concern remains unresolved. The team aim to resolve any concerns that are raised with them quickly and informally with the cooperation of the department/ward involved in the care of the patient. Should the patient or carer feel that their concern should be formally investigated they are able to make a formal complaint. The Trust operates a centralised complaints service, which ensures that a patient centred approach is taken to the management of complaints and that all complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt, or where necessary an agreed timescale dependent upon the complexity of the complaint.

During 2019/20 the Trust received 383 complaints, this showed a 3% decrease on the previous year. In the same reporting period we responded to 93% within the recommended 25 days or agreed timescales when complaints are complex, A total of 394 (includes 11 from 2018/19) complaints were investigated and findings were shared with the complainant by a written response (350) or local resolution meetings(44). While performance against the 25 working day standard was reduced compared to 2018/19 (2%) the overall caseload was carefully managed to avoid complainants experiencing delays in receiving a response to their complaint. All complainants were kept updated on the progress of their complaint and a personal written apology was provided to all complainants.

Services receiving the most complaints included: Emergency Medicine, Trauma and Orthopaedic, Maternity, Gastroenterology and General Surgery. Maternity and Gastroenterology had not previously featured in the top five reported specialities. There are no patterns to the timing of receipt of the complaints, most related to episodes of care provided during 2019/20.

Fig.4 Table showing complaint themes 2017/18, 2018/19 and 2019/20

	2017/18	2018/19	2019/20
1	Clinical Treatment	Clinical Diagnosis	Clinical Treatment
2	Clinical Diagnosis	Clinical Treatment	Clinical Diagnosis
3	Communication - Dr	Communication/Attitude – Dr	Communication – Dr
4	Attitude - Dr	Communication/Attitude – Nurse/Midwife	Clinical Discharge
5	Admissions/Transfers/Discharge Procedures	Admission/Transfers/Discharge Procedures	Administration Communication

Clinical diagnosis and clinical treatment continue to be reported as the subject of dissatisfaction. Themes relating to discharge process including the completion of Continuing Healthcare Checklists, inclusion of next of kin/family members and communication with patients and relatives during the discharge plans, in particular, patients who lack capacity. These complaints have been triangulated with all relevant concerns raised with the safeguarding team to further analyse for themes and trends and escalated to division and the Trust Mental Capacity Task and Finish Group.

A joint approach with safeguarding to the review and management of Section 42 (enquires from local authorities) has been developed to determine if a safeguarding or complaint investigation is appropriate. This has resulted in an increase in complaints relating to discharge. Where Section 42 enquiries result in a complaint investigation, these are managed in accordance with the Trust complaint policy and procedures. All discharge complaints and concerns relating to discharge are shared with the Head of Operations and Matron for Integrated Discharge Advisory Team.

Examples the subjects include:
Clinical Treatment:
- Unhappy with consultation (breast care)
- Unhappy with care during attendances to Sherwood Birth Unit and Maternity
- Concerns regarding triaging in Emergency Department

Clinical Diagnosis:
- Delay in diagnosis of fractures and safety netting efficiency

- Communications and advice with the Next of Kin prior to discharge from ward
- Unhappy with lack of investigations in ED

Communication-Doctor:

- Poor communication following early pregnancy/gynaecology procedure
- Lack of information regarding End of Life care
- Breast Care – Concerns regarding clear communication regarding treatment options and medication

Clinical Discharge:

- Poor communications between ED and Discharge Lounge
- Lack of communication regarding discharge and advice post discharge
- Inaccurate discharge summaries

Administration – Communication:

- Delay in notification of cancelled appointments (ENT and Ophthalmology)
- Difficulties contacting Endoscopy and information provide prior to procedure

Of these, 59% were upheld/partially upheld, which shows a slight increase of 2% with previous year. This has provided an opportunity for learning and service improvements. 2% complaints were withdrawn after following initial investigation and discussions with the patient, local resolution was achieved.

The Trust received 41 complaint requests to re-open previous complaint investigation due to complainants remaining dissatisfied with the complaint response/meeting. Following a review of the complaint file, a total of 23 were re-opened as it was identified the complainant had raised new concerns. All requests are formally responded to, reiterating the options relating to the next steps, which include PHSO, independent advocate and access to medical records procedure.

A total of 3 complaints received by PET were reported as incidents, which were scoped and deemed necessary for divisional/STEIS investigation and the legal team are currently managing 5 claims linked to closed complaints.

The PHSO decided to investigate 13 new complaints in 2019/20. A total of 20 cases between 2018-20 were investigated with 7 of these being closed between this two year period. Of these cases, 2 were upheld, 4 partially upheld, 2 not upheld and 12 remain as on-going.

A financial remedy was recommended on 2 of these cases, to cover the costs incurred as a result of the failings identified and to compensate the patient for the pain and suffering caused. In response to the to the COVID-19 pandemic, the PHSO paused all investigations in March 2020.

Responsiveness to personal needs of patients is reported through the National Inpatient Survey data reported annually and the Friends and Family Data collected daily and reported weekly to the relevant teams and departments.

Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reason: the survey was undertaken by Quality Health for Sherwood Forest Hospitals NHS Foundation Trust using the methodology determined by the survey coordinating centre for the overall national inpatient survey programme.

The 2019 survey of adult inpatient's experiences involved 143 NHS acute trusts in England. SFHFT received responses from 76,915 patients, a response rate of 45%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during July 2019 and were

not admitted to maternity. SFHFT have received the embargoed report in June 2020, publication date to be confirmed by the Care Quality Commission (CQC).

SFHFT were selected as part of an Adult Inpatient Survey Pilot conducted by the CQC between 3rd October 2019 and 20th December 2019, therefore providing the most recent patient feedback. The purpose of the pilot was to test offering both online and paper completion to understand if this would improve response rates and the timeliness of reporting the findings. SFHFT scored better than most trusts in a number of areas and the findings correlate with a number of the themes of complaints reported during this period, including Clinical Treatment, Clinical Diagnosis, Clinical Discharge, Communication and attitude of doctor. As a result of the survey feedback, the revised FFT questions focus on the identified lower scoring areas in the Adult Inpatient pilot survey, therefore the real-time feedback and monthly reporting and dashboards will enable teams to understand if this was a time specific issue or on-going areas of concern. A Patient Experience Dashboard has been developed to incorporate all aspects of feedback highlighting areas for escalation and practice.

As a result of the pilot survey, a number of changes are proposed for the survey programme for 2020 including a reduction in questions, mixed methods of collection will continue, patients will receive reminders and a postal paper survey if online completion not taken up. The 2020 Maternity survey cancelled by NHS England and NHS Improvement as scheduled between March – May 2020

Governance continues to be reported and monitored at the monthly Quality and Safety Assurance Cabinet (previously Patient Safety and Quality Group), chaired by members of the Trust Executive Team. Friends and Family Data is monitored as a reported KPI to Trust Board monthly and as part of the monthly Nursing Ward Assurance programme.

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5. Staff Friends and Family Responses and Recommendation Rates

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

Staff Friends and Family Test (FFT)
The Staff FFT acts as a barometer at a moment in time and is undertaken in quarters one, two and four of each year. For quarter three the national NHS Staff Survey is undertaken at this time and includes the same two key questions.

The Staff FFT asks staff to rate how likely (using a scale between extremely likely and extremely unlikely) they would be to recommend the organisation to family and friends as a place to:

1. Receive care or treatment.
2. A place to work.

The Quarter three NHS Staff Survey questions are worded slightly different:

1. “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”
2. “I would recommend my organisation as a place to work”

The following table compares the Staff FFT and the national NHS Staff Survey results for staff saying they would be likely, or extremely likely to recommend the Trust in 2018/19 and 2019/20 as a place to received care and a place to work.

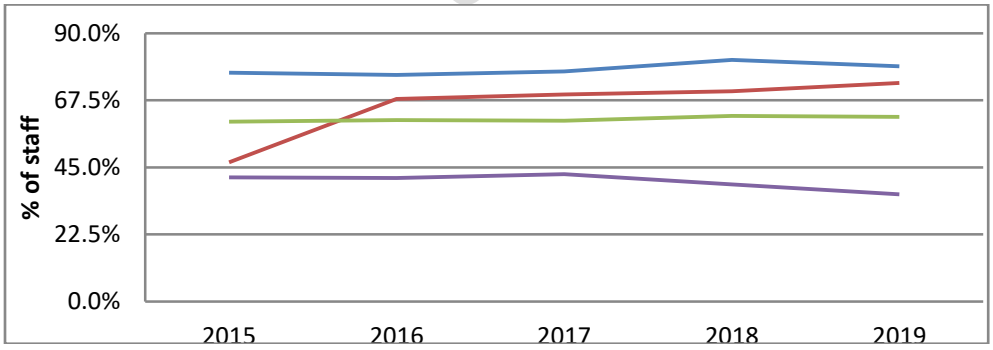
Table 5

Date	How likely would you be to recommend this organisation to friends and family if they needed care or treatment?	How likely would you be to recommend this organisation to friends and family as a place to work?	Number of respondents
2018/19			
Q1 Staff FFT	88.%	77%	1,140
Q2 Staff FFT	88.47%	76.69%	1,180
Q3 Staff Survey	79.4%	70.6%	2,739
Q4 Staff FFT	88.41%	78.15%	1,208
2019/20			
Q1 Staff FFT	88.43%	76.11%	1,180
Q2 Staff FFT	87.28%	75.02%	1,061
Q3 Staff Survey	78.6%	73.3%	3,161
Q4 Staff FFT	86.96%	76.05%	981

The graphs below presents the results from the national Staff Survey on recommending the Trust as place to work from 2015 to 2019.

Graph 8

a) **I would recommend my organisation as a place to work**

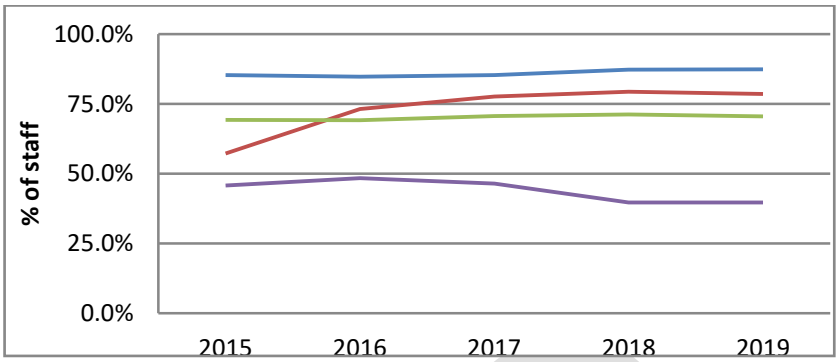


These results indicated a very positive step change for the Trust in 2016 and since then there has been incremental improvement each subsequent year. Since 2016 the Trust's score has continued to be well above average for an acute Trust in England. The Trust's Maximising our Potential Workforce Strategy has been a key driver in increasing this success and has resulted in many positive impacts for our recruitment and retention activities.

The table below presents the results from the annual Staff Survey on recommending the Trust as a place to receive care from 2015 to 2019.

Graph 9

b) If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.



These results indicated a very positive step change for the Trust in 2016 with incremental improvements in the 2017 and 2018 Staff Surveys. In 2019 the national average dipped by 0.7%, with the Trust's score following this trend being 0.8% below the score for 2018. However, the Trust's score is well above average for an acute Trust in England and is very significantly above the worst scoring acute trust.

National NHS Staff Survey – 2019

Our national Staff Survey closed at the end of November 2019 with a response rate of 66.2%, compared to 62% in 2018. The national average response rate for acute trusts in England was 47%.

The best national performing acute Trust was 72.9% and the worst performing acute Trust scored 33.8%.

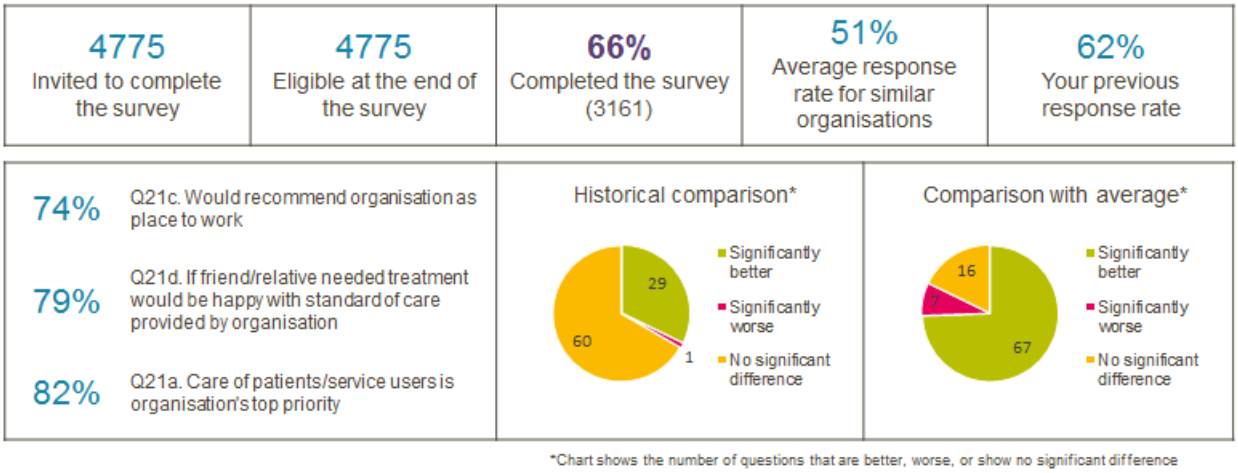
Table 6 - SFHFT 2018 NHS Staff Survey

4583	4526	62%	47%	57%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (2789)	Average response rate for similar trusts	Your previous response rate

70%	Q21c. Would recommend organisation as place to work	Historical comparison*	Comparison with average*
80%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation		
84%	Q21a. Care of patients/service users is organisation's top priority		

*Chart shows the number of questions that are better, worse, or show no significant difference

Table 7 - SFHFT 2019 NHS Staff Survey



Performance in the five Staff Survey domains

The Staff Survey questions are grouped into five domains; Your Job, Your Manager, Your Health, Well Being and Safety at Work, Your Personal Development and Your Organisation. Answers to the questions in the five domains are then used to form the eleven themes reported in the Staff Survey.

The score distribution for SFHFT across the five domains of the survey is shown below.

Table 8

	Your Job	Your Manager	Your Health, Wellbeing & Safety	Your Personal Development	Your Organisation
Above average	28	11	20	6	10
Average	2	0	3	0	0
Below average	0	0	7	2	0

All the scores relating to the member of staff's own job, their manager and the Trust are predominantly above average for an acute Trust in England.

The scores relating to health, wellbeing and safety are much more variable, with ten at average or below average. The main themes of concern in this domain are around the staff member's experience of violence and aggression from patients and families, muscular skeletal problems and staff feeling under pressure to come to work when feeling unwell. The Trust like most NHS organisations has experienced a significant increase in demands for its services over the Spring and Summer periods which traditionally have been more manageable compared to the winter period and have left staff feeling exhausted.

There has been a slight reduction in the number of staff saying they have experienced bullying from colleagues. However the number of staff reporting experiences of harassment, bullying or abuse is 42% and is below the national average.

The personal development scores have improved slightly for some questions compared to the previous year. The results largely reflect that staff have regular appraisals, the Trust's CARE Values are discussed and they feel their work is valued and that managers are supporting them to receive the training, learning or development identified in appraisal.

Overview of the 11 key Staff Survey indicators

Below are the first five of the 11 key indicator themes from the 2019 SFHFT Staff Survey:

Table 9 – Best, average and worst acute trusts in England in the 2019 NHS Staff Survey by the first 5 key domains.

(Score 1 - 10)	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
Best (Acute Trusts in England)	9.4	6.7	7.4	6.7	6.6
Trust (SFHFT)	9.3	6.1	7.1	6.5	5.8
Average (Acute Trusts in England)	9.0	5.9	6.8	6.1	5.6
Worst (Acute Trusts in England)	8.3	5.3	6.0	5.5	4.8

Table 10- SFHFT 2019 NHS Staff Survey results by first 5 key domains.

(Score 1 - 10) Trust comparison	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
2017 score	9.3	5.9	6.9	NA	5.4
2018 score	9.2	5.9	7.0	6.4	5.6
2019 score	9.3	6.1	7.1	6.5	5.8
Trust comparison statistically significant change from 2018 to 2019	Not significant	Not significant		Not significant	

All five areas were above the national average for acute Trusts in England in 2019 as outlined in table 3 above and two have significantly improved from 2018.

The table below lists the remaining six of the eleven key indicator themes:

Table 11 – Best, average and worst acute trusts in England in the 2019 NHS Staff Survey by the remaining 6 key indicators

(Score 1 - 10)	*Quality of Care*	*Safe Environment Bullying & Harassment*	*Safe Environment Violence*	*Safety Culture*	*Staff Engagement*	*Team Working*
Best (Acute Trusts in England)	8.1	8.5	9.6	7.2	7.5	7.2
Trust (SFHFT)	7.7	8.1	9.3	6.9	7.2	6.9
Average (Acute Trusts in England)	7.5	7.9	9.4	6.7	7.0	6.6
Worst (Acute Trusts in England)	6.7	7.3	9.2	5.7	6.1	5.9

Table 12- SFHFT 2019 NHS Staff Survey results by the remaining 6 key indicators

(Score 1 - 10) Trust comparison	Quality of Care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement	Team Working
2017 score	7.8	8.0	9.3	6.7	7.2	NA
2018 score	7.8	7.9	9.3	6.8	7.3	NA
2019 score	7.7	8.1	9.3	6.9	7.2	6.9
Trust comparison statistically significant change from 2018 to 2019	Not significant		Not significant		Not significant	

Five of the six scores are above the national average for acute Trusts in England as outlined in table 5 and one (safe environment) is below the national average. This score has not changed since 2017 and will be a key focus for improvement of the Maximising our Potential Workforce Plan for 2019.

There are no significant changes to the scores in three of the themes. Apart from the Safe Environment score, all other scores are above average and better than the worst score for acute trusts in England.

Leaver interviews

Staff that are leaving the Trust are automatically sent an email link requesting completion of an exit questionnaire via Survey Monkey, and on average it takes less than 3 minutes to complete the survey. Staff are also able to request a face to face leaver interview; this can be requested via line managers and/or Human Resources. If a face to face leaver interview is requested this can be conducted by an employee's line manager, higher line manager or a member of Human Resources (HR).

All medical staff that leave the organisation (excluding junior doctors 'rotation as part of the training programme) are invited to a face to face exit interview with a member of the Medical Workforce Team.

The information collected helps us to understand the staff experience more effectively. HR Business Partners (HRBP) and Assistant HR Business Partners (AHRBP) utilise this information to identify trends, inform initiatives and support the coaching and mentoring work they undertake with managers. Where a leaver's feedback raises a concern or identifies an issue, work is undertaken discretely to explore and address the problem. Any significant concerns initiate an investigation.

All medical leavers do attend a face to face meeting, and the number of other staff agreeing to give feedback via the on line survey has increased over the last year.

Speaking Up

Sherwood Forest Hospitals NHS Foundation Trust is committed to taking seriously all concerns raised and in ensuring that an open and honest culture is embedded within the Trust. It will ensure staff have access to support and are encouraged to speak up at an early stage.

The Trust has updated the Speaking up Policy, which is sometimes referred to as Raising Concerns or Whistle-blowing Policy and staff are encourage to speak up to whomever they feel is most appropriate. This could be line management, senior management, Freedom to Speak Up (FTSU) Guardian, Freedom to Speak Up Champions, Executive and Non-Executive leads for FTSU; Executive Directors, the Chief Executive or external agencies.

The Trust appointed a substantive FTSU Guardian in April 2019 and 15 FTSU Champions in October 2019, whom are there to support staff to raise their concerns and escalate concerns where appropriate.

Speaking Up is promoted through regular communications to the Trust via social media campaigns, quarterly bulletin updates, posters, banners, videos and screensavers. There is also monthly stalls to encourage staff to speak up and monthly drop in sessions run by the Guardian and Champions to make Speaking Up more accessible to staff.

The number of concerns being raised through the Speaking Up service is rising each quarter as demonstrated by the below table:

Table 13

Quarter	Number of concerns raised
Q2: 2018-19	3
Q3: 2018-19	2
Q4: 2018-19	4
Q1: 2019-20	11
Q2: 2019-20	22
Q3: 2019-20	29
Q4: 2019-20	29

This supports the effectiveness of the new Guardian role within Trust, with the blue cells showing the rising numbers since the introduction of a substantive Guardian.

The Trust's Speaking Up Policy makes it clear to staff that all concerns raised will be treated in the strictest confidence without fear of retribution

Summary

The overall improvements in the 2019 national Staff Survey have largely been positive for the Trust with many scores above the national average for acute trusts in England but there is still work to do in order to improve the experience of our patients and colleagues.

Each year the Maximising our Potential action plan is refreshed and has specifically focused on improving themes from our annual staff survey and Friends and Family (FFT) tests. Evidence from our staff surveys, Staff Friends and Family Test and HR workforce data indicates that many of our HR and Organisational Development (OD) initiatives have contributed to improving our culture. That said there remains much more we can do to enhance our culture through the capability and capacity of our people.

A key to the success of this strategy is the alignment to our Trust strategic objectives and the strong interactions and relationships between HR and Training, OD, Freedom to Speak Up mechanisms, and our well-being services

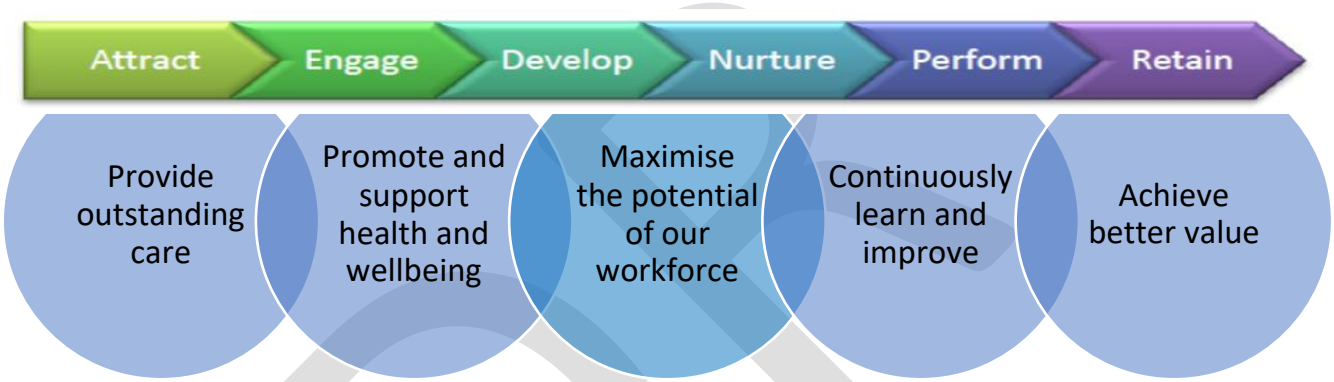


Figure 2. Maximising our Potential

Since 2017, the staff survey demonstrates the culture at SFHFT has gradually begun to improve. The summary below gives an overview of the key cultural improvements that the Trust has seen which has been supported through this strategy and reflected in analysis of our staff survey results from 2016 to the present.

SFHFT Today – our culture and improvements supported by our Maximising our Potential Workforce Strategy include:

- Colleagues would strongly recommend SFHFT as a great place to work as they feel valued and want to stay at the Trust. This has improved 6% over the last 3 years in our staff survey.
- In 2018 we were the top scoring Trust in the Midlands and East Region as a place to work and receive care.
- Colleagues want to stay at this Trust because of the way we support and develop them.
- We enjoy a high retention rate, 0.89% turnover rates and the reputation of the Trust as a great place to work is attracting more talent to the organisation.
- We have improved our on-boarding experience for new starters to ensure that it is a personal experience that is slick, informative and effective.

- The Trust has made significant improvements to support colleagues with disabilities to do a good job through combined Occupational Health and Moving and Handling services.
- Supporting colleagues in a fair and just manner where they have been involved in incidents has improved through the implementation of Schwartz Rounds, restorative approaches, better feedback mechanisms and a supportive Occupational Health service.
- Significant investment in leadership development to ensure managers and leaders are visible and inclusive, although there is still work to do in addressing pockets of inconsistency.
- Improvement in the quality of colleagues experience of appraisal and leaving them feeling valued has been achieved through a refreshed appraisal training programme.
- Successful local, national and international recruitment campaigns have resulted in increased appointments and have contributed to ensuring that colleagues feel supported to deliver safe patient care which comes out as a strength in our 2019 Staff Survey.
- Improvements in colleagues not experiencing bullying and harassment through CARE values visits, leadership development, civility saves lives and #bekind initiatives.
- Supportive line managers and senior managers who value their colleagues have increased through leadership tool box talks such as leading high performing and inclusive teams.
- Support for colleagues health and wellbeing through 24/7 phone counselling services introduction of CBT resources, health heroes initiatives and pop up well-being clinics

SFHFT will take the following actions to improve even further our organisational culture and so the quality of its services provided to patient and colleagues through its Maximising our Potential Workforce Strategy for 20/21.

Actions and Monitoring

- The results from the 2019 Staff Survey are to be communicated to staff in a number of ways including electronic and face to face briefings.
- An executive led Staff Survey engagement session will be carried out with each division to better understand local themes, areas for improvement and what actions can be carried out corporately and at divisional level to help drive improvements in organisational culture, patient and staff experiences.
- Establishment of team level Staff Engagement Boards to promote ownership and visibility of staff survey results and improvement initiatives.
- The results from the 2019 Staff Survey will also be triangulated with other data sources such as the quarterly Staff Friends and Family Test; workforce KPI's and speaking up concerns. This will enable more targeted actions and interventions to be identified for improvement, supported by the Trust's OD Team and HR Business Partners
- There will be Trust wide initiatives for incorporation into the Maximising our Potential Workforce Strategy 2020/21 Implementation Plan to address key themes identified from the 2019 Staff Survey and FFT's. These will include a strong focus on staff health, safety and well-being, leadership development, behavioural expectations and diversity and inclusivity. Some of the positive results from the 2019 Staff Survey will also feature in Trust recruitment campaigns.
- The Trust's People, Culture and OD Committee will provide oversight and assurance against the progress and successful completion of the Maximising our Potential Workforce Strategy Implementation Plan and associated KPIs on behalf of the Board.

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

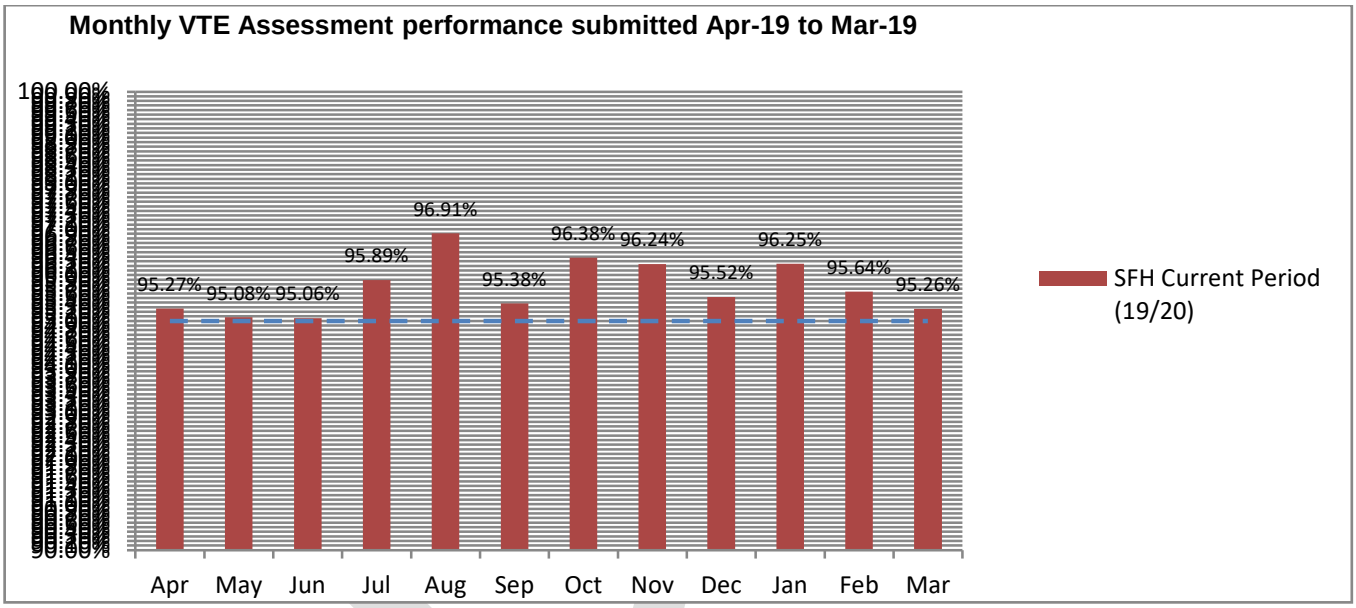
acquired venous thromboembolism (VTE) every year. This includes patients admitted to hospital for medical and surgical care. VTE is an important cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long term morbidities is associated with considerable cost to the health service.

The Sherwood Forest Hospitals NHS Foundation 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 reporting period April 2019 – March 2020, 95% compliance has been met each month with January, February and March national figures still to complete. The Trust can report there were two potentially hospital acquired deep vein thrombosis incidents during this period which are both currently undergoing investigations to establish learning and action required.

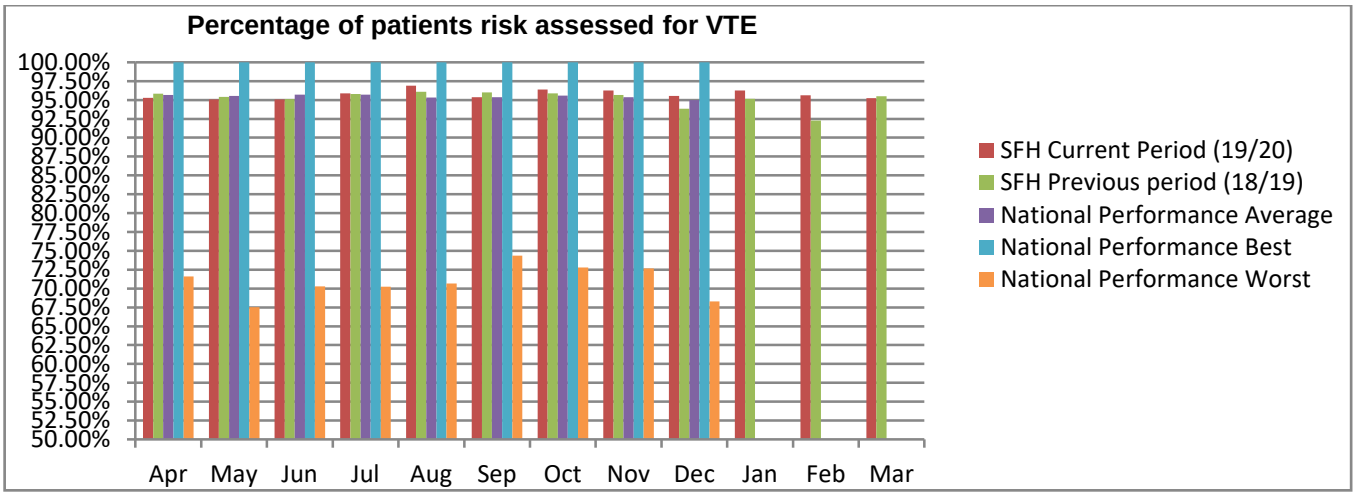
Graph 10

Monthly VTE assessment rate (April 2019-March 2020)



Graph 11

% patients risk assessed for VTE



National performance figures taken from https://improvement.nhs.uk/

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

- All patients' records are manually checked for completed VTE risk assessments. A process for targeted supplementary follow up is in place to collect the previous day's missed or blank assessments. When the planned Electronic Prescribing and Medicine Administration system is in place, VTE screening will become an electronic rather than a manual process. The implementation and roll out of EPMA is planned to take place within the next twenty four months.
- The Trust took part in the Getting It Right First Time (GIRFT) VTE Survey which commenced September 2019.
- Additional actions are in place and consist of reviewing patients who have a potential or confirmed VTE to identify if there were any missed risk assessments. A random sample of patient records is also undertaken to ensure that all eligible patients have had appropriate VTE prophylaxis in accordance with Trust guidance. To date this review demonstrates that appropriate VTE prophylaxis is being initiated.

7. Clostridium Difficile Infections

The Sherwood Forest Hospitals NHS Foundation Trust considers that this data is as described for the following reasons.

Clostridium Difficile infection (CDiff) is acknowledged as an issue that impacts upon the whole health economy. There continues to be partnership working between colleagues from primary care which commenced in 2014/15 and has evolved to consider all potential aspects causing infections across the health economy and includes joint working to promote infection prevention messages. The definition of a Trust acquired case changed for 2019/20 and the Trust is now responsible for any case identified more than 2 days after admission and any case where the patient has been an inpatient in SFHFT within the preceding four weeks (Community Onset Hospital Associated (COHA). This year's trajectory has been adjusted according to this criteria and the CDiff tolerance is 79.

The Trust aims for 2019/20 are outlined below:

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

- To share relevant learning between divisions in the Trust and with the local infection prevention teams.
- To ensure that the Trust attributable cases in the reporting period remain below 79.

How Was This Achieved

In 2019/2020 the numbers of cases identified as post 2 days of admission were 31, this does not include the COHA's. A rise in numbers was identified during September is displayed in the graph below.

Graph 12
Cumulative total of trust apportioned Cliff cases

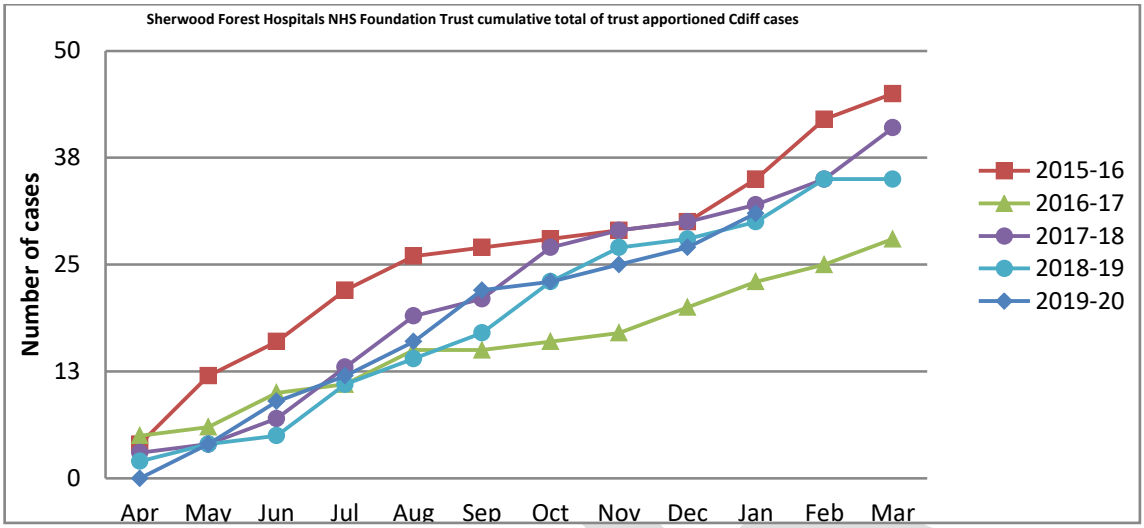


Table 14
C-Difficile Rates per 100,000 bed days

Period	April	May	June	July	August	September	October	November	December	January	February	March
2013/14	9.0	18.4	9.9	9.2	19.0	18.9	22.3	23.6	9.0	8.5	4.7	21.5
2014/15	22.6	26.5	23.7	30.9	22.9	31.5	13.6	32.7	41.6	12.9	28.4	18.1
2015/16	20.4	38.9	20.4	30.8	20.7	5.3	5.2	5.3	5.4	25.4	38.8	15.2
2016/17	26.8	5.6	22.3	5.4	21.7	0.0	5.5	5.4	15.7	14.9	11.4	16.0
2017/18	17.6	5.7	18.8	36.1	36.5	11.8	22.2	11.1	5.4	10.2	17.0	30.9
2018/19	10.9	10.9	5.9	33.9	16.7	17.2	32.9	22.2	5.8	10.4	28.6	0.0

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

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

SFHFT will take the following action to improve these percentages, and so the quality of its services by placing even greater emphasis on Clostridium difficile management and implementing the interventions outlined below:

- Re-introduced the C-Diff ward round including a Gastroenterologist
- Patient reviewed bi-weekly to monitor their treatment and their environment
- Antimicrobial Stewardship rounds including the Microbiologist, Antimicrobial Pharmacist and Sepsis Nurse are undertaken twice a week
- Where lapses of care have been identified, targeted actions in relevant areas have been undertaken and these actions are monitored at respective Divisional Governance meetings

Education and Training:

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

Cleanliness:

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

Auditing:

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

Monitoring and reporting

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

The threshold for 2020/21 is a maximum of 79 cases. This figure has increased on the 2018/19 figure due to the changes in Public health England definitions of trust acquired cases. Monitoring will continue through the Infection Prevention and Control Committee.

8. Patient Safety Incidents

The Sherwood Forests Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Sherwood Forests Hospitals NHS Foundation Trust is committed to reporting and investigating adverse events and near misses, as it is recognised that this provides the Trust with invaluable

opportunities to learn, improve the quality of services and reduce the risk of those types of event happening again.

- The process for the management of reported incidents is described within the Trust's Incident Reporting Policy and Procedures.
- Any incidents that affect patients are graded according to the Data Quality Standards (September 2009) published by the National Reporting and Learning System (NRLS) and, along with all other types of adverse incidents, are reported and investigated using the Trust's Datix Risk Management System.
- All patient safety incidents recorded by the Trust are reported to the NRLS on a regular basis. The NRLS publishes a 6-monthly report which provides information on the quantity and types of reported incidents, comparing the organisation with other non-specialist acute trusts.

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

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

The table below shows the comparative level of patient safety incident reporting within Sherwood Forests Hospitals compared with other non-specialist acute providers.

Table 15

	Sherwood Forest Hospitals			All non-specialist acute providers
Period	Number of incidents uploaded to NRLS from SFHFT	Number of incidents reported by NRLS	Rate per 1,000 bed days, reported by NRLS	Median average rate per 1,000 bed days
1st Oct 2015 – 31st March 2016	3687	3657	34.63	39.31
1st April 2016– 30th Sept 2016	3397	3339	32.82	40.02
1st Oct 2016 – 31st March 2017	3581	3507	33.51	40.14
1st April 2017 – 30th Sept 2017	3277	3180	34.09	Report indicates 'No evidence for potential under reporting'

	Sherwood Forest Hospitals			All non-specialist acute providers
Period	Number of incidents uploaded to NRLS from SFHFT	Number of incidents reported by NRLS	Rate per 1,000 bed days, reported by NRLS	Median average rate per 1,000 bed days
1st Oct 2017 – 31st March 2018	3563	3406	32.64	Report indicates 'No evidence for potential under reporting'
1st April 2018– 30th Sept 2018	3904	3739	37.76	Report indicates 'No evidence for potential under reporting'
1st Oct 2018 – 30th March 2019	4160	4068	39.8	Report indicates 'No evidence for potential under reporting'
1st April 2019 – 30th Sept 2019	4190	4083	40.82	Report indicates 'No evidence for potential under reporting'

Level of Patient Safety Reporting

Sherwood Forest Hospitals NHS Foundation Trust will take the following action to improve these percentages and in turn, the quality of its services by:

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

From the 1 April 2019 to 31 March 2020 the Trust declared a total of 30 Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the 30 incidents, 2 were deemed to be a Never Event.

All Serious Incidents were investigated and action plans developed to mitigate the risk of recurrence. The number of Serious Incidents reported by the Trust has remained largely unchanged from the previous year from 31 to 30. The type of Serious Incident remains largely static however treatment and care incidents have reduced from 12 to 2, which meet the Serious Incident criteria. Identifying and disseminating the learning arising from incidents in order to improve patient safety remains a key

priority. During this year two new posts have been appointed to support this process. The Quality Governance Facilitator is a new role to support the dissemination of learning both Trust wide and at a very local ward/department level. The Clinical Director of Patient Safety has come into post to support the development of incident investigation processes that explore human factors and lead to robust action plans and mitigations that will improve the safety and the quality of care delivered.

Of the 30 investigation reports, 29 were submitted to the CCG within agreed timeframes, with one being submitted one day later than agreed.

The Trust has continued to invest in all aspects of the Datix system with developments throughout the year, working to enhance the reporting and investigation processes and improve the provision of essential management information at divisional and ward level to support informed, evidence-based decision making and robust accountability. This includes a review of the Datix dashboards; these allow the user to interrogate incident trends and themes. 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 on-going to raise awareness, and encourage a good reporting and learning culture.

The Datix system is also utilised by Legal Services with regular use of the DatixWeb Legal module, which has enhanced recording of information and shared communication. The Patient Experience module is still being developed to ensure it is fit for purpose to assist with recording and sharing information related to complaints and patient experience.

Duty of Candour

The Trust has a statutory responsibility to formally offer an apology, verbally and in writing (within 10 working days), for any patient safety incident which is graded moderate, severe or catastrophic harm and for any Serious Incident.

Table 16

Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total for 2019/20
1. Number of Qualifying Incidents	4	3	5	4	4	6	10	2	3	2	5	2	**50**
2. Confirmation of Notification complete	4	3	5	4	4	6	9	2	3	2	5	2	**49 (98%)**

Of the 49 incidents meeting the criteria for formal Duty of Candour (1 April 2019 – 31 March 2020), the Trust has provided Duty of Candour in 98% of these. The Trust also provided an apology as a response to an incident in a further 34 cases demonstrating our commitment to openness and transparency.

The Internal Audit 360 Assurance review of Duty of Candour in May 2019 demonstrated significant assurance in all seven key indicators audited.

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:

- 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 Sherwood Forest Hospitals NHS Foundation Trust there has an identification of patient safety culture as an organisational priority and work has been ongoing. An Associate Director for Service Improvement was appointed by the Trust in March 2018 with a specific remit to deliver the Patient Safety Culture programme. The programme has delivered a series of outputs to support the organisation to identify current cultural levers and barriers to delivering safe care.

PASCAL Patient Safety Culture surveys undertaken with staff in Emergency Department (ED), Maternity and Theatres.

Over 500 clinical and non-clinical staff in ED, Maternity and Theatres have had the opportunity to complete a survey involving several domains that influence patient safety (teamwork, job satisfaction, working conditions, response to errors etc.). This has been followed up by 1-2-1 sessions to share the results with staff, and to build on the response and identify any actions needing to be undertaken. This process has facilitated 'safe 'opportunities for staff to share their experiences of delivering care, in often difficult circumstances; this has been delivered via 'kitchen table 'events delivered in local areas. All outputs from the programme have also been shared with people who can influence decisions and who can progress actions, for example, local and senior managers. The Trust Executive team are committed to this work, and provide input and support to help it to achieve its goals.

There is a commitment to re-survey the staff involved in the PASCAL surveys from 2020, and to continue this work going forward. Outputs are reported to the Trust Management Team, and are monitored via the Divisional Performance.

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.

Collaboration and commitment from staff, the Trust and the Sherwood Forest Hospitals NHS Foundation Trust Charities has supported the introduction Schwartz Rounds. 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.

Schwartz Round dates have been agreed, and are in place to occur bi-monthly in 2019/20 with funds to support training and refreshments for staff. The outputs and themes of this work reports in to Quality Committee.

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 and means our pursuit of safety focuses on strategies that maximise the frequency of things going right.

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

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

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

Sherwood Forest Hospitals NHS Foundation Trust, continues to work within the existing framework as a Trust believe that the Trust can begin to move towards the systems approach described in the NHS PSS. In November 2019 the Trust appointed to a new role of Clinical Director for Patient Safety. This post fulfills the requirement that each Trust has a patient safety 'specialist 'The Clinical Director for Patient Safety has returned to the Trust from a secondment with the Healthcare Safety Investigation Branch (HSIB) training and working as a healthcare incident investigator. HSIB has brought together investigation expertise from a variety of other high-reliability and safety-critical industries and developed them for the healthcare system.

Based on this developing expertise and following a three-month review of the existing processes the Trust is developing a refreshed training programme to equip our investigators with the knowledge and skills to conduct 'systems 'investigations and also provide additional support to those managing and scoping incidents, devising and implementing action plans, and liaising with families and relatives.

Other high risk industries teach their workforce about safety and the NHS should do the same. This is not the same as teaching clinicians how to practice safely – that happens already. It is about teaching everyone in healthcare that error is normal and what the right approaches are to reduce risk and maximise the chances of things going well. Key to this is the field of Human Factors/ Ergonomics (HFE). Whilst commonplace in other industries the NHS is only beginning to understand its importance. Part of the role of the patient safety specialist will be to ensure that systems thinking, human factors and just culture principles are embedded in all patient safety activity. They will need to work closely with others, including medical device safety officers and medication safety officers.

To support this vision we propose the creation of a 'Patient Safety Academy 'at the Trust which has diverse representation and crosses the traditional organisational boundaries. One of the key elements

of this plan is raising awareness and knowledge of human factors across all areas of the Trust to support the fundamental principle that patient safety is everyone's responsibility.

A bespoke human factors training programme is currently being developed for consideration by the Trust and safety/human factors sessions have been included in the junior doctors 'training programmes and upcoming Medicines Safety events.

The Trust will strengthen links between our Governance Support and Audit/Quality Improvement colleagues with the aim to bring design and change management expertise into our responses to safety incidents.

3.2 Safety – Reducing Harm from Falls

Aims for 2019/20

- Achieve the National CQUIN 2019/2020 description within the Trust
- Continue to progress with evidence based practice. Develop improvement programmes through networking with neighbouring Trust's to develop innovations and best practice
- Develop and progress the Trust's Falls Mitigation Strategy 2018/2020

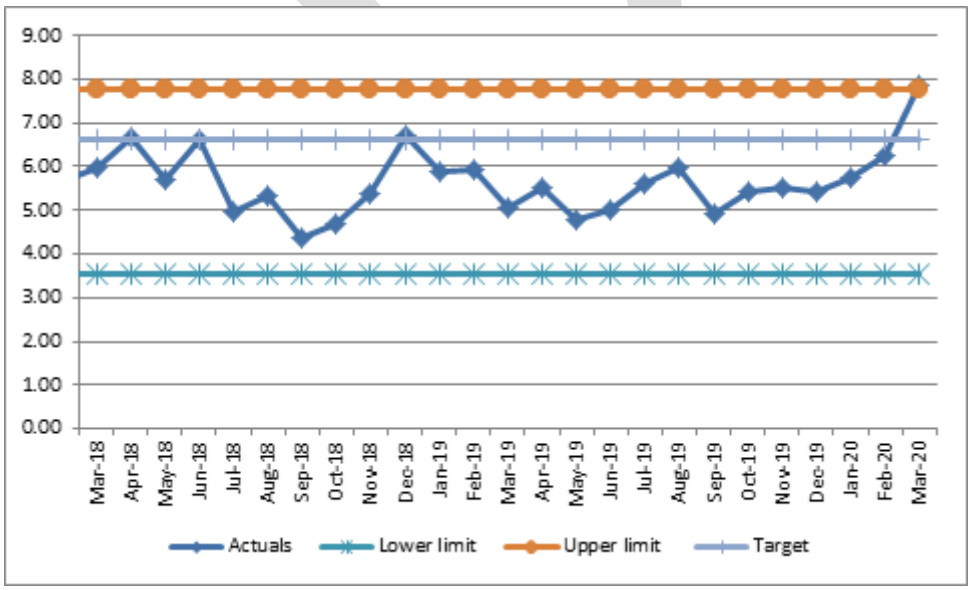
Performance against this Target

Reducing harm from falls is identified as a quality priority in line with the Quality Strategy. Our aim as a Trust is to be below the National Average target for rates of falls per 1000 occupied bed days and also our local Trust targets on a monthly basis.

There are fluctuations with the National and local indicator improvement trajectories and the Trust is focused on embedding improvements to see another step change in reducing the number of falls.

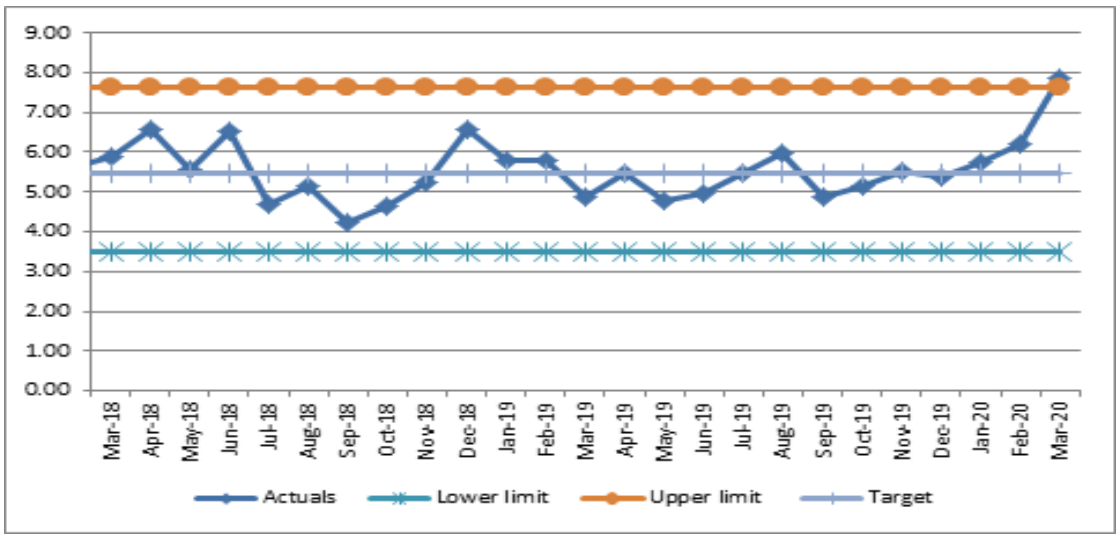
The graph below demonstrates the percentage of falls calculated by 1000 occupied bed days (OBDs) as per the National Audit of Inpatient Falls (2015) criteria. Currently, the Trust performance for the end of March 2020 indicates 7.85 falls / per 1000 occupied bed days in comparison to 6.63 nationally. Whilst the Trust has been below the national average for a period of months the peak in March 2020 coincided with the onset of Covid-19.

Graph 13



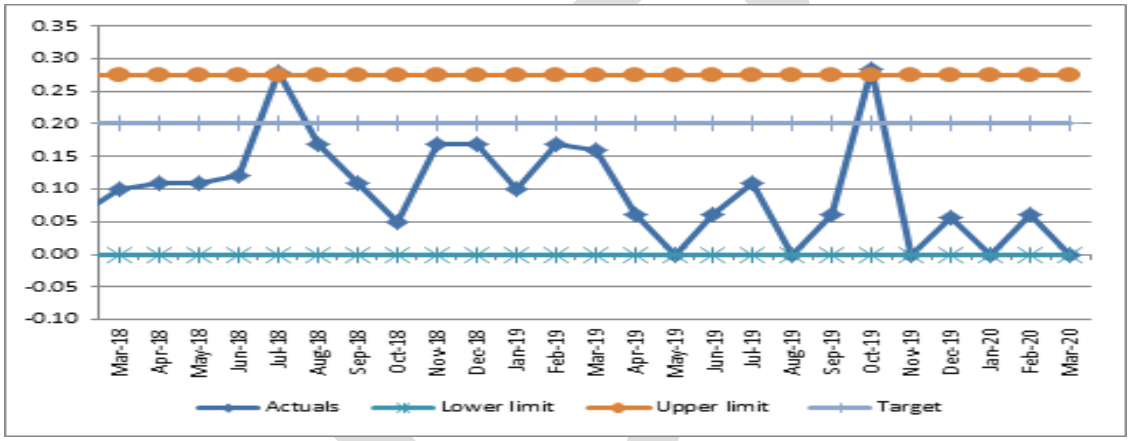
The graph below demonstrates the number of falls up to and including end March 2020 resulting in low or no harm/1000 bed days is 7.85 against an internal target of 5.5 falls/1000 bed days

Graph 14



The graph below demonstrates the number of falls up to and including March 2020 resulting in moderate or severe harm/1000 bed days is 0.0 against an internal target of 0.2 falls/1000 bed days

Graph 15



How was this achieved?

Falls mitigation and improvement is guided by recommendations contained in the Trust's 2018/20 Multi-Disciplinary Falls Prevention and Post Fall Strategy [41] in conjunction with the monthly Falls and Mobility Group Meetings. The Strategy outlines best practice approaches for mitigating falls in the hospital including implementing standard falls prevention strategies and identifying falls risks.

Nearly 350,000 patients currently spend over three weeks in acute hospitals each year. Many of those are older people who are often frail, and while a short period of treatment in hospital is sometimes necessary, staying too long can leave them vulnerable to infections and deconditioning. Research suggests that more than one in three 70-year-olds and over experience muscle ageing during a prolonged stay in hospital, rising to two thirds of those aged over 90 years old, which can leave some permanently less mobile or not able to perform tasks they could before. (NHS England 2019).

The Trust acknowledges that the risk of patient falls occurring can never be entirely removed, and that 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.

Patients are encouraged to mobilise on a regular basis in order to aid their recovery and rapid discharge home. The aim should be to reduce sedentary behaviour and reduce prolonged sitting throughout the day. This in turn will prevent frailty, preserve bone health and muscle strength and reduce injuries.

Achieve the National CQuIN description within the Trust - Receiving key falls prevention actions.

Data for the Falls CQUIN was fully submitted each quarter however final submission in Q4 was suspended due to the declaration of the Covid-19 pandemic. Throughout the period of data collection learning was taking place with actions to improve the key falls prevention recommendations.

- Education for staff centred on the Falls CQuIN, high impact interventions to embed key falls mitigation actions including escalation of any themes from the audit results to the monthly Falls and Mobility Group and the Operational Harm Free Group.
- Development of educational programmes that will ensure a consistent approach to the assessment of lying and standing blood pressure including escalation of positive results using the Royal College of Physicians recommended Guidelines.
- Progression with plans to digitalise the results of lying and standing blood pressure assessments to nervecentre
- Actions plans implemented following the audit process and submission of CQUIN quarterly results to improve patient outcomes

Develop and progress the Trust's Falls Mitigation Strategy 2018/2020.

- Continue to progress with evidence based practice and develop improvement programmes through networking with neighbouring Trusts with the East Midlands Falls Group to develop innovations and best practice
- Collaborative work going forward with the Trusts Fracture Liaison Nurses as part of the Falls Mobility and Falls Mitigation Strategy.[42]
- Falls mitigation health promotion at a Local Health event for people with learning disabilities to develop partnership working with the Community.
- Continuation of the monthly Fundamentals of Care Study Day for staff focused on risk assessment and post-fall best practice incorporating a patient journey.
- Development of bespoke study sessions for different staff groups including falls champions to highlight falls awareness within the Trust.
- Develop post incident information ward and department areas.
- Falls Champions in the Trust received a guideline and information booklet to highlight the role of a champion.
- Mobility and falls data shared with wards and departments. Mobilisation data is collected within the Division of Medicine; there are plans to progress this to other divisions [44] within the Trust.
- Development and digitalisation of the Perfect Ward audit questions in relation to falls. This enables the Falls Lead Nurse to view immediate trends in clinical areas .The results are also discussed at ward assurance monthly meetings supported by the Falls Lead Nurse
- Participation in the 2019/2020 Royal College of Physicians National Audit of Inpatient Falls (NAIF) Phases 1 and 2. The dataset has been extended to collect detailed information on fall risk reduction activities prior to the fall, the circumstances surrounding the fall and post-fall care.

National Audit of Inpatient Falls (NAIF) standards are based around National Institute of Clinical Excellence (NICE).

- Development of the 2020/2022 Falls Mitigation and Mobility Strategy to incorporate the 2020 NAIF annual report and implement recommendations and findings.

Monitoring and Reporting for Sustained Improvement

In 2019/20 performance was reported through the Mobility and Falls Group. This group led the implementation of the Falls Mitigation and Post Falls Care Strategy 2018/20. 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 Group. Falls performance was also monitored through monthly ward assurance meetings to discuss the Perfect Ward 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 an increased incidence of falls during March. A falls safety summit was convened in early May to review the increased incidence and identify actions. The fall incidence trend is back toward the Trust target below the national figure. This coincided with the onset of the Covid-19 pandemic and this was a contributory factor in the increase.

Aims for 2020/21

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

3.3. Safety - To Reduce the Number of Infections

Aims for 2019/20

- To achieve a 10% reduction of post 48 hour Escherichia coliform (E.coli) bacteraemia associated with urinary tract infection using the 2018/2019 rate as a benchmark. This is in line with NHSI recommendations.
- To minimise the number of surgical site infections in the mandatory orthopaedic fields to within the national benchmark.

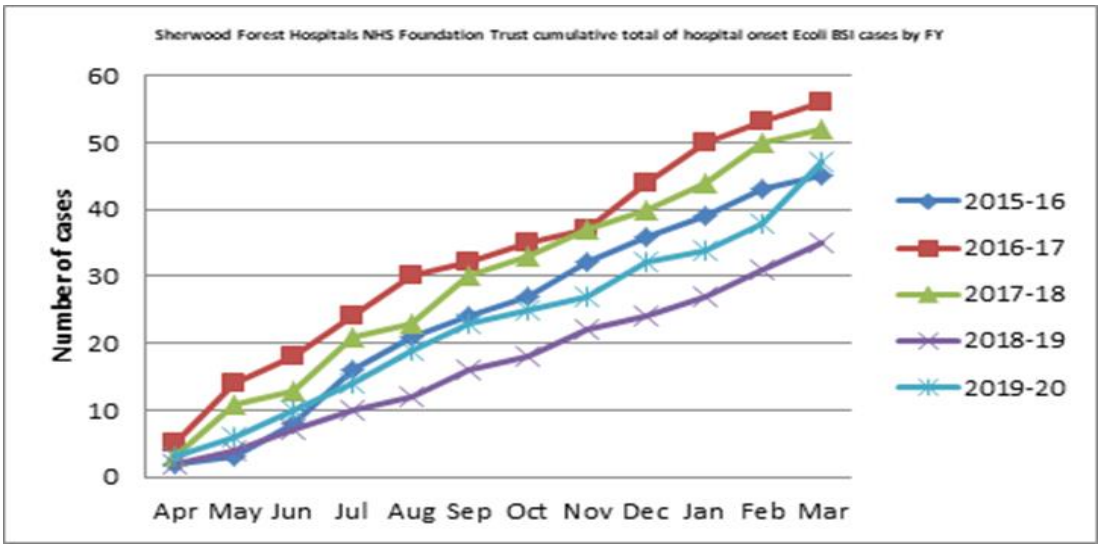
Performance against this Target

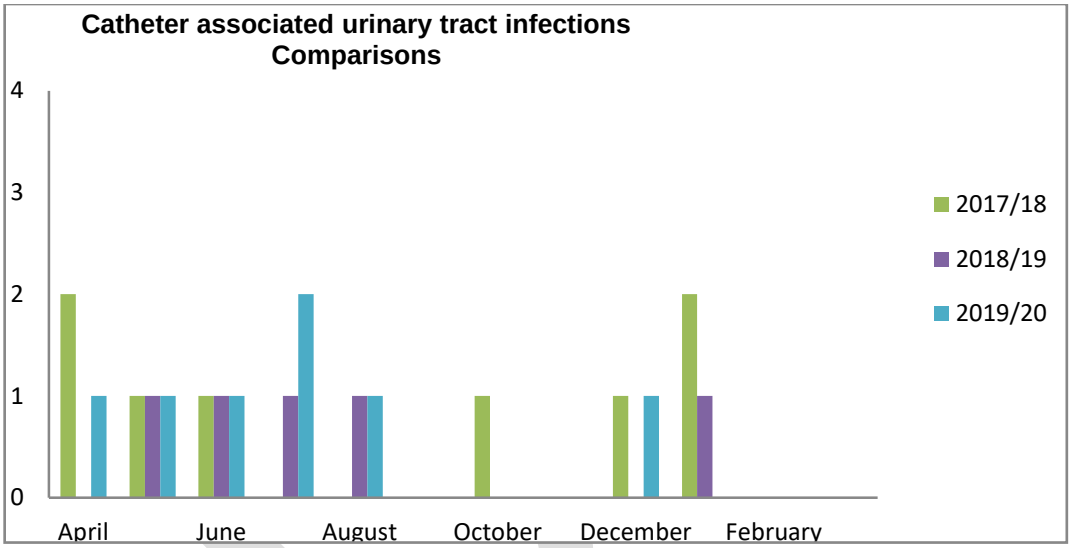
Below is a summary of the performance against the two aims outlined above:

- 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 Clinical Commissioning Groups (CCG) by 2024. The main causative organism is Escherichia coliform (E. coli). Data published by Public Health England suggest that most E. coli's tested at the Trust are not Trust apportioned. The primary causative factor remains urine, focused within the community. In 2019/2020 there has been an increase in the number of Trust acquired cases (Graph 16). This increase has corresponded with an increase in the number of Catheter-Associated Urinary Tract Blood Steam Infections (CAUTI) (Graph 17). Work to review the cause for this increase has taken place and actions have been implemented to improve device use.
- Campaigns to improve urinary tract health through better hydration and hygiene have been promoted within the Trust during 2019/2020 and this included work with the microbiology laboratory that explained to patients and staff how to obtain samples and how they would then be processed to get the results. There was considerable interest from the general public.

- We have had significant engagement with the Orthopaedic teams, to monitor practice and investigate any surgical site infections related to any total hip/knee replacements or fractured neck of femurs.

Graph 16





Graph 17

The report from Public Health England for January – March 2020 (see table below) indicates that for last four periods the Trust continue to perform in line and slightly better than with national benchmarking. The table indicates the summary result that suggests in all three fields the Trust has a rate lower or the same than the amalgamated average.

Table 17

Surveillance site	% inpatient/readmission infected Sherwood forest		% inpatient/readmission infected All Hospitals
	January- March	Last 4 periods	Last 5 years
Total Hip Replacement	0.0	0.0	0.4

Total Knee Replacement	0.0	0.3	0.3
Neck of Femur	0.0	0.4	0.9

Monitoring and Reporting for Sustained Improvement

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

What do we aim to achieve in 2020/21

- To improve practice standards in use of invasive device.
- To achieve the new Clostridium Difficile Infection (CDI) target of 79 cases
- To work to reduce the Trust's E-Coli in line with national targets.
- To work to reduce the Trust's surgical site infection rates in line with national target.

3.4 Effectiveness – Improving the Effectiveness of Discharge Planning

Aims for 2019/2020

- To develop new and improved ways of working to promote safe, timely discharge with the philosophy of 'home first.'
- Continue to work in partnership with local health and social care providers to ensure safe and appropriate discharges.
- To continue to work with local housing authority in relation to new government legislation.
- Support patients to continue to live independently at home where possible.

Performance against this Target

During 2019/20 the Trust has developed new and improved ways of working, along with continuing to work in partnership with local health and social care providers to promote safe, timely discharge with the philosophy of 'home first', supporting patients to continue to live independently at home wherever possible. Further to previous initiatives, good practices have been identified to build upon the integrated discharge model:

- Review of Sherwood Forest Hospital Trust Discharge Policy.
- Distribution of timely removal letters for patients who are Medically Fit For Discharge (MFFD).
- Continue close working relationships with the Patient Experience Team to identify improvements that could be made to the Trust discharge planning arrangements and monitor compliments, complaints and Datix Incident Reporting.
- Working in partnership with our Community Services.
- Continuing the existing good practice such as the ASSIST scheme from Mansfield District Housing which supports patients with housing needs, in particular the Homeless.
- Twice weekly review of patients with a LOS 5 - 14 days.
- Weekly review of patient with LOS 21 days and over individual Ward Sisters/ Charge Nurses and Matrons have sight and are more proactive in the discharge of this cohort of patients.

- Home first and criteria led discharge information on every patient's locker also includes Call 4 Care patient line number and social service Golden Number.
- More cohesive working relationship with End of Life Care team.
- Extension of FIT Team to support admission avoidance in the Emergency Department.
- Introduction of Integrated Discharge Advisory Team Dashboard to Nerve Centre live and in real time.
- Introduction to DT2/ in its infancy but very productive on Woodland Ward and currently trailing on Ward 51 to be rolled out to other areas in a phased stage.
- Non- weight bearing Home pathway.
- Proactive involvement from AGE UK that are based alongside Integrated Discharge Advisory Team (IDAT).

How Was This Achieved

- Onward referral to Community Services where appropriate via Call 4 Care – Request for Holistic Assessments, District Nursing Team, CURTT (Community Urgent Reablement Therapy Team).
- Working alongside Call 4 Care to promote hospital avoidance and utilisation of EDASS to support vulnerable patients, and enable them to remain safe at home until longer term plans can be put in place.
- Dedicated referral line via Call 4 Care for End of Care / Specialist Palliative Nurses (both Community and Hospital teams).
- The introduction of the "Interoperability" system within SystmOne to enable staff to ascertain promptly the name and details of a patients care provider.
- IDAT Team use care home tracker IT system to allow view of care home bed vacancies.
- Extra funding from HFID (Home First Integrated Discharge) for staffing resources
- Nerve Centre - ensure patients are identified and placed on the appropriate pathway needed (in real time).
- Instigation of the "Home First – Planning your transfer leaflet" for all patients to keep them fully informed of the discharge process.
- Specific "Transfer of Care" letters for patients that are transferred back to a Care Home setting.
- Purchase of winter beds in a variety of Care Home settings to ensure patient flow and allow Social Care assessments to take place outside the Acute Hospital setting.

Monitoring and Reporting for Sustained Improvement

The IDAT dashboard on Nervecentre has provided the team and the Trust with real time information on the current discharge status of every in-patient across the Trust, including the identification of simple and complex discharges and delayed transfers of care.

With this monitoring process, the Trust has been able to gather accurate real-time information regarding length of stay and any delays. This information is also used to identify gaps in capacity across the local health and social care system.

The HFID administrator record and monitor all Discharge to Assess (D2A) patients that are discharged home and all patients that are discharged home on the Non-Weight Bearing pathway.

3.5 Effectiveness – Improve our Care and Learning from Mortality Review

The Trust recognises that learning from the care given to patients in their final days of life enables us to understand where we have provided excellent care but also where there are opportunities for learning

and improvement. It is vital to recognise that acknowledging the care given to patients at such a difficult time will improve the standard of care for all patients.

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

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

Aims for 2019/20
As described in the 2018/19 Quality Account, SFHFT planned to focus on mortality within specific services, in particular looking to improve our mortality rates for patients admitted with a cerebrovascular or cardiovascular diagnosis, a fractured neck of femur, known learning disability or a specified health condition.

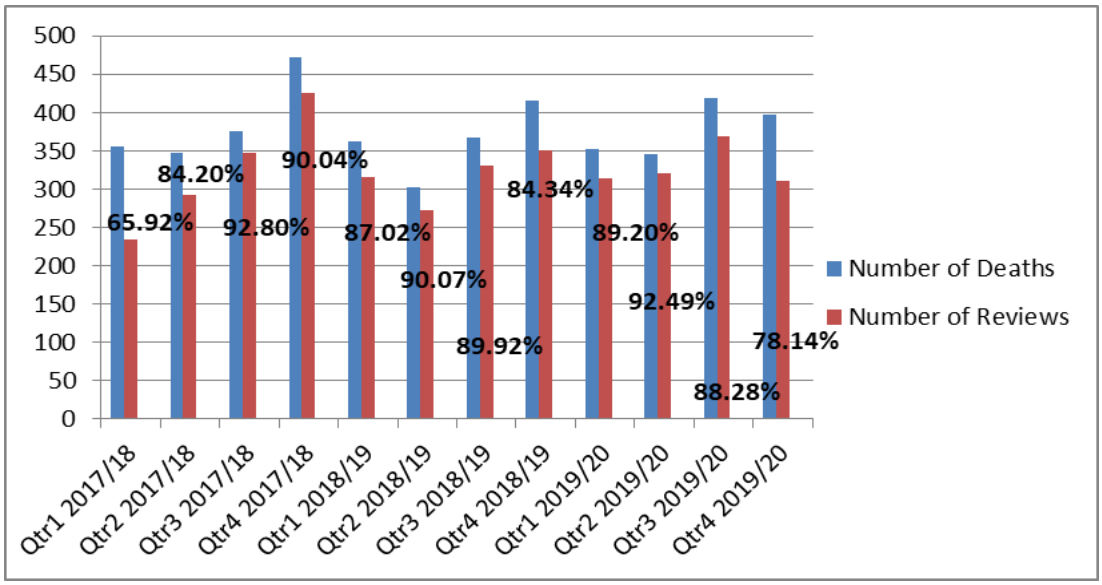
This work has commenced and the Trust has worked closely with Cardiology, Stroke and Critical Care services. In addition, there is an established review process for patients with an identified Learning Disability, sharing the outputs of our reviews with the external Learning Disability Mortality Review Body (LeDER).

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

Table 18

Learning from Deaths Dashboard Quarter 4 2019/20				
Inpatient & Emergency Department Deaths	**Total**	**Reviews completed**	**% Reviewed**	**Avoidability Assessments**
Jan-20	148	122	82.43%	Not collected
Feb-20	124	91	73.39%	Not collected
Mar-20	126	98	77.78%	Not collected
Qtr. 1	352	314	89.20%	7
Qtr. 2	346	320	92.49%	17
Qtr. 3	418	369	88.28%	17
Qtr. 4	398	311	78.14%	Not collected
Year 19/20	**1514**	**1314**	**86.79%**	**41**
Year 18/19	***1446***	***1267***	***87.62%***	***11***
Year 17/18	***1550***	***1300***	***83.87%***	***21***

Graph 18



How was this achieved?

The Learning from Deaths Table above indicates that the overall performance for the quarter against the >90% review of all deaths standard is 87%for the full 2019/20 financial year. The table indicates performance across a three year period between April 2017 and March 2020 indicating year on year progress. 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 increase in the number of Avoidability Assessments in Quarter Three 2019/20 is due to a change in reporting. The Dashboard reflects the number of Avoidability Assessments (Stage 3 review) actually carried out to demonstrate the robust mortality review process in place. In previous reports we only reported those that were formally presented to the Mortality Surveillance Group thus missing the opportunity to recognise learning and improvement happening at specialty level. From the 17 cases reported for this current year zero identified any avoidable factors.

Monitoring and Reporting for Sustained Improvement

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

MSG 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 2020/21

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

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

families. The aim through the year is to increase the service to provide a full five day (Monday to Friday) cover with the aim of having a seven day service in place by 31 March 2021.

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

Aims for 2019/20

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

- Progress Alliance programme of work.
- Launch the Macmillan Project.
- Embed EoLC elements from ReSPECT.
- Participate in the next cycle of National Audit for Care at End of Life (NACEL).
- Update all medical and nursing EoLC plans and documentation.

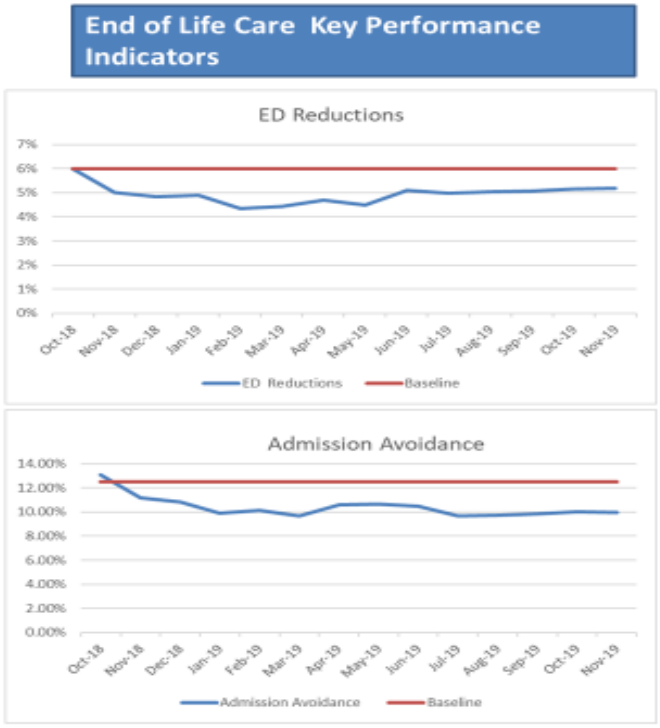
Performance against this Target

Progress Alliance programme of work

During this year the Trust has continued to positively influence the development of the 'End of Life Care Together 'service which was launched in October 2018. This is helping patients, their carers and staff by providing a single point of access through 'Call for Care 'which helps manage the referrals to, and the responses of the many services involved, in caring for the dying. It is helping the service coordinate the delivery of services for people's every day needs as well as responding in a crisis. This is helping the service to identify patients and register their needs earlier; it has improved the way care has been delivered, reduced admissions to hospital and aided the patients to be discharged earlier from hospital.

Below are graphs that demonstrate the Key Performance Indicators (KPIs) around Emergency Department reductions & admission avoidance for the first year of the service as presented at the EoLC Together Board in November 2019.

Graph 19



Launch the Macmillan Project

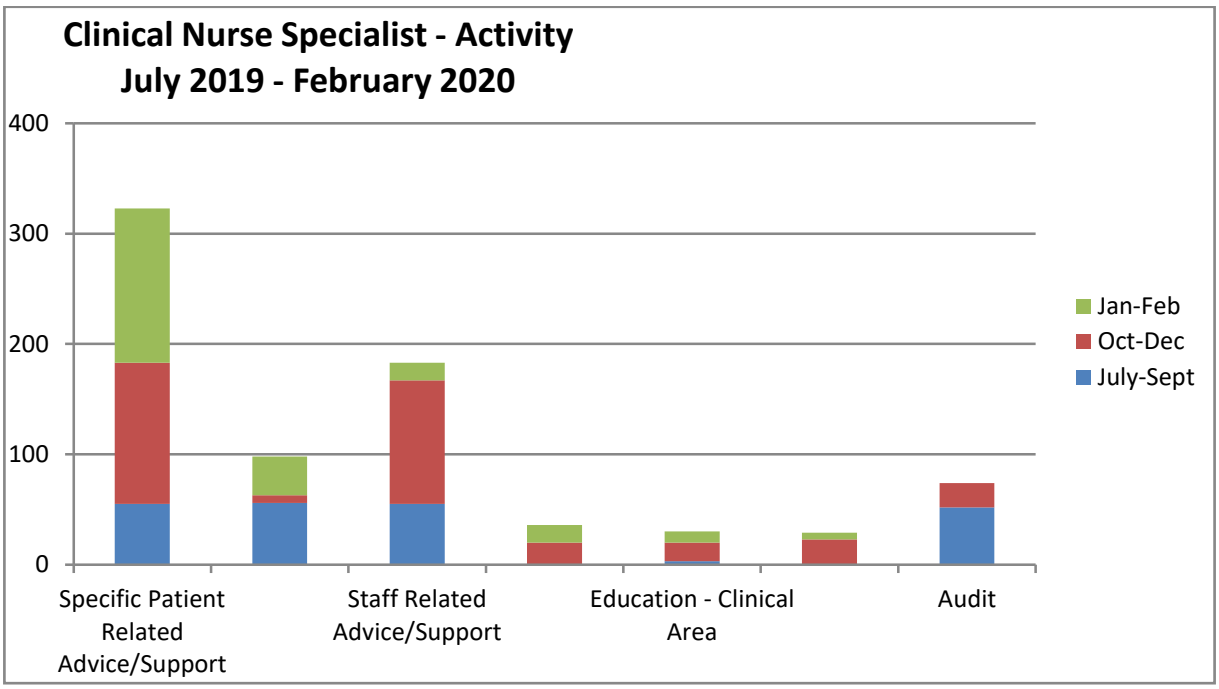
The Macmillan EoLC Team have been funded for two years to undertake a project entitled “Delivering Choice in the Times of Need”. This additional temporary resource to the Trust’s EoLC Team has been fully operational since July 2019 and supports the substantive EoLC Nursing and Medical Leads in the Trust.

. The overarching aims of the project are to:

- Proactively identify patients admitted to hospital who are in the last year of life.
- Focus on discharge & reduced length of stay.
- Work collaboratively with partners to keep palliative care patients well for longer and enable resilience of carers.
- Support patients to die in their preferred place of care through advance care planning.
- Educate and support colleagues to develop EoLC practices in acute sector.
- Scope the future requirements and remit of an EoLC Team at Sherwood Forest Hospitals and secure sustainability.

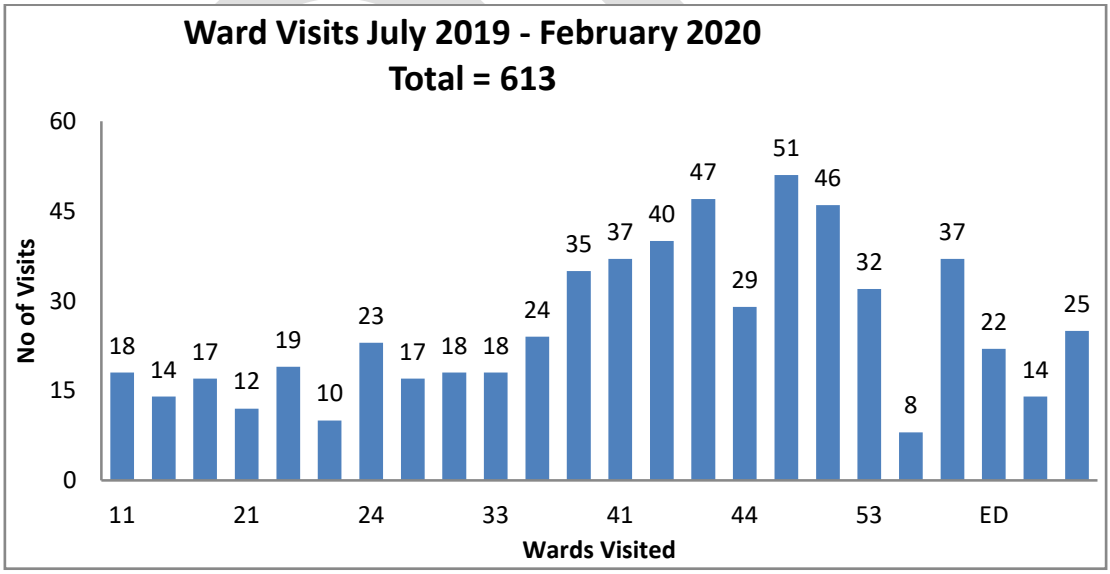
These additional posts in the EoLC Team have already demonstrated significant impact in several areas. The team identifies patients across the Trust who are in the last days of life using the EoLC model on Nerve Centre and contact ward staff to offer support and advice. The table below outlines the activity that the team have undertaken between July 2019 – February 2020. The majority of activity is patient related advice and support for the staff caring for patients in the last days of life.

Graph 20



The chart below demonstrates the amount of contact the EoLC Team have had by ward. It is clear the highest number of visits are within the Medical Division (Wards 41 - 53) as this is where the majority of expected deaths will happen. Since the addition of the new resource we have been able to offer regular support to all hospital sites including Mansfield Community Hospital (14 visits) and Newark Hospital (25 visits). However, it is clear from the figures below that the EoLC Team has an impact in all departments. This ensures equity of access for staff support to enhance the quality of EoLC for patients and their families wherever they are cared for in the Trust.

Graph 21



The team are currently undertaking a three month pilot to enhance support for Palliative & EoLC patients that attend the ED/Emergency Assessment Unit (EAU). There are several ways that these patients are identified:

- Via SystmOne using the special patient note/Electronic Palliative Care Co-Ordination System (EPaCCS)
- Direct telephone call from staff in the ED/EAU
- The Macmillan EoLC Clinical Nurse Specialist (CNS) attended the board round and proactive visits to ED/EAU

The table below demonstrates activity data collected by the EoLC Team from 6th January – 21st February 2020 (7 weeks):

Table 19

Patients **identified** with **special patient note**	Patients who had **F2F intervention** with EOLC team	Patients **verbally discussed** with EOLC team	Patients with **EPaCCS generated** in ED	Patients with **EPaCCS updated** in ED/KMH	Patients with no special patient note **identified by EOLC team as possibly in last year of life**
194	**33**	**45**	**42**	**27**	**10**

The project found that not all patients with a special patient note need intervention from the team:

- 78 out of 194 were either seen face to face to assess care needs, establish preferred place of care, refer onto EoLC Together Services or were discussed with the ED/EAU teams to offer advice. Whilst the EoLC CNS was in the department.
- 10 patients were identified incidentally as having EoLC needs. One of the key priorities of the EoLC Together Service is to increase the identification of the 1% of patients at EoL who are on a General Practitioner's register using EPaCCS. The EOLC Team have demonstrated impact towards this by initiating an EPaCCS (42) or updating an existing record (27) and this contributes to advance care planning.

The EOLC Team have significantly increased the delivery of education and training and this is detailed in that section below.

Embed EOLC elements from ReSPECT

The Trust implemented this new process in April 2019. ReSPECT is a national voluntary clinical standard, which is being adopted in many parts of the UK. The resources from the national team were used to plan this implementation. The preparation for this clinical change assisted the Trust in many ways including raising the profile of better, more proactive and shared decision making and where necessary helped to teach about the transition into EoLC when treatment no longer works. This is part of the Trust's strategy to develop the culture and leadership about EoLC.

During 2019/20 the ReSPECT process has been monitored by the Trust's Deteriorating Patient Group (DPG). Consultation about the process and any modifications are discussed and ratified; this included the introduction of the Mental Capacity Assessment (MCA) form which accompanies the ReSPECT process and aims to ensure that any decisions and discussions around mental capacity are clearly documented. As patients take the ReSPECT form home with them on discharge, an additional feature of this MCA form is to provide a visual reminder in a patient's notes that they have the ReSPECT process in place, if they are re-admitted in the future. There are also alert flags on the Trust clinical management system (Nerve Centre) that show whether a patient has the ReSPECT process in place and also what their resuscitation status is.

There continue to be challenges to the embedding of the ReSPECT process, therefore continual support, training and audit is in progress. In November 2019, the ReSPECT process was further implemented in local partnership Trusts which has further validated the process within the Trust.

The EoLC Team have delivered road shows to raise public awareness of the ReSPECT process as part of 'Dying Matters 'Awareness week in May 2019, at a local event for people with Learning Disabilities in June 2019 and at a CCG Patient/Carer Group in August 2019.

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

This year we have participated in the second round of NACEL, coordinated by NHS Benchmarking. The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit has monitored the progress against the five priorities for care set out in One Chance to Get It Right and NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

A total of 40 sets of notes were audited of patients who died in the Trust between 1-14 April 2019 (n=20) and 1-14 May 2019 (n=20) who met the audit criteria.

We are currently awaiting analysis of the audit and will update this report as soon as possible.

Update all medical and nursing EOLC plans and documentation

All patients that are identified as dying have their care planned and recorded in an individualised care plan which is in line with 'The Priorities of Care for the Dying Person '(Leadership Alliance, 2014). The Trust currently use separate medical and nursing Last Days of Life Care Plans and the service has piloted a combined care plan that all members of the multidisciplinary team can contribute to. The EoLC Team have benchmarked the care plans that are used by Trusts across the East Midlands and have produced a document that will be piloted on Wards 53, 43 & Short Stay Unit in 2020. The aim is to ensure that the document supports clinical practice to further enhance outstanding individualised EoLC and facilitates inter-professional communication.

Monitoring and Reporting for Sustained Improvement

Throughout 2019/20 the Trust has continued to monitor the number of hospital deaths. In 2019/20 1538 patients died in hospital (37 at Newark Hospital). The Trust mortality statistics are included in the Quality Account.

Training & Education

It is well documented that in order to provide high quality, outstanding EoLC staff need to be equipped with confidence, competence and skills commensurate to their role (Ambitions for Palliative & EoLC Strategy, 2015). The Trust continues to deliver core and bespoke training programmes for EoLC. Between 1 April 2019 and 31 March 2020, 487 new starters (Nursing & Allied Healthcare Professionals - AHP) have attended the EoLC induction session and 2,906 (90% compliant) have completed the EoLC Mandatory Booklet. Both training events include the Care after Death video and associated competence framework as per the Care after Death policy. This is a 'one off 'competence and from April 2020 will only be delivered during induction training.

Bi-monthly EoLC Champions meetings throughout 2019/20 have been attended by a core group of Registered Nurses, Healthcare Care Assistants and AHP's. This is an educational, sharing and supportive forum focused on enabling frontline staff to deliver outstanding EOLC. This year we have recruited a group of Medical and Pharmacy EoLC Champions who will support the ongoing EoLC audit programme.

The service has continued to participate in the clinical phase two and three medical student training sessions in addition to collaborating in Foundation and Core Medical doctor training & 'Dying to Communicate 'courses with the Specialist Palliative Care Team.

With the addition of the Macmillan EoLC Team funding we have been able to greatly enhance our training programme since September 2019:

Course Title	Staff Group	Attendance	Comments
Care after Death training 6 sessions Nov 2019 – Mar 2020	Radiology Staff at KMH & Newark	39 KMH 17 Newark	This course was requested by the Radiology Senior Team in response to a death experienced in the department. The aim was to ensure if this happens again staff are equipped & supported to deliver compassionate care after death in the department. Although this is a rare occurrence, it is key that practices & principles are adopted across the Trust.
Fundamentals of Care Monthly	RN's & HCSW's	180	This session is part of a corporate nursing course and includes an emphasis on the importance of Mouth Care, Pressure Area Care & appropriate observations at EOL
T34 Syringe Pump Training Jul 2019 – Feb 2020	RN's	58	A mixed method of training delivery including road shows, ward based & Train the Trainer courses
EOLC Workshop Dates Oct 2019 – Feb 2020 5 Workshops	RN's & AHP's Health Care Support Workers	23 23	A 1 day workshop that covers ACP, Symptom Management, communication skills, ReSPECT, EOLC Tools **(see evaluation comments below)**

Evaluation Comments from EOLC Workshops

- *"Fantastic training day. I'm very passionate about palliative care – and it's very important to get things right when patients reach the last days in their life"*
- *"Really good study day, good comprehensive refresher and also update. Was good sharing ward practice which can itself help those that help us to improve practice"*
- *"Really beneficial study day and very informative. Has expanded my knowledge and confidence on caring for EOL patients. Thank you!"*
- *"I can more understand patient feelings when they are EOL"*
- *(I understand)… "What end of life means and how to explain it to patients and relatives"*
- *(I understand)… "How to approach the questions about death"*
- *"I think all staff who are working on wards should come on this training"*

Quality End of Life Care for All (QELCA©)
QELCA© is an intensive training course & has been incorporated into the EoLC training portfolio. Six nurses from across the Trust engaged in the first pilot programme, which has combined structured teaching with experiential learning. The nurses attend monthly, facilitated Action Learning Sets, sharing examples of positive changes in EoLC practice and provide peer support to each other. This first course completed in May 2019 and was showcased in the Trust's EOLC Conference.

As a result of this successful pilot, the course has been commissioned by the EoLC Together Service for two years to provide a foundation for collaborative training across the Alliance. We have two trained facilitators in the Trust and have delivered the second course to six nurses, from across all hospital sites, in February 2020. A further two courses are planned for June and September 2020.

Fast Track Continuing Health Care Discharges from hospital
Please see Quality Priority 2: Patient Experience 2.2.5 for this year's update

Aims for 2020/21

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

3.7 Patient Experience – Improve the Experience of Care for Dementia Patients and their Carers

As identified in the Trust's strategy 2019 the Trust is proud of the developments but recognises the further improvement that could be made. With the continued aim to provide outstanding care to all our patients the Trust will need to continue to maximise the potential of our workforce, focusing on the experiences of people including patients, public or the colleagues we work with. By continuously learning and improving, choosing to adopt evidence based practice utilising information and digital technology whilst using research being innovative and improving for the benefit of the local community.

Aims for 2019/20
The aims set in 2019/2020 were identified as part of the work plan when the current dementia nurse specialist was appointed and commenced in post August 2019, they included:-

- Assisting with the promotion and monitoring of the dementia and delirium assessments as the assessment had been moved to an electronic system on Nerve Centre.
- Adding of dementia alerts/flags to the Trust's electronic systems, allowing all staff to have information regarding confirmed dementia diagnosis and where possible the type of dementia. This in turn would provide accurate occupancy of beds related to patients with a dementia diagnosis, on a daily, weekly, monthly and annually basis.
- Updating of all mandatory training including orientation, induction and yearly mandatory updates and review of the current tier 2 training available with a plan to make the training more practical focused.
- Supporting identification of newly diagnosed individuals with a dementia diagnosis for a study undertaken by Health Watch that will provide insight into the support and care received post diagnosis.

- Embed the Dementia Specialist Nurse support within the PLACE team, assisting with audits and supporting developments to improve the environment.
- Provide fundamental (tier 1) training for other members of the hospitals team including domestic, catering, porter and voluntary staff.

Performance against this Target

- Assessment completion continued to be a challenge, various strategies have been applied since they were commenced electronically in May 2019, additional investment has been agreed and the service has commenced to improve compliance, further actions will be implemented and monitored to establish an impact on this figure further with the aim of becoming compliant at 90% heading into Q3 2020.
- Alerts have been added, this will be rolling over as part of the 2020/2021 plan, three systems have had approximately 500 confirmed diagnose added to them including on one of the system the type of confirmed dementia diagnosis.
- Orientation and induction training has been updated in August 2019 and evaluations remain positive, the yearly mandatory update presentation has remained the same due to the need to ensure all staff receives a consistent message for the financial year 2019/2020, a new presentation will be implemented in April 2020.
- The Tier 2 training has been changed to Best Practice in Dementia Care and these were provided in 2019/20, the first two sessions were evaluated by staff.
- The Healthwatch report is in the process of being written and we await the findings, the identification of individuals to take part was challenging and lessons learnt should this occur in the future.
- The Dementia Nurse Specialist has been part of 2019/20 'PLACE' audits, including the pre-visit work and the post-visit action plans.
- The leads for the Medirest and the voluntary services have agreed a plan of training and these commenced in March 2020 for both groups of staff.

How was this achieved?

The substantive recruitment of the Dementia Nurse Specialist has been positive and has supported the delivery of the aims for 2019/20 The appointment has supported and driven to develop the service for SFHFT has already begun to see the rewards, with further plans in 2020/21

There is a clear work plan and targets set that were both realistic and achievable that could be monitored and updated to provide evidence of what has been achieved and the projects needs to maintain pace and drive.

Monitoring and Reporting for Sustained Improvement

The service is required monthly to produce evidence for the national database regarding the percentage of achievement of dementia assessments completed. This is reported to the Trust Board of Directors and uploaded to the national database. The reports and options appraisals have been provided as to the cause and possible solutions of the poor percentage achieved and additional support has been provided. These figures will continue to be monitored at the Trust's Board of Directors meeting monthly and through the Single Oversight Framework, where the service will be held to account.

All training in the organisation is reported onto a Trust database providing the uptake and valuations. These are reviewed and changes made accordingly.

Aims for 2020/21

The aims for 2020/21 will continue to focus on the assessment of patients during their hospital stay; with the aim to see the completion target for dementia screening, in patients over 75 years of age and above achieve the national target of 90%.

Mandatory training will provide insight into some of the lessons learned as part of review of incidents and expressions of concerns or complaints identified with the approach that by learning from incidents in order to improve the experience for our patients.

The focus on identification on electronic systems of individuals with a confirmed diagnosis will continue, and working alongside the coding department will ensure that the correct information is added to both medical and nursing notes.

The Trust has identified that there is a need to have a greater awareness of Working Age Dementia and the support needed by the both the person with the diagnosis and the carers who support them. By education and raising awareness to the Trust will support this group of patients and have the knowledge and skills to be able to care for them should they require hospital admission for an acute illness.

There is written evidence that supports the identification and treatment of hearing loss as a way to improve the cognitive decline caused by dementia. In collaboration, the audiology department and our commissioners will develop a pathway for all newly diagnosed patients to undergo an audiology assessment as part of their diagnosis pathway.

The Trust will utilise the learning from the report with Healthwatch to improve outcomes for patients newly diagnosed with dementia.

The Trust will continue to work with Integrated Care System to improve the overarching care of patients living with dementia and their families and carers.

3.8 Patient Experience – Using feedback from patients and their carers

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

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

Since the original roll-out of the FFT in 2013, the Trust has extended the services included in the FFT including community based services. The modes of collection have expanded to include paper surveys, SMS text messaging, Ipad collection and feedback via the Trust website.

The Trust has worked hard to achieve and sustain a response and recommendation rate which places SFHFT high in the NHS England North Midlands region.

Table 20

FFT Feb 2020 - IP

Trust	Response Rate		Rec Rate	
	IP	A&E	IP	A&E
Chesterfield Royal Hospital NHS Foundation Trust	19.8%	7.4%	97%	84%
Nottingham University Hospitals NHS Trust	26.6%	12.4%	96%	92%
Sherwood Forest Hospitals NHS Foundation Trust	40.1%	15%	97%	94%
Shrewsbury And Telford Hospital NHS Trust	21.4%	7.0%	97%	93%
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	50.0%	NA	99%	NA
University Hospitals of Derby and Burton NHS Foundation Trust	11.0%	2.6%	97%	86%
University Hospitals of North Midlands NHS Trust	25.3%	22.8%	99%	69%

How was this achieved?

The FFT response and recommendation rates continue to be reported as a key performance indicator at the Trust Board meetings and exception reports are submitted relating to any areas where internal standards are not met. The FFT is monitored monthly as part of the Nursing Ward Assurance Group and Nursing, Midwifery and AHP Board with agreed plans for areas of non-compliance. All FFT data is reported weekly to all relevant teams, managers and the Divisional Triumvirate for review and action, all negative responses and narrative around the patient experience is included in the reporting and areas for improvement are identified.

During 2018/19, a review of the FFT was carried out by NHS England and there are a number of planned changes from April 2020. The changes include:

- Changes to the mandatory question; “Overall, how was your experience of our service?” with a new response scale.
- Patients can provide feedback at any time following their experience (previously within 48 hours of episode of care). Currently SMS text messaging are sent on the evening of attendance/discharge
- Maternity Services – Women can provide feedback at any time during their pregnancy (previously not done until 36th week of pregnancy)

There are service specific questions included on the FFT surveys for our Day Case Unit, Neo Natal Unit and Discharge Lounge.

From April 2020, the new question and response scale will be implemented and we continue to extend the SMS test messaging service in the Urgent Emergency Care and Maternity services.

SFHFT introduced additional questions to the mandated question to support national and local audits within specialties during 2019/20. Following the planned changes by NHS England in April 2020 to ensure services are focusing on areas where patients report a poor experience a review of the questions was undertaken using FFT comments along with other mechanisms of feedback, complaints, concerns and national survey data.

The review identified poor experience consistently relates to the following themes:

- Support with personal care needs
- Ability to administered own medication brought into hospital with them
- Support at meal times
- Pain management and access to help within reasonable time
- Discharge – Home situation considered as part of discharge plan
  Post-discharge – information and support from health and social care following discharge

This correlated with the findings of the National Inpatient Survey for 2019 for SFHFT, and patient feedback.

As a result of the review, additional questions linked to the FFT results and National Inpatient Survey have been added to the FFT surveys for Inpatient, Emergency Care and Outpatient Services to provide real-time feedback and quality measure of experiences in 2020/21 in advance of the National Surveys. All National Patient Surveys planned for 2020 were paused in early 2020 due to Covid-19.

In March 2020, NHS England paused all FFT surveys; however SFHFT continued to collect FFT data complying with Infection Prevention Control Guidance by SMS Text Messaging. This ensured continued feedback and triangulation with complaints, concerns and compliments. Although nationally NHS Trusts are not externally reporting FFT data, SFHFT have continued to collect and report data weekly and monthly internally.

Monitoring and Reporting for Sustained Improvement

In order to continue to understand patient experience and maintaining high standards, we continue to strive to provide feedback received from complaints, concerns, compliments, and Friends and Family data. Complaints, concerns and compliments will continue to be triangulated with incidents, legal claims and Coroners 'Inquests to identify themes and trends. The learning from complaints is managed by action plans that are tracked with divisions to ensure learning is embedded and evidenced.

All patient experience data continues to be reported monthly and quarterly to divisional and specialty governance structures, which will identify how well we are doing against the standard operating frameworks targets and understand our patients, relatives and carers experiences when using our services.

Patient Experience data is reported monthly to divisions as part of the Divisional KPI dashboards, Ward Assurance Group, and Single Operating Framework.

Aims for 2020/21

PET will be moving under the Nursing Directorate in April 2020 to strengthen links with the nursing and AHP teams and review the aspects of the complaint management processes to align additional responsibility for complaint responses to the senior divisional teams.

A monthly PET dashboard will be created to centralise Patient Experience data, along with a quarterly Patient Experience report to include thematically data.

A review of the wider Patient Engagement and Involvement agenda is planned for 2020 to understand how SFHFT involves our patients in improving services. The review will include a gap analysis of the progress of Equality, Diversity and Inclusion priorities for our patient and carers.

The results of the review will develop SFHFT Patient and Carer Experience and Engagement Strategy for 2020-2023.

9. Patient Experience – Safeguarding Vulnerable People

Aims for 2019/20

- To promote and maintain safe practice in respect of safeguarding and ensure staff are aware of their responsibility to the safety of patients, carers, family and employees.
- To evidence the effectiveness of the care provided to vulnerable children, young people and adults.
- To implement initiatives that enhance service user experiences and demonstrate person-centred care, with a focus on best interest, less restrictive interventions and improving the transition from child to adult care delivery.

Performance against this Target

- The Trust continued to embed the safeguarding training strategy developed in 2018/19. The training remains aligned to local and national safeguarding drivers. The Trust has revised this in line with learning from local and national safeguarding issues including County Lines and Child Sexual Exploitation.
- The use the mandatory training to raise the awareness of learning from incidents within the Trust, in 2019/20 this included the management of bruising in non-mobile babies and allegations against staff. This training is revised on an annual basis and the compliance for all clinical facing staff remains at over 90%.
- All staff commencing employment in the Trust attend Think Family Safeguarding induction training in the first month of employment.
- From implementation of the Think Family model of safeguarding training the Trust set a three year trajectory to ensure that all presently employed staff attended the Think Family training. This compliance trajectory ends on 31st March 2020. It is expected when completing the trajectory period that the compliance against the set standard will be 98%. The safeguarding team are presently reviewing the outstanding 2% of non-compliant staff, as it is anticipated many will either be on long term leave or have accessed external training that has not been recorded. Moving into the next year the updates will now be reviewed and move to half day three yearly updates supported by annual mandatory thematic updates.

Wider Safeguarding Support

- Duty advice line support – Monday to Friday 09.00 – 17.00- the subject of calls continue to be monitored closely and any trends or themes addressed or additional training is provided.
- Safeguarding referrals are monitored and where required the safeguarding team work in partnership with the local authorities and partner agencies. Where challenge or escalation are required the divisions are supported to escalate in line with policy and procedure to ensure the best interests of the patients, families or carers are met.
- The Trust participates in multi-agency reviews and ensures learning is shared in order to support service developments.

Audit and assurance

- Following at 360 audit of Mental Capacity Act the Trust led by the safeguarding team have revised its audit processes to ensure a consistent process of audit and learning. This will be a key area of focus for 2020/21.
- The Safeguarding team continue provide assurance to the commissioners, CQC and safeguarding boards via our Safeguarding Adults Assurance framework and Section 11 safeguarding children reviews, the outcomes of these reviews are overseen via the Safeguarding Steering Group.
- The Safeguarding team participate in multi-agency audits for both children and adults the key areas audited during this year included:
  - Multi-Agency Safeguarding Hub (MASH) referral for children that conclude in no further action
  - Bruising in non-mobile babies
  - Familial sexual abuse
  - Missing children
  - S.136 Mental Health Act 1983
  - Harmful sexual behaviour
  - Child sexual exploitation

This is fed into training, procedure and practice development where relevant. The Safeguarding governance process oversees this through the Safeguarding Steering Group. All policies and procedures are reviewed and are in date, these reflect new local and national guidance. The Safeguarding Team continue to work with the divisions to support transitions between service's for service users and families and where needed provide expert input into the relevant case meetings.

Monitoring and reporting for sustained improvement

- The Safeguarding team continue to use and refine our quarterly reporting mechanisms. These are drawn together to provide an overarching annual report (each Trust is required to provide safeguarding annual report and the quarterly reporting process used to support this is evidence of best practice).
- The data is drawn from the reporting processes which are used to analyse areas for development, intervention but also evidence the Trust is doing a 'good job'.
- Training attendance will continue to be reviewed and forms part of our standardised reporting mechanisms, non-compliance and issues are escalated via the Safeguarding Steering Group, Patient Safety & Quality Group and divisional reporting mechanisms where needed.
- The Safeguarding team continue to review and update training content to enable lessons to be learnt from internal and external issues and guidance.

Aims for 2020/21

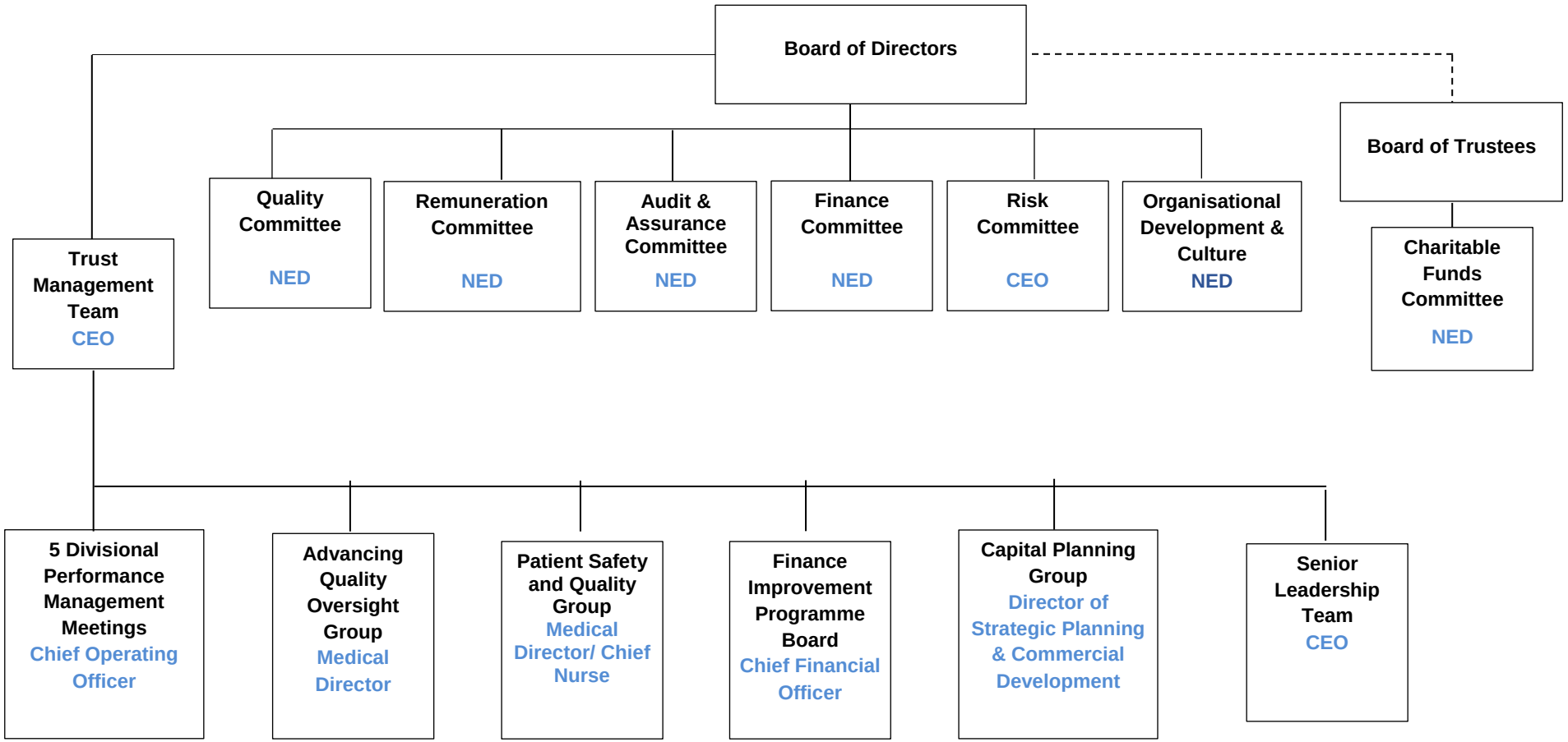
- The Trust will continue to ensure where there are safeguarding concerns - adults, children and carers are recognised as partners in the outcomes and where possible will be consulted upon what they wish to happen.
- The Safeguarding team will continue to embed the IDVA service commissioned with Women's Aid, the process was formalised in November 2020 and during 2020/21 the aim will be to review the process effectiveness, review the outcomes for patients presenting with Domestic Abuse related issues and feed this through our reporting mechanisms.
- The Trust will work in partnership with external partners regarding the Trust's response to the safeguarding agenda.
- The Trust will continue to learn from local and national safeguarding issues and ensure where relevant these are reflected into the Trust services.

3.10 Mandatory Key Performance Indicators

Indicators identified within the Single Oversight Framework	Target	Performance	Performance
		2018/19	2019/20
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92.0%	90.2%	87.6%
A&E : maximum waiting time of four hours for arrival to admission / transfer / discharge	95.0%	94.2%	90.1%
Cancer 2 week wait: all cancers	93.0%	96.1%	94.8%
Cancer 2 week wait: breast symptomatic	93.0%	95.1%	96.8%
Cancer 31 day wait: from diagnosis to first treatment	96.0%	98.1%	96.2%
Cancer 31 day wait: for subsequent treatment – surgery	94.0%	93.3%	82.9%
Cancer 31 day wait: for subsequent treatment –drugs	98.0%	95.6%	97.1%
Cancer 62 day wait: urgent GP referral to treatment for suspected cancer	85.0%	81.4%	77.0%
Cancer 62 day wait: for first treatment – NHS cancer screening service referral	90.0%	92.5%	81.8%
Maximum 6- Week wait for diagnostic procedures	99.0%	99.1%	98.2%
Clostridium difficile variance from plan	48	35 (13 less than plan)	37 (11 less than plan)
Summary Hospital-level Mortality Indicator (SHMI)	100	95.33	96.55
VTE Risk assessment	95.0%	95.2%	95.8%

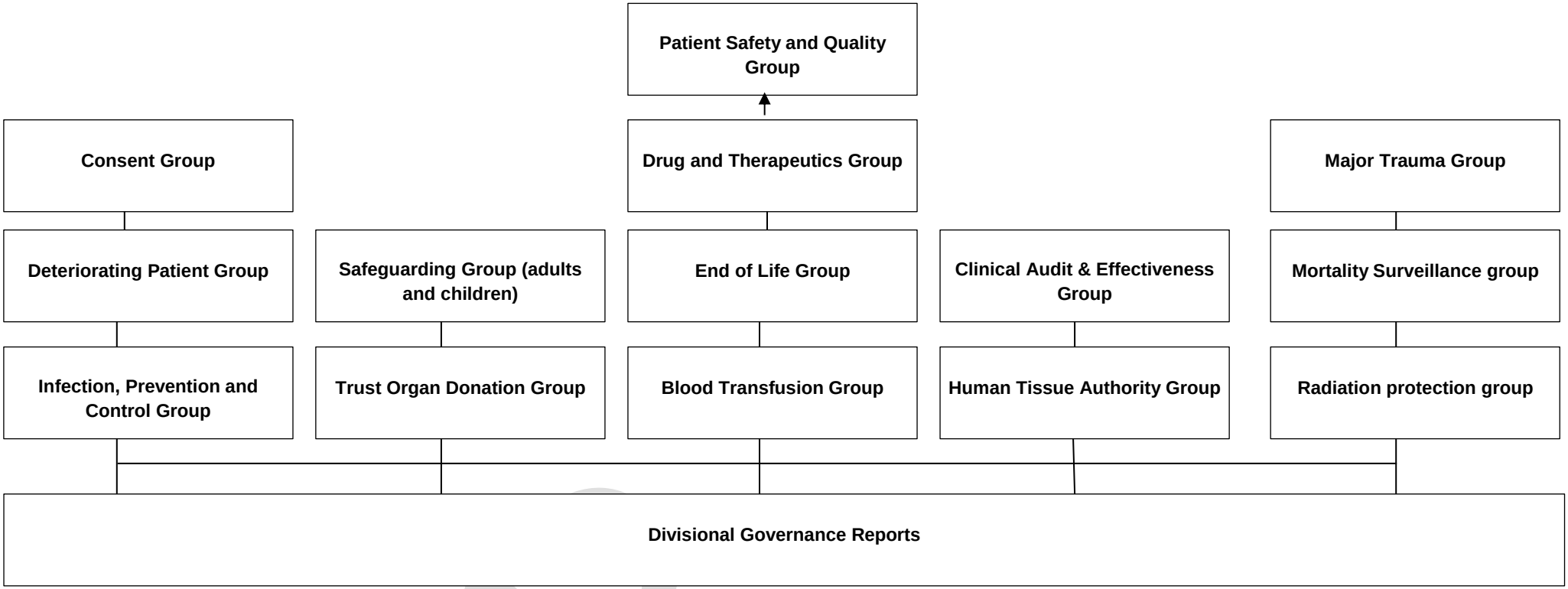
Appendix 1

Sherwood Forest NHS Foundation Trust –Committee Structure – 2019/20



Appendix 2

Sherwood Forest NHS Foundation Trust –Quality & Safety Structure – 2019/20



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

Appendix 3 Assurance over Mandated Indicators

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

This section includes the statements from our stakeholders about the Trusts quality performance during 2019/20 following review by Stakeholders

Statement from NHS Nottingham and Nottinghamshire Clinical Commissioning Group

NHS Nottingham and Nottinghamshire Clinical Commissioning Groups (NNCCGs) (formally consisting of Greater Nottingham Clinical Commissioning Partnership, Mansfield and Ashfield CCG and Newark and Sherwood CCG) collaboratively commission services from Sherwood Forest Hospitals (SFH). NNCCG acts as the co-ordinating commissioner and leads on the contract on behalf of the other CCGs in gaining assurance on patient safety and quality of care delivered by SFH.

The quality assurance framework that Commissioners use consists of reviewing information on safety, patient experience, outcomes and performance, in line with the quality schedule and national and local contractual requirements. Intelligence is gained in various formats, including local and national reported data, this is complimented by quality visits to areas of care delivery provided by SFH, which enables commissioners to experience the clinical environment and gain first hand experiences from patients and front-line staff.

SFH has continued to provide the CCG with high level reporting in line with their 2019/20 contract. The CCG has measured and reviewed reporting via Quality meetings. The CCG has also undertaken quality and insight visits to various wards and departments within the Trust to gain additional assurance around safety, effectiveness of services and patient experience. The Quality Account provides information which is consistent with the information received by the CCG during the year.

In 2019/20, SFH has continued to ensure that patients receive consistent high quality, safe care with good health outcomes and experience. Reducing harm from falls is identified as a quality priority in line with the Quality Strategy. It is noted that the Trust still has an aim to be below the National Average target for rates of falls per 1000 occupied bed days. Falls mitigation and improvement is guided by recommendations contained in the Trust's 2018/20 Multi-Disciplinary Falls Prevention and Post Fall Strategy in conjunction with the monthly Falls and Mobility Group Meetings. Commissioners are part of the core membership to these meetings and the Strategy outlines best practice approaches for mitigating falls in the hospital.

The Trust encourages staff to report all incidents and to immediately escalate any that may require consideration as a Serious Incident (SI), including Never Events. SFH has internal processes in place for reporting SIs on the Strategic Executive Information System (StEIS) and to Commissioners. Commissioners review all SIs regularly and work closely with SFH on obtaining further assurance when needed and final closure of incidents. Commissioners are members of the Trusts SI scoping and Sign Off meetings. It is clear in the Quality Account that SFH identifies and disseminates the learning arising from incidents in order to improve patient safety.

The Quality Account demonstrates examples of good work and achievement undertaken by SFH over the past year around; End of Life Care, Discharge Planning, Learning from Deaths, Infection Prevention & Control and Staff Engagement.

Commissioners note that following the CQC inspection during January and February 2020, visiting King's Mill Hospital and Newark Hospital, the Trust overall rating remained 'Good', with 'Outstanding' for the Caring domain and 'Good' for the remaining four domains.
SFH has achieved a majority of the Commissioning for Quality and Innovation (CQUIN) goals in 2019/20.

SFH focussed on three key quality priorities in 2019/20 around clinical care, patient experience and patient safety with success measured in all three areas. Some challenges still remain for the Trust. The 28 day readmission rate for patients across the Trust continues to be monitored through the Executive-led Divisional Performance meetings and reported to the Board of Directors on an exception basis. The decision to cease all routine elective work to create capacity for COVID-19 patients will continue to impact on the Trust's RTT performance. C.Difficile and MRSA at SFH were above trajectory for 2019/20 and the Trust has developed effective programmes of surveillance and remains committed to improving and sustaining high levels of environmental cleanliness.

The COVID-19 pandemic has significantly affected the audit programme in 2019/20, but during 2019/20, the relevant health services that SFH provides covered 57 national clinical audits and 2 national confidential enquiries. During that period the Trust participated in 100% of national clinical audits and 100% of national confidential enquiries that it was eligible to participate in. SFH benchmark well nationally, and acknowledge there is opportunity to improve the care provided to patients through audit. The alignment of clinical audit and quality improvement will enable them to do this systematically in the future

Commissioners acknowledge the work the Trust has undertaken around mortality and end of life care. Clinical teams have continued to improve their mortality processes presenting consistent and comprehensive reports to the Trust Mortality Surveillance Group each month, which commissioners attend and gain further assurance of work undertaken. The Royal College of Physicians Structured Judgment Review Methodology (SJR) is now well established across the organisation.

The learning themes from the SFH mortality reviews have helped shape the Trust Quality Strategy and improvement requirements for the coming year whilst optimising their learning opportunities and sharing good practice across the organisation and wider health system.

Commissioners acknowledge the work the Trust is undertaking around the Freedom to Speak Up (FTSU) with The Trust appointing a substantive FTSU Guardian in April 2019 and 15 FTSU Champions in October 2019, whom are there to support staff to raise and escalate their concerns where appropriate. It is positive how FTSU is promoted through regular communications to the Trust via social media campaigns, quarterly bulletin updates, posters, banners, videos and screensavers.

The work undertaken on PASCAL, which is the Patient Safety Culture surveys, is commendable, over 500 clinical and non-clinical staff in ED, Maternity and Theatres had the opportunity to complete a survey involving several domains that influence patient safety (teamwork, job satisfaction, working conditions, response to errors etc.). Commissioners also recognise the good work involving the 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.

Commissioners recognise that SFH is working actively with system partners as a member of the Nottinghamshire Integrated Care System, to transform the Trust's approach to focus on population health needs and 'system' ways of working

Statement from the Health Scrutiny Committee

The Health Scrutiny Committee for Nottinghamshire welcomes this opportunity to comment on Sherwood Forest Hospital's draft Quality Account.

This year's Quality Account from the CEO of Sherwood Forest Hospitals is particularly impressive; not only because of the very positive improvements across the Trust and the shift in the financial position, but because of the strong commitment to continuous improvement. Under the current leadership, this is not just a statement, but is demonstrated very vividly throughout the report

There is much to celebrate, and the committee was particularly impressed by the improved pathway for people with learning disabilities.

The Health Scrutiny Committee would also like to take this opportunity to thank the staff of Sherwood Forest Hospitals for all of the work they have undertaken during the particularly challenging time of the COVID-19 pandemic.

Statement from Healthwatch

As the independent watchdog for health and care services in Nottingham & Nottinghamshire, Healthwatch Notttingham and Nottinghamshire (HWNN) works hard to ensure patient and carer voices are heard by those who design and deliver services. The HWNN team has had an opportunity to view and comment on the Sherwood Forest Hospitals NHS Foundation Trust Quality Account (QA) 2019/20 and critically evaluate the aims set for 2020/21.

The QA outlines the upcoming launch of the "Sherwood Six Step" QI approach, which HWNN is pleased to see being implemented. As part of this process it is positive to see over 200 staff have been trained in the new approach, something that was a key priority to be delivered.

The Trust is committed to developing a safety culture within the organisation, which is of key importance in the delivery of safe care. Therefore the added training and learning from safety, improvement and governance events is welcomed. The Trust has launched the NHS Patient Safety strategy that sits alongside the NHS Long Term Plan and aims to improve patient safety. There is a firm commitment by the Trust in this area, which is evident from the appointment of the Clinical Director for patient safety and the human factors training programme. This is a significant step in terms of enhancing patient safety and staff retention as the Trust strives and a culture of improvement.

It is acknowledged that complaints are completed within 25 working days most of the time and the number of referrals to the Parliamentary and Health Service Ombudsman is also reducing, although in 2 cases there has been a financial remedy. Moving forward the Trust should strive to bring this number to zero and put clear measures in place in order to achieve this.

The Trust has an increased number of C Diff infections in 2019/20 and to combat this intervention measures have been outlined. These should be adhered to and monitored in order to keep the target number of C Diff to no more than 79 for 2020/21.

The Trust has an ambitious plan for end of life care and aims to launch a new End of Life Care strategy. This strategy will need to be implemented in a way that it adds to the current system and enhances delivery of end of life care.

Furthermore it is positive to see the Trust is repeatedly achieving previously set targets. Priorities signposted for improvement during 2020/21 are on-track. Improving inpatient mobility to help ease a safe discharge has already successfully measured that 85% of clinically appropriate patients are dressed and out of bed by 12.00. This is welcomed, especially because safe discharge arose as a significant issue during the 2019/20 period.

The QA highlights that the Trust has the momentum to achieve other improvement priorities also, such as increasing service user involvement to at least five committees or groups by the end of 2021.

The Trust has targeted clinical effectiveness as a specific focus for 2020/21, and it would be reassuring to see further details of the “health and wellbeing package” for diabetes that the Trust is developing.

The Trust acknowledges the significant impact COVID-19 has had on the care provided to patients through audit. In 2019/20 only 36% of audits had been documented and completed and 39% of data has been submitted. The Trust acknowledges that this is primarily due to a vacancy and the complex nature of the auditing process. It is good to see that whilst the Trust still performed well nationally they are committed to improving their auditing process in the future.

The Trust is active and engaged within the community of Nottingham & Nottinghamshire and nationally. It has participated in 100% of available audits and enquiries when eligible, and these are listed in the QA.

It is reassuring that the Trust aims to learn from the HWNN report on dementia diagnosis and support post diagnosis and will consider how to implement the recommendations with a view to improving outcomes for newly diagnosed patients.

Overall HWNN is reassured that the Trust is heading in the desired direction and acting upon advice, guidance and recommendations made to them by others. It has also identified areas where improvement is needed and is committed to delivery on these in the coming period.

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 2019/20 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 2019 to March 2020
    2. Papers relating to quality reported to board over the period April 2019 to March 2020
    3. Feedback from commissioners dated 28 September 2020
    4. Feedback from governors - awaited
    5. Feedback from local Healthwatch organisation dated 28 October 2020
    6. Feedback from Health Scrutiny Committee dated 29 October 2020.
    7. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009, dated 2019/2020
    8. The 2018 national patient data survey dated July 2019. The 2019 survey is expected to be published in July 2020.
    9. The 2019 national staff survey dated February 2020
    10. The Head of Internal Audit's annual opinion of the trust's control environment - TBC
    11. CQC Inspection report dated May 2020
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- The Quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

……..Date ……Chairman

……..Date ……

Glossary of Terms Used

Term	Description
A&E	Accident & emergency
AKI	Acute kidney injury
CCG	Clinical Commissioning Group
C Diff	Clostridium difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRT	Cardiac resynchronisation therapy
COPD	Chronic obstructive pulmonary disease
DH	Department of Health
ECHO	Echocardiogram
ED	Emergency department
EDASS	Emergency department avoidance support service
EMPSC	East Midlands Academic Health Science Network
EPACCS	Electronic palliative care co-ordination system
EPMA	Electronic prescribing and administration
FFT	Friends and Family Test
GP	General practitioner
HSCIC	Health & Social Care Information Centre
HSMR	Hospital standardised mortality ratio
IDAT	Integrated discharge advisory team
IG	Information governance
LCRN	Local clinical research network
LOS	Length of stay
LTC	Long term condition
MRSA	Methicillin resistant staphylococcus aureus
MSO	Medicines safety officer

NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute for Health Research
NRIG	Nottinghamshire records information group
NRLS	National Reporting and Learning System
OBD	Occupied bed days
PDD	Predicted date of discharge
PEAT	Patient environment action team
PLACE	Patient led assessment care environment
PROMS	Patient reported outcome measures
PSIG	Patient safety improvement group
QIP	Quality improvement plan
RCA	Root cause analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Children's Health
SFHFT	Sherwood Forest Hospitals Foundation Trust
SHMI	Summary hospital mortality index
SSI	Surgical site infection
TTO	To take out
VTE	Venous thromboembolism
WHO	World Health Organisation
WTE	Whole time equivalent