Quality Account

Yeovil District Hospital

2021/22

Yeovil Hospital Healthcare

Our year 2021/22

47,798
patients admitted

156,035
radiology tests

60,009
ED attendances

2,760
children admitted

1,311
babies born

1,978
patients treated for cancer

referral to treatment within 18 weeks
(Target 92%)
up to March 2022

464
stroke patients treated

ED patients seen within 4 hours
(Target 95%)

355
fractured hips mended

647
patients assessed by the frailty team

Diagnostic six week performance
(Target 99%)

4,053
admissions avoided through AEC

Cancer
2 Week Wait
(Target 93%)

Cancer
31 Day First
(Target 96%)

Cancer 62 Day Standard
(Target 85%)

29
new doctors

40
new nurses inc. unregistered & students

1,632 treated for COVID-19

1,540 recovered from COVID-19

Contents

Part 1: Statement on quality from the Chief Executive of Yeovil District Hospital

1.1 Our commitment to quality, Statement from the Chief Executive

Welcome to the annual quality account and report for Yeovil Hospital NHS Foundation Trust, for the financial year 2021-2022.

This quality account sets out how we performed against the key quality improvements that we set ourselves over the last year. It also provides an opportunity for us to reflect on our achievements and challenges during what has been another extraordinary year for YDH, the NHS and the country as a whole.

The impacts of the pandemic have continued to be felt across the Somerset health and care system and have made it more complex for us to deliver care in the ways that we have in previous years.

At the heart of our response to both the direct and indirect impacts of the pandemic are colleagues working across all of our services and locations throughout the county. Throughout the last year, they have demonstrated incredible resilience, responding to frequent changes to guidance and policy, and adapting processes and working arrangements in order to maintain access to care and treatment.

My appointment, across both YDH and Somerset FT, and the subsequent appointment of a single executive team for the trusts, have been important steps towards bringing our organisations together, which we are aiming to complete in April 2023. You can read more about that and about our overall performance within the Trust's annual report.

Teams from both organisations are already working together to develop and deliver on opportunities to improve the services they provide and to contribute to the completion of the business case later this year.

During 2020/21 we continued to work together with colleagues across the health and care system in Somerset to build our care and support strategy based on our knowledge of our services and the needs of the population. Together we defined our clinical objectives as to:

- Improve the health and wellbeing of the population
- Provide the best care and support to people
- Strengthen care and support in local communities
- Reduce inequalities
- Respond well to complex needs

Our quality priorities for 2021/22 build towards achieving these objectives.

As we move towards further integration with our colleagues at SFT, as provider of acute, community, mental health and a significant proportion of primary care services in Somerset, we will be in a position to have a positive impact upon the health of the population and contribute to the development of more sustainable health and care services in the county. We look forward to working closely with colleagues in the new Integrated Care Board to deliver this ambition.

PETER LEWIS
Chief Executive

1.2 Our vision, values and strategy

Yeovil District Hospital NHS Foundation Trust's (the Trust) vision and four strategic objectives for 2021-22 are shown below.

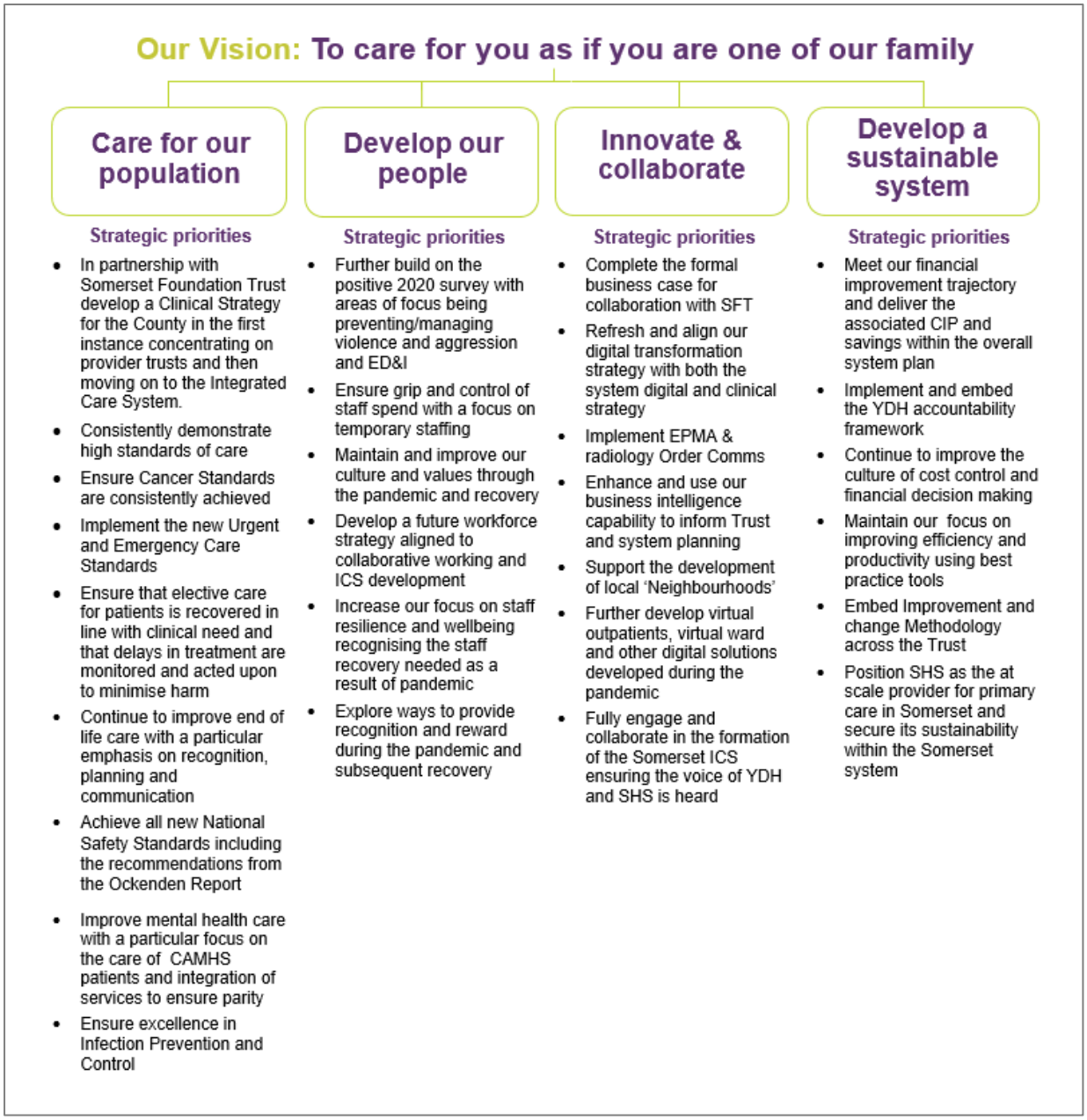
Our Vision and strategic objectives

The four strategic objectives are supported by a clear set of organisational priorities for the year, these are shown over the page.

The Trust vision and strategy helps to guide the way the organisation develops. Both the vision and strategy have been developed in collaboration with staff from across the organisation. As well as guiding decision-making, our strategy is also intended to provide staff with opportunities to identify and implement improvements in their own areas of work.

To underpin this strategy, there is a clear set of values that are based on our principles of iCARE. These principles were initially developed over fifteen years ago by nursing staff and underpin all activities within the hospital; whether it is providing life-saving treatment, how staff relate to one another or our ambition of providing a warm and caring welcome to our hospital. All staff are introduced to iCARE at the Trust Induction Day, where the expectations and standards outlined by iCARE are shared. In addition, the iCARE principles are included in staff appraisals, in job descriptions and are reiterated in policies, procedures and training programmes. The main focus, however, is to ensure that these values are evidenced in our daily work and in our care of patients, their visitors and our staff.

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



Our objectives and strategic priorities

As part of the Trust's plans to integrate with Somerset NHS Foundation Trust (SFT), it is recognised that there is a need to create a vision and strategy for the new organisation. It is intended that there will be one clear organisation strategy, starting with vision, values and strategic objectives. These will be delivered through a number of co-ordinated supporting strategies and clinical transformation plans. The organisation strategy will form part of the Integrated Care System strategy.

For 2022-23, eight strategic objectives have been agreed and are outlined below:

1. Improve the health and wellbeing of the population
2. Provide the best care and support to people
3. Strengthen care and support in local communities
4. Reduce inequalities
5. Respond well to complex needs
6. Deliver more people, working differently, in a compassionate and inclusive culture

7. Live within our means and use our resources wisely
8. Develop a high performing organisation delivering the vision of the trust.

All of the organisational strategic aims, supporting strategies and clinical transformation plans will contain measurable benefits for patients, carers and colleagues. A key measure will be how best we use time as a currency, to deliver on our vision of “More time to live well”, ‘more time in good health’ for patients, carers and colleagues, as well as ‘making every minute count’ for all in health care.

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

2.1 Quality Improvement Priorities

Quality and patient safety priorities for 2021/22 were to continue to focus on preparing and managing the infection prevention and control response to the COVID-19 pandemic and the restoration of services including the recovery of all elective activity.

Summary of Performance

Managing the infection prevention control response to COVID-19 pandemic

The Infection Prevention, Control (IPC) Team have continued to maintain COVID-19 requirements and review ongoing governance requirements throughout the operational year (2021-22). This has included a number of activities:

> Involvement in organisational COVID-19 incident management response including working collaboratively with the Patient Flow Team.

> Management of nosocomial (hospital acquired) COVID-19 infection has continued throughout the year, this will have included the completion of post infection reviews, reporting on the national portal and sharing learning across the regional and local networks.

> All non-COVID-19 related infection prevention and control measures have remained in place and the Trust's performance against this has been shared internally to the Governance Quality Assurance Committee and externally to the Somerset Infection Prevention Control Committee. In addition to the IPC dashboard (page 27) the following table provides a summary of additional measures monitored.

Process Measures – YTD 2021/22

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Hand Hygiene Compliance (Target 90%)	95%	96%	95%	97%	95%	96%	98%	98%	97%	98%	99%	98%	
Cleaning Scores Very High Risk	99.7	99.14	95**	96.5	99	96*	98	99	99	99	98	100	
High Risk	99.4	99.42		98.8	99	99	99	99	99	99	98	99	
IP&C Training Compliance (YDH, SSL)	86%*	86%*	87%*	85%*	85%*	84%*	81.77*	80.4*	79.51*	79%	84%	84%	

*IPC team covering all mandatory training sessions, on the ward face to face training on daily basis not fully recorded. Comms team supporting new guidance (PPE) updates to staff. Clinical staff required to complete mandatory training and attend sessions.

> The Trust has participated in the Clostridium difficile (C-Diff) collaborative across the region.

> Responding to changes in guidance for COVID-19 management as required to ensure organization remains up to date on current local prevalence and requirements of national guidance and current research.

> Continue to review Personal Protection Equipment (PPE) guidance and support staff enquiries across all specialties. Implementation of PPE visual guide.

- The IPC Board Assurance Framework has been updated and reported on a quarterly basis to the Trust's Board of Directors.
- There has been a continual programme of training provided, although this has been amended to provide targeted training within clinical areas.

Restoration of services

National and regional referral to treatment (RTT) performance is being tracked and reported regionally and nationally as part of the national elective recovery programme and reviewed at the monthly Somerset elective recovery meeting with NHS England / Improvement.

The Trust continues to follow national policy with patients cancelled on the day rebooked within 28 days. Those waiting over 104 weeks are contacted every three months.

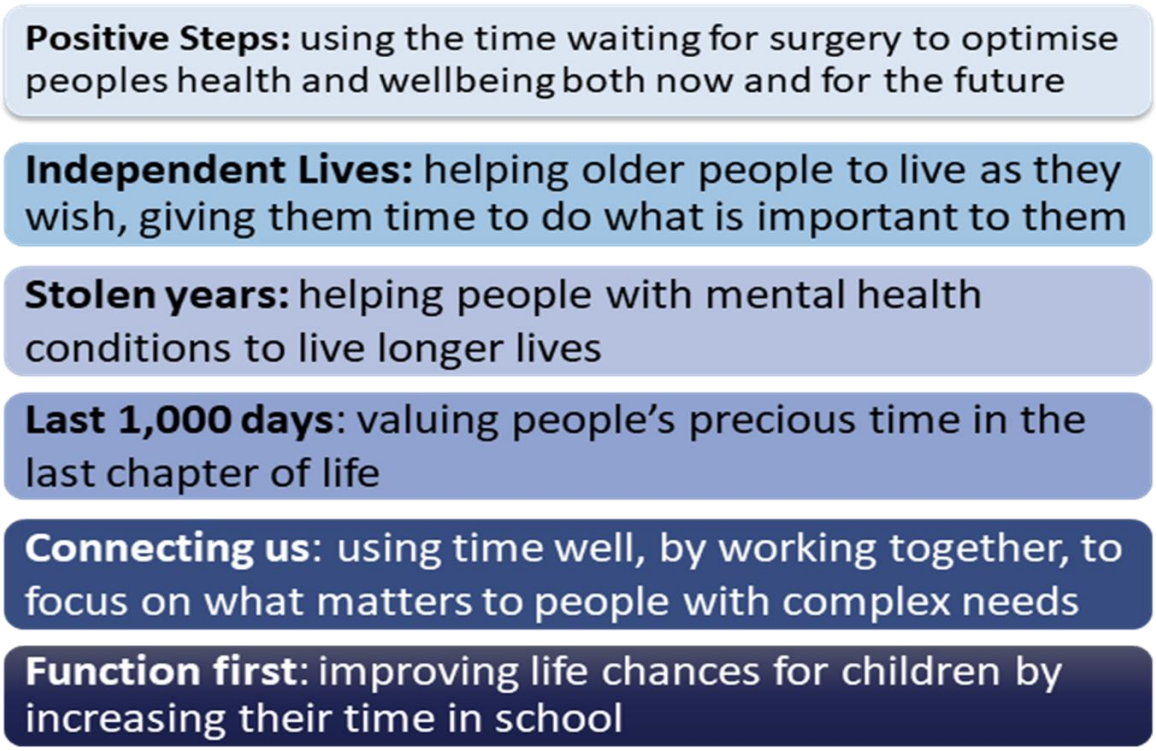
Please also refer to the annual report and accounts document for 2021/22.

Quality improvement priorities for 2022/23

The new Joint Executive Team and other key stakeholders have been working to agree the quality improvement priorities for 2022/23; these will be finalised as part of the merger transformation programme and in collaboration with the Integrated Care System and Board.

With the move toward establishing an integrated care system (ICS) and the proposed merger with Somerset NHS Foundation Trust (SFT), it was important to refresh the countywide clinical strategy with further input from partners. The joint Clinical Care and Support strategy has been agreed across the system with five aims. Whilst the existing flagships were agreed to continue as the Trusts' priorities for 2022/23, it was proposed in light of the new population health aim, that a sixth flagship should be added. The priority of work identified was 'peri-operative care' and the programme of work will be developed over this year.

The priorities for 2022/23 have therefore been agreed as:



2.2 Statements of assurance from the board

Service Income

In response to the COVID-19 Pandemic, NHS England and Improvement (NHSEI) extended the suspension of all contractual arrangement through to 31 March 2022.

As part of this response, Somerset Clinical Commissioning Group (SCCG) and the Trust were instructed to agree a block contract which guaranteed a minimum level of income reflecting the cost base at that time. Additional costs could be claimed in year, where incurred costs were higher than those reflected in the guaranteed minimum income.

Information on participation in clinical audits and national confidential enquiries

During 2021/22 44 national clinical audits and 3 national confidential enquiries covered relevant health services that the Trust provides. During that period the Trust participated in 95% of the national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate during 2021/22 are shown in the table below.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during the 2021/22, are also listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the teams of that audit or enquiry.

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

The reports of 49 national clinical audits were reviewed by the Trust in 2021/22. The actions that the Trust intends to take to improve the quality of health provided are detailed in Part 3.

The reports of 32 local clinical audits were reviewed by the Trust in 2021/22. The actions that the Trust intends to take to improve the quality of health provided are detailed in Part 3.

National audit YDH eligible to participate in / Audit Provider	YDH participation 21/22	Percentage of required number of cases submitted
Case Mix Programme - Intensive Care National Audit & Research Centre		
Case Mix Programme	Yes	100%
COVID 19 Audit	Yes	100%
Child Health Clinical Outcome Review Programme 1 National Confidential Enquiry into Patient Outcome and Death (Note there were no running studies during the year)	No	--
Chronic Kidney Disease registry - The Renal Association/The UK Renal Registry	Not applicable	--
Cleft Registry and Audit Network Database - Royal College of Surgeons - Clinical Effectiveness Unit	Not applicable	--
Elective Surgery (National PROMs Programme) - NHS Digital	Yes	Continuous audit of all eligible patients
Emergency Medicine QIPs - Royal College of Emergency Medicine		
a. Pain in children	Yes	Continuous audit of all eligible patients
b. Infection prevention and control	Yes	Continuous audit of all eligible patients
Falls and Fragility Fracture Audit Programme - Royal College of Physicians		
a. Fracture Liaison Service Database	Yes	Continuous audit of all eligible patients

b. National Audit of Inpatient Falls	Yes	100% (8 pts)
c. National Hip Fracture Database	Yes	Continuous audit of all eligible patients
Inflammatory Bowel Disease Audit - IBD Registry	Yes	Continuous audit of all eligible patients
Learning Disabilities Mortality Review Programme - NHS England	Yes	Continuous audit of all eligible patients
Maternal and Newborn Infant Clinical Outcome Review Programme - University of Oxford / MBRRACE-UK collaborative	Yes	Continuous audit of all eligible patients
Medical and Surgical Clinical Outcome Review Programme - National Confidential Enquiry into Patient Outcome and Death		
a. Alcohol Related Liver Disease (Organisational Questionnaire only)	Yes	N/A
b. Epilepsy Study	Yes	100% (5 pts)
c. Transition from Child to Adult Services	Yes	100% (6 pts)
Mental Health Clinical Outcome Review Programme - University of Manchester / NCISH	Not applicable	--
National Adult Diabetes Audit - NHS Digital		
a. National Diabetes Core Audit	Yes	99.3% (1079 pts)
b. National Pregnancy in Diabetes Audit	Yes	100% (6 pts)
National audit YDH eligible to participate in / Audit Provider	**YDH participation 21/22**	**Percentage of required number of cases submitted**
c. National Diabetes Foot care Audit (Note contribution to this audit did not start / be maintained during the finical year, however is being collected now)	No	--
d. National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms (Note the audit did not run this year)	Not applicable	--
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme - Royal College of Physicians		
a. Paediatric Asthma Secondary Care	Yes	TBC
b. Adult Asthma Secondary Care	Yes	TBC
c. Chronic Obstructive Pulmonary Disease Secondary Care	Yes	TBC
d. Pulmonary Rehabilitation-Organisational and Clinical Audit	Not applicable	--
National Audit of Breast Cancer in Older Patients 1 - Royal College of Surgeons	Yes	TBC
National Audit of Cardiac Rehabilitation - University of York	Yes	TBC
National Audit of Cardiovascular Disease Prevention - NHS Benchmarking Network	Not applicable	--
National Audit of Care at the End of Life - NHS Benchmarking Network	Yes	Continuous audit of all eligible patients
National Audit of Dementia - Royal College of Psychiatrists (Note the audit did not run during this time period)	No	Continuous audit of all eligible patients
National Audit of Pulmonary Hypertension - NHS Digital	No applicable	--
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) 1 - Royal College of Paediatrics and Child Health (Note due to clinical capacity we did not commence participation until March 22)	No	Continuous audit of all eligible patients

National Cardiac Arrest Audit - Intensive Care National Audit and Research Centre / Resuscitation Council UK	Yes	Continuous audit of all eligible patients
National Cardiac Audit Programme - Barts Health NHS Trust		
a. National Audit of Cardiac Rhythm Management	Yes	Continuous audit of all eligible patients
b. Myocardial Ischaemia National Audit Project	Yes	Continuous audit of all eligible patients
c. National Adult Cardiac Surgery Audit	Not applicable	--
d. National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Not applicable	--
e. National Heart Failure Audit	Yes	Continuous audit of all eligible patients
f. National Congenital Heart Disease	Not applicable	--
National Child Mortality Database - University of Bristol	Yes	Continuous audit of all eligible patients
National Clinical Audit of Psychosis - Royal College of Psychiatrists	Not applicable	--
National Comparative Audit of Blood Transfusion - NHS Blood and Transplant		
a. The 2021 PBM Survey	Yes	100% (of audit sample)
National audit YDH eligible to participate in / Audit Provider	**YDH participation 21/22**	**Percentage of required number of cases submitted**
b. The 2021 Audit of Patient Blood Management against NICE Guideline NG24	Yes	
National Early Inflammatory Arthritis Audit - British Society of Rheumatology	Yes	TBC
National Emergency Laparotomy Audit - Royal College of Anaesthetists	Yes	Continuous audit of all eligible patients
National Gastro-intestinal Cancer Programme - NHS Digital		
a. National Oesophago-gastric Cancer	Yes	TBC
b. National Bowel Cancer Audit	Yes	TBC
National Joint Registry - Healthcare Quality Improvement Partnership	Yes	Continuous audit of all eligible patients
National Lung Cancer Audit - Royal College of Physicians	Yes	--
National Maternity and Perinatal Audit - Royal College of Obstetrics and Gynaecology	Yes	Continuous audit of all eligible patients
National Neonatal Audit Programme - Royal College of Paediatrics and Child Health	Yes	Continuous audit of all eligible patients
National Paediatric Diabetes Audit - Royal College of Paediatrics and Child Health	Yes	Continuous audit of all eligible patients
National Perinatal Mortality Review Tool - University of Oxford / MBRRACE-UK collaborative	Yes	Continuous audit of all eligible patients
National Prostate Cancer Audit - Royal College of Surgeons	Yes	--
National Vascular Registry - Royal College of Surgeons	Not applicable	--
Neurosurgical National Audit Programme - The Society of British Neurological Surgeons	Not applicable	--
Out-of-Hospital Cardiac Arrest Outcomes Registry - University of Warwick (Note this is now being collected within the community)	Not applicable	--

Paediatric Intensive Care Audit - University of Leeds / University of Leicester	TBC	TBC
Prescribing Observatory for Mental Health - Royal College of Psychiatrists		
a. Prescribing for depression in adult mental health services	Not applicable	--
b. Prescribing for substance misuse: alcohol detoxification	Not applicable	--
Respiratory Audits - British Thoracic Society		
a. National Outpatient Management of Pulmonary Embolism	Yes	TBC
b. Smoking Cessation audit Maternity and mental health services	Yes	100% (100 patients)
Sentinel Stroke National Audit Programme - King's College London	Yes	Continuous audit of all eligible patients
Serious Hazards of Transfusion - Serious Hazards of Transfusion	Yes	Continuous audit of all eligible patients
Society for Acute Medicine Benchmarking Audit - Society for Acute Medicine	Yes	100% (37 pts)

National audit YDH eligible to participate in / Audit Provider	**YDH participation 21/22**	**Percentage of required number of cases submitted**
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment - BURST Collaborative / British Urology Researchers in Surgical Training	TBC	--
Trauma Audit & Research Network - The Trauma Audit & Research Network	Yes	Continuous audit of all eligible patients
UK Cystic Fibrosis Registry - Cystic Fibrosis Trust	Yes	TBC
Urology Audits - British Association of Urological Surgeons		
A. Cytoreductive Radical Nephrectomy Audit	Not applicable	--
B. Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit) (Note these audits closed December 2020 and did not run)	Not applicable	--

Information on Participation in Clinical Research

The number of patients receiving relevant services provided or subcontracted by the Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 1,397.

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

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

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

CQUIN payments with an assumed achievement of 100%, were included within the guaranteed minimum level income (see service income, page 10).

No CQUIN goals were agreed for 2021/22 as a result of the COVID 19 Pandemic.

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

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

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

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

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

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

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

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

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

The matrix of core service results is shown below.

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

CQC inspection core service results

Information on the quality of data

Secondary Uses Service Data

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

The Trust submitted records during 2021/22 to SUS for inclusion in the Hospital Episode Statistics which are included in the latest published data, see table below.

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
- 99.5% for accident and emergency care.

The percentage of records in the published data which included a valid General Medical Practice code was:

- 100% for admitted patient care;
- 99.7% for outpatient care; and
- 100% for accident and emergency care.

Secondary Uses Service Data

Information Governance Assessment Report / Data Security & Protection Toolkit

All NHS trusts are required annually to carry out an information governance self-assessment using the NHS Data Security & Protection Toolkit (DSPT) based around the following 10 standards of good practice:

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

Due to COVID-19 the submission of 2020/21 toolkit was postponed from March 2021 to June 2021, the Trust achieved 'standards met'. The submission of the toolkit for 2021/22 will be 30 June 2022.

The Trust recognises data security and information governance as a high priority and continues to ensure that high standards are met throughout the organisation with data security and information governance breaches reported and monitored through the Information Governance & Information Technology Oversight Group (IGITOG), which, in turn, reports to the Audit Committee.

While the Information Governance Group meetings were suspended during the pandemic, they were restarted under the title IGITOG in May 2021.

In order to provide clinical oversight to digital transformation the Clinical Design Authority was put in place and has met monthly from November 2020 onwards. A number of risks were resolved through system improvements within TrakCare (the Trust's electronic patient record system) and other systems, this resulted in risks being successfully removed from the Trust risk register.

For the period of September 2021 to date two incidents were submitted via the DSPT portal. One incident related to the electronic patient record system where some personal patient information changes were not updating correctly. This was reported to and investigated by the Information Commissioners Office and NHS England. The second incident related to a document containing personal and sensitive information

that was found outside of the Trust, this was reported and investigated by the Information Commissioners Office.

There was adequate assurance for both incidents that no further action was required

The outcome of both incidents was no further action due to immediate corrective action being taken.

Moving forward, with the Merger with SFT, the Information Governance processes and guidance remain a high priority with teams from both Trusts coming together to provide a robust overarching IG Framework.

Payment by Results Clinical Coding Audit

The Trust was not subject to a Payment by Results clinical coding audit during by NHS Improvement in 2021/22.

Actions to improve data quality

A series of Clinical Coding audits were undertaken by an NHS Digital Approved Clinical Coding Auditor on behalf of the Trust. This examined the clinical coding accuracy of 200 Finished Consultant Episodes (FCEs) for activity between 1 April 2021 and 31 March 2022, see below.

Spells tested	%of HRG changes	Pre-audit value	Post-audit value	Net change	Net change %
200	4.5%	£322,602	£327,719	£5,117	1.6%

Clinical coding audits summary of results

The areas reviewed were a random sample covering, but not limited to, the following core specialities: general medicine, general surgery, trauma and orthopaedics, paediatrics, obstetrics, gynaecology and day theatre activity.

The coding accuracy (see below) achieved the highest Standards Exceeded Data Security and Protection Toolkit attainment level. Compared to the 2020/21 audit this has highlighted the Trust has maintained the highest DSPT Advisory accuracy level. Of note, the auditor identified that all errors were coder errors indicating that source material, both full paper case notes and electronic patient records, are of good quality and fit for purpose.

Acute Trust	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Standards exceeded	>=95%	>=90%	>=95%	>=90%
Standards met	>=90%	>=80%	>=90%	>=80%
Yeovil District Hospital	**97%**	**96%**	**95%**	**93%**

Summary of coding accuracy

The majority of errors identified from the audit stemmed from the ‘Secondary Diagnosis Omitted’ and Secondary Diagnosis Not Required’ error keys, these accounted for 55 and 19 errors respectively. Despite the Trust achieving the highest advisory attainment level these error keys can be indicative of a difficulty in extracting the salient information without straying over into “over coding” incidental or irrelevant conditions.

The error rate resulted in a potential net financial undercharge of £5,117 (1.6%) to the commissioners for the sample audited. This was the result of 9 Healthcare Resource Group (HRG) changes (4.5%) with the largest single HRG change being an increase from £6,233 to £8,582 in a general medical admission.

The gross change totalled £9,879 (3.1%). However, this financial analysis is not a true representation of the financial impact on the trust as the majority of activity is billed as per local agreements rather than National Tariff and the results should not be extrapolated further than the actual sample audited.

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

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

- Particular focus will be given to secondary diagnosis assignment training.
- In line with the YDH Data Quality policy we have identified the roles and responsibilities across the hospital to achieve good data quality. To assist in this the YDH Data Quality Steering Group is responsible for monitoring and compliance of coding standards with a particular focus on reporting. It also monitors the Trust Risk Register and reports on the standards of Data Quality, and monitors the implementation of any recommendations from both internal and external authorities in the Trust to the Information Governance Steering Group, now known as the Information Governance and Information Technology Oversight Group (IGITOG).
- Utilise healthcare intelligence from Dr Foster and Summary Hospital Level Mortality Indicator (SHMI) in addition to key external performance frameworks such as the model hospital and more specifically the Data Quality Maturity Index (DQMI) to help both monitor and improve data quality at source.
- The Trust's DQMI score for 2021/22 was 89.2%, the National Average score for the same time period was 76.3%

Learning from Deaths

1	During 21/22 863* YDH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: > 188 in the first quarter > 201 in the second quarter > 240 in the third quarter > 234 in the fourth quarter *This includes those who died in the Emergency Department
2	By 31 March 2022, 558 case record reviews and 50 more detailed investigations have been carried out in relation to 558 of the deaths included above. There was one case where death was subjected to both a full case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: > 132 in the first quarter > 127 in the second quarter > 116 in the third quarter > 184 in the fourth quarter These figures include those cases reviewed initially by the Medical Examiner who performs the first stages of a full Mortality Review and refers cases for further investigation where any potential issues have been identified.
3	Two cases representing 0.23% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: > 1 representing 0.53% for the first quarter > 0 representing 0% for the second quarter > 1 representing 0.42% for the third quarter > 0 representing 0% for the fourth quarter These numbers include all cases rated 1-3 according to the avoidability scale contained within the Structured Judgement Review (SJR) tool developed by the Royal College of Physicians. This tool has been adopted throughout the Trust with formal mortality reviews recorded on a central database to enable learning to take place.
4	Summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above. > Evidence of good practice is being identified and recorded with feedback provided to the appropriate individual or team. > Timely and appropriate Do Not Attempt Resuscitation (DNAR) discussions and decisions were evidenced on admission, but Community DNAR and Treatment Escalation Plans do not always inform the decision to admit or in-hospital management plans.

- Clear Treatment Escalation Plans are essential when patients are transferred for ongoing care including clear directions about readmission to the acute unit and under what circumstances this would be appropriate.
- There has been a need to continue to provide effective formal review of patients who have died as a result of a COVID-19 infection, particularly if this was a hospital-acquired infection.
- Prophylactic anticoagulant therapy can be difficult to balance in patients with significant co-morbidities. Continued review of anticoagulation guidance is required to ensure appropriate professional decisions are reflected within the guidance, particularly in respect of patients with a high BMI.
- Where specific assessments or investigations are not performed as they are deemed unnecessary the decision and reason should be documented to ensure this is not seen as an omission.
- Further education is required about how to involve patients and their families in the DNAR decisions, whilst retaining the clinician's responsibility for the decision, based on the clinical possibilities and realistic outcomes.
- Delays in diagnosis and a reduced level of senior support for junior doctors were reported where significantly increased activity has been seen within the acute wards. Although it is difficult to triangulate this data, staffing issues have been cited as leading to a lack of senior decision making at these times.

- The Medical Examiner role is essential to the identification of cases where a full Mortality Review should be undertaken and if the Medical Examiner does not have capacity to review all inpatient deaths this leads to a lower number Mortality Reviews being undertaken.
- The number of patients readmitted who die within 48 hours appears to have increased.
- Patients with chronic haematological diseases admitted with other acute conditions must be discussed with the specialist team when decisions about surgical management and future needs are being made.
- When patients are under multiple Multidisciplinary teams and pathways there is a potential for delays in treatment where priorities conflict.
- All pre-hospital information should be accessed to inform clinical need when patients attend the Emergency Department.
- Running two medical record systems (electronic and paper) alongside each other allows a greater margin for error and risk of staff not accessing or using the information available.
- Clinical assessments and investigation/scan findings should be used together to inform and determine diagnosis. Reliance on scan reports and findings can be misleading.
- The fact that a patient is a cancer patient, albeit a curative one, can negatively impact on their care and management including the timeliness of potential ICU escalation.
- Early and active intervention from the Mental Health Team needs to be requested and actioned to prevent patient deterioration before formal assessments can be completed. Formal Capacity assessments need to be completed in a timely manner and documented effectively.

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

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

- Analysis of case reviews at local Governance Meetings have continued enabling the findings from formal reviews to inform decision making and learning.
- Post-Infection Reviews incorporating Mortality elements have been developed to capture information about any patient with a hospital acquired COVID-19 infection.
- Review of information relating to Prophylactic Anticoagulant dosages in bariatric patients through the VTE working Group and pharmacy teams. Active discussions within Medical Governance Meetings about the risks and benefits of increased anticoagulant doses.
- Education and sharing of learning in respect of DNAR and escalation discussions and the role of clinical decision making alongside family/patient involvement.
- Measures are already in place to facilitate further education regarding the need for Treatment escalation plans that reflect changing circumstances as patients move from one setting to another – reducing the likelihood of inappropriate readmission or misinterpretation of the intended escalation limits.

	> Ongoing work to ensure that escalation plans are updated and clearly documented to facilitate appropriate decision making when patients deteriorate and may be unable to convey their wishes. > Joint review of patients where care has been provided by multiple organisations to ensure collaborative learning. > Electronic records from external sources, in particular the Ambulance Service are now downloaded and saved within the hospital records system (Trakcare) to facilitate ease of access to clinical staff. > Continued progress to develop Trakcare and ensure effective use of electronic patient records is integral to the induction process, especially for rotating staff. > Continued progress to develop Trakcare and ensure effective migration to electronic patient records. > Work within Oncology to ensure that patients admitted to general wards during ongoing treatments such as chemotherapy have a clear documented plan, especially where long-term remission is anticipated. This enables the acute physicians to make appropriate decisions about continued management and escalation.
6	An assessment of the impact of the actions described above which were taken by the provider during the reporting period. > Individual learning has been evidenced within the junior doctors when reviewing the quality and content of medical records. > The Trust continues to use a Post infection Review tool incorporating mortality details and an avoidability score for those patients who have suffered a hospital acquired COVID-19 infection and subsequently died. This process includes compliance with the national requirement for Duty of Candour. > Review of information relating to Prophylactic Anticoagulant dosages and additional guidance has improved knowledge and compliance. > Enhanced practice in respect of DNAR and escalation discussions and the balance between clinical decision making and family/patient involvement. > Improvements in the quality of Treatment escalation plans as patients move from one setting to another – reducing the likelihood of inappropriate readmission or misinterpretation of the intended escalation limits. > Downloading electronic records from external sources, into the hospital records system (Trakcare) has facilitated access for clinical staff allowing pre-hospital details to be known. > Oncology Service providing more detailed care plans to facilitate acute physicians to make appropriate decisions about continued management and escalation when patients are admitted with acute conditions.
7	No case record reviews or investigations were completed after 31 March 2021 which related to deaths which took place before the start of the reporting period.
8	None, representing 0% of the patient deaths occurring before the reporting period, but reviewed after the previous report are judged to be more likely than not to have been due to problems in the care provided to the patient.
9	None representing 0% of the patient deaths during 20/21 and reviewed following that reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Performance against national core set of quality indicators

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

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

Organisational health indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
Overall patient experience of hospital care	NHS Digital	Jan21 to May21	77.7%	77.0%	87.0%	71.7%	77.1%	78.1%

Responsiveness to patients' needs	NHS Digital	Jan21 to May21	74.6%	65.9%	85.4%	67.3%	74.5%	69.4%
Staff sickness	NHS Digital	Apr 21 to Dec 21	4.2%	3.4%	0.5%	9.6%	5.1%	3.8%
Staff turnover	Trust	Apr 21 to Mar 22	16.4%	15.6%	8.6%	21.8%	15.0%	15%
NHS staff survey response rate	NHS Digital	Apr 21 to Mar 22	57%	65%	79.9%	29.5%	46.4%	-

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

Effective Indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
Palliative care coding	NHS Digital	Dec 20 to Nov 21	64.0%	55.0%	64.0%	11.0%	39.5%	-
SHMI	NHS Digital	Dec 20 to Nov 21	0.95	0.88	0.7161	1.1949	1	1
PROMS: Hip replacement EQ VAS	NHS Digital	Apr 20 to Mar 21	No data	66.7%	-	-	69.7%	-
PROMS: Hip replacement EQ 5D index	NHS Digital	Apr 20 to Mar 21	No data	100%	-	-	89.9%	-
PROMS: Hip replacement Oxford Hip Score	NHS Digital	Apr 20 to Mar 21	No data	100%	-	-	97.3%	-
PROMS: Knee replacement EQ VAS	NHS Digital	Apr 20 to Mar 21	No data	85.7%	-	-	59.3%	-
PROMS: Knee replacement EQ 5D index	NHS Digital	Apr 20 to Mar 21	No data	71.4%	-	-	82.1%	-
PROMS: Knee replacement Oxford Knee Score	NHS Digital	Apr 20 to Mar 21	No data	100%	-	-	94.6%	-
Readmissions in 30 days: 0-15yrs	NHS Digital	Apr 20 to Mar 21	13.6	14.10%	5.10	19.5	11.3%	-
Readmissions in 30 days: 16+years	NHS Digital	Apr 20 to Mar 21	14.00	13.90%	1.1	31.5	12.6%	-

The Trust considers that this data is as described as this is the latest available on the NHS Digital (HSCIC) website. There was no data for the PROMS programme due to the reduction in elective surgeries during the COVID-19 pandemic.

Caring indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
MSA breaches	NHS Digital	Feb 21 to Feb 22	0	0	0.0	0.4	0.0	-
Complaints rate	Trust	Apr 21 to Mar 22	0.49	0.54	-	-	-	-
Staff: friends and family test	NHS Digital	2021	67.1%	79.1%	-	-	-	-
Maternity: friends and family test	Trust	Apr 21 to Feb 22	100.0%	98.4%	1.0	0.6	0.9	-
Inpatients and day cases: friends and family test	Trust	Feb 22	98.4%	98.1%	1.0	0.8	0.9	-
Emergency Department: friends and family test	Trust	Feb 22	98.3%	100.0%	1.0	0.5	0.8	-

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

expectations.

- In relation to Staff, friends and family test, we would like to acknowledge the work of the Health and Wellbeing team, and also key metrics in the staff survey which indicated:
  - "My organisation take positive action on health and wellbeing", best score - 74% our score - 74%, The average score was 56.4%
  - "How often, if at all, do you feel burnt out because of your work?" Best score - 28.1% our score - 29.8%. The average score was 35.2%
  - My immediate manager takes a positive interest in my health and wellbeing – best score - 75.4%, our score - 75.4%, the average score was 66.3%
- The Health and Wellbeing team have provided a significant number of interventions throughout the year, including:
  - Launch of wellbeing physical clubs – running club, netball club and walking club
  - Just Because nominations – recently shared with SFT
  - Somerset Emotional Wellbeing Colleague Support line launched with YDH
  - REACT90 training available to all supervisors, team leaders and managers
  - Wellbeing pulse survey continues with good responses
  - Menopause Meet ups launched

Safe indicators

Indicator	Source	Latest date range	21/22 value	20/21 value	Best performance (national)	Worst performance (national)	National average	National target
VTE risk assessment	NHS Digital	Apr 21 to Mar 22	95.8%	94.%	-	-	-	95.0%
Percentage of Patient Safety Alerts (PSA) completed within the required timeframe	NHS Digital	Apr 21 to Feb 22	92.3%	100%	-	-	-	-
Never events	NHS Digital	Apr 21 to Mar 22	2	0	0	10	-	-
Emergency C-section rates	Trust	Apr 21 to Mar 22	32.9%	20.0%	-	-	-	-
Rate of C.diff infection per 100,000 bed days	NHS Digital	Apr 21 to Feb 22	12	7	-	-	-	-
MRSA bacteraemias	NHS Digital	Apr 21 to Feb 22	1	0	-	-	-	-
Rate per 1000 bed days: patient safety incidents	Trust	Apr 21 to Mar 22	54.3	50.1	-	-	-	-
Percentage of patient safety incidents that resulted in severe harm or death	Trust	Apr 21 to Feb 22	0.120%	0.586%	-	-	-	-

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

- There was one national patient safety alert that was not completed within the deadline The Trust took the decision not to report compliance with this alert by the deadline due to the complexities of the requirements for different specialities, this was also recognised nationally.
- The two never events reported during the reporting period are outlined on page 25.
- The maternity team undertake a review of every non-elective caesarean section to assess the clinical appropriateness of the decision making; and also recognise that an emergency caesarean section is always done in the best interests of mother and baby. The appropriateness of this target is an area of both national and local discussion.
- The rate per 1000 bed days of C.Diff has increased nationally and in particular in Somerset. The Trust

is part of the regional C.Diff collaboration to understand the reasons for this increase and to agree an improvement plan.

> The rate per 1000 bed days of patient safety incidents has increased; this was predominately due to the reporting requirements for COVID-19 infection.

Risk assessment framework indicators

Indicator	Source	Latest date range	20/21 value	19/20 value	Best performance (national)	Worst performance (national)	National average	National target
C.diff meeting the C.diff objective (all)	NHS Digital	Apr 21 to Feb 22	12	7	-	-	-	-
Certification against compliance with requirements regarding access to health care for people with a learning disability	Trust Board Declaration	Apr 21 to Mar 22	Compliant	Compliant	-	-	-	
62 day wait for first treatment from urgent GP referral: all cancers	CWT return	Apr 21 to Feb 22	81.0%	84.7%	100.0%	33.3%	75.9%	85.0%
62 day wait for first treatment from consultant screening service referral: all cancers	CWT return	Apr 21 to Feb 22	71.4%	41.7%	100.0%	20.0%	64.5%	90.0%
31 day wait from diagnosis to first treatment: all cancers	CWT return	Apr 21 to Feb 22	95.1%	97.4%	100.0%	52.6%	93.7%	96.0%
31 day wait for second or subsequent treatment: surgery	CWT return	Apr 21 to Feb 22	92.4%	93.4%	100.0%	48.1%	84.3%	94.0%
31 day wait for second or subsequent treatment: anti-cancer drug	CWT return	Apr 21 to Feb 22	99.1%	99.1%	100.0%	85.7%	99.0%	98.0%
Two week wait from referral to date first seen: all cancers	CWT return	Apr 21 to Feb 22	84.8%	94.7%	100.0%	41.7%	80.7%	93.0%
Two week wait from referrals to date first seen: breast symptoms	CWT return	Apr 21 to Feb 22	91.4%	94.9%	99.7%	4.0%	54.8%	93.0%
18 week maximum wait from point of referral to treatment (incomplete pathways)	NHSI return	Apr 21 to Feb 22	65.6%	65.6%	100.0%	1.0%	65.7%	92.0%
Maximum 6 week wait for diagnostic procedures	Weekly SitRep	Apr 21 to Feb 22	80.7%	93.7%	100.0%	32.1%	74.6%	99.0%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	Weekly SitRep	Apr 21 to Feb 22	95.1%	95.1%	100.0%	57.0%	68.3%	95.0%

The Trust considers that this data is as described as this is the latest available. RTT performance has continued to be a challenge. This is primarily due to the increasing activity in primary care and emergency departments, resulting in more admissions to hospital. The organisation has worked collaboratively with it's system partners to address the issues in both bedded, and workforce, capacity which has impacted on the ability to discharge patients in a timely way.

Part 3: Other information

3.1 Patient Safety

Patient Safety Incidents

NHS England defines a patient safety incident (PSI) as any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. A 'harm' can include an injury (physical or psychological), disease, suffering, disability or death. Where a patient is concerned, harm can be considered unexpected if it is not related to the original cause of the patient's illness or underlying condition or treatment.

All incidents are reported through the Trust's incident reporting system, Ulysses. At the time of completing the incident report, the reporting staff member will identify whether or not it is deemed a patient safety incident, this is then validated by the Clinical Governance Team. The Clinical Governance Team monitor all incidents for trends and themes.

All PSIs are uploaded to the National Reporting and Learning System (NRLS) which is a central database where all of the information is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

The Trust aims to promote a culture that encourages high level reporting low level harm with regard to patient safety incident incidents.

During 2021/22 there was a total of 10,693 incidents reported, this is a 10.2% increase from the number reported in 2020/21 (9,706). Of these 6,237 (56.9%) were classified as patient safety incidents, this was a 13.3% increase on the previous year (5419). The table below shows the number of incidents over the year.

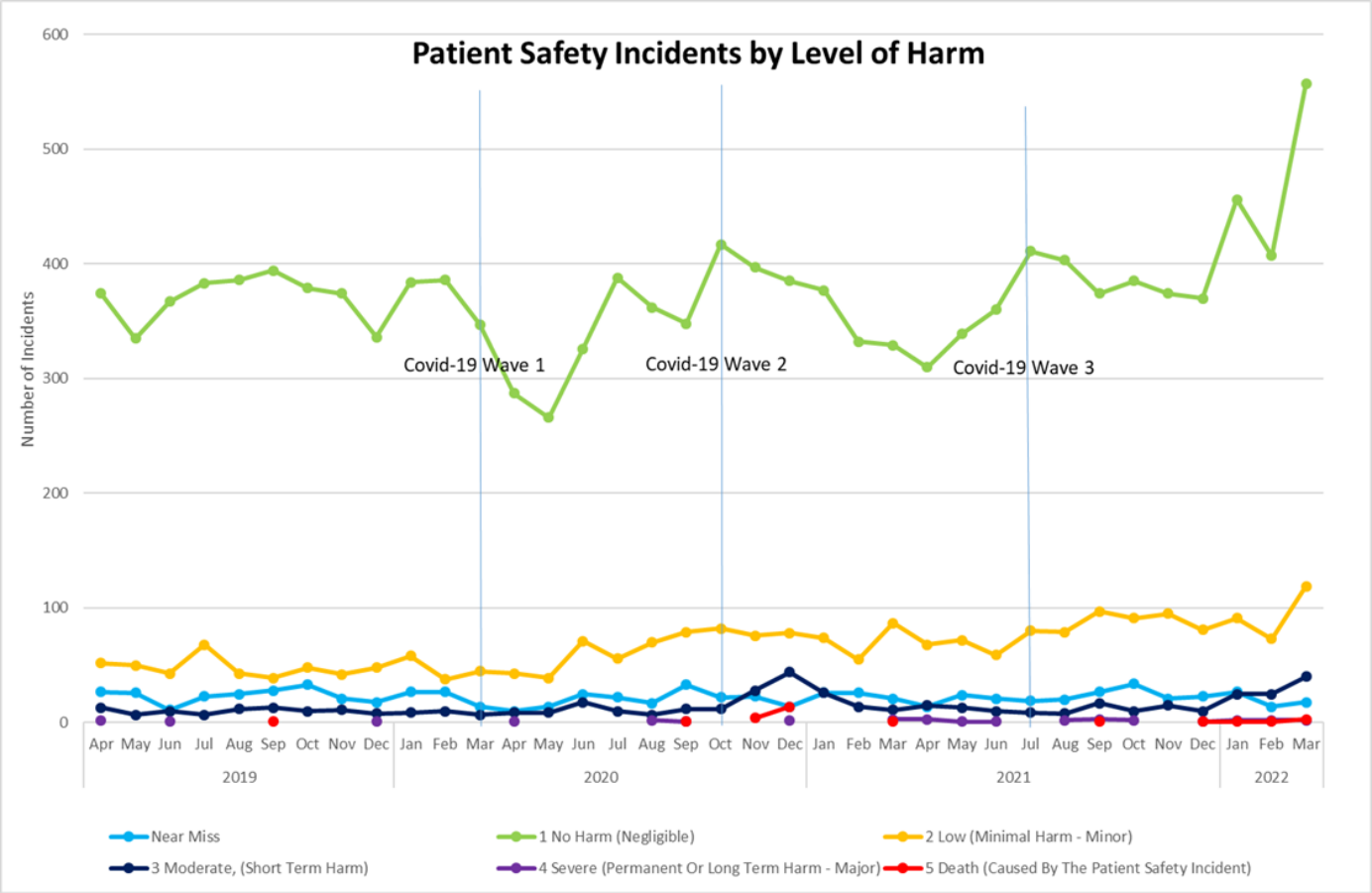
	20/21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 YTD
Total incidents	8892	746	832	797	897	879	845	917	868	889	1033	888	1107	10699
PSIs	5419	409	449	451	519	514	519	522	505	489	601	531	743	6245
PSIs (%)	61%	55%	54%	57%	58%	58%	61%	57%	58%	55%	58%	60%	67%	58%
PSI per 1000 BD	47.46	47.25	49.05	50.38	53.02	49.88	51.38	48.72	49.95	48.68	56.03	54.19	54.19	51.00

Incidents reported 2021/22

Incidents are categorised by their level of harm. These are defined as follows:

- Near miss (0)
- No harm (1)
- Low harm; patient(s) required extra observation or minor treatment (2)
- Moderate harm; patient(s) required further treatment, or procedure, short term harm (3)
- Severe harm; permanent or long term harm (4)
- Death caused by the patient safety incident (5)

It is the responsibility of the manager signing off incidents to confirm the level of harm, however there is a process of validation within Clinical Governance to ensure consistency with reporting. The chart over the page shows the patient safety incidents by level of harm.



Patient safety incidents by level of harm

Serious Incidents

A total of 45 investigations were commissioned in 2021/2022. Of these, seven required a comprehensive root cause analysis (level 2 investigation) as they met the definitions of a serious incident requiring investigation in accordance with national guidance.

Never Events

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

There were two Never Events during the year; these occurred in ophthalmology and theatres. The key learning from these events is outlined below:

> Strengthening the counting and checking process of instruments used in theatre.

> Enhancing the process for consenting patients for ophthalmology day procedures including the steps for confirming the accurate procedure site.

Duty of Candour

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

> Inform the relevant person, as soon as reasonably practicable after becoming aware that an incident has occurred, and provide support to them in relation to the incident;

> Provide an account of the incident which, to the best of our knowledge, is true of all the facts known about the incident;

> Advise the relevant person what further enquiries we believe are appropriate;

> Offer an apology;

> Follow up the apology by giving the same information in writing, and providing an update on the enquiries; and

> Keep a written record of all communication with the relevant person.

The incident reporting system has a section for recording compliance with the Duty of Candour and for including the detail of who has been spoken with (the patient, or where the patient lacks capacity, their next of kin). When an incident review or investigation is triggered for moderate harm incidents patients and / or their family are written to setting out an apology and the process of investigation. Formal investigations include patient involvement and a full copy of the report is shared with them accordingly. The table below shows the trust's performance with Duty of Candour over the past 12 months for all serious (nationally reportable) incidents.

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	21/22
Number of incidents requiring 1st DoC	0	1	0	1	0	2	1	1	0	0	0	1	7
% compliance with first DoC	-	100%	-	100%	-	100%	100%	100%	-	-	-	100%	100%
Number of investigations quality assured / signed off	2	0	0	3	0	0	0	0	1	0	0	0	6
Number of incidents requiring 2nd DoC	2	0	0	3	0	0	0	0	1	0	0	0	6
% compliance with 2nd DoC	100%	-	-	100%	-	-	-	-	100%	-	-	-	100%

Compliance with duty of candour 2021/22

Pressure Ulcer Prevention

At the end of the year a total of 109 hospital acquired pressure ulcers (category 2 and above) were reported, this is a 94.6% increase on the previous year (56 in 2021/22).

The Trust acknowledges that pressure ulcer prevention has been challenging during the COVID-19 pandemic. This is due to a number of factors, including staffing pressures, and in particular the level of acuity of patients on admission has significantly increased leaving them more susceptible to pressure damage. This has also been recognised nationally and is associated with self-isolation, limited or no contact and with personal support, poor self-care and anxiety in terms of seeking medical assistance. In addition to this, difficulties in discharging patients into intermediate care settings has resulted in longer length of stays further increasing the risk of pressure damage and falls.

Over the past year the Tissue Viability Team have continued to support ward teams and ensured sufficient supplies of pressure relieving equipment. In addition the Team undertake daily clinical ward reviews to support and educate staff to ensure the patients are appropriately risk assessed and preventative measures are in place.

Due to the increase in pressure damage incidents the Pressure Ulcer Steering Group has met monthly to discuss themes and strategies for improvement. A number of incident reviews have been undertaken in to category 3 and 4 pressure damage, deep tissue injuries and unstagable pressure damage. Four key themes have been identified; documentation, assessment, training, and revalidation of category. These will be core areas of focus during 2022/23. During 2022/23 a process for rapid reviews will be developed to ensure the prompt identification of learning, feedback to ward staff and appropriate communication with patients.

During the year the Team have maintained strong links with acute and community partners, and are in the process of aligning equipment, procedures and policies to ensure a consistent approach for patients accessing healthcare within Somerset.

As a result of the easing of COVID-19 restrictions face to face training has recommenced focussing on pressure ulcer awareness and prevention as part of the Trust's induction programme. More practical

training sessions are planned for 2022/23, this will include information around reporting and validating incidents.

The Trust participated in promotion activities for national Stop the Pressure Day in November 2021 and Moisture Associated Skin Damage Day in March 2022.

Healthcare Associated Infections (HCAI)

Since 2008 there has been a legal requirement for the NHS and other health and social care organisations to implement and meet the standards of the Health and Social Care Act 2008. The Trust continued to sustain focus and energy on the infection prevention and control agenda, sharing key learning and best practice against the need for compliance with the HCAI national targets. The additional challenge has been the management of COVID-19.

The implementation and maintenance of robust infection prevention and control practice remains a key action for the Trust in reducing avoidable health care associated infections. Ensuring infection prevention control policies and guidance are in place and implemented, is essential for confidence of all those that use the service and their families. The Infection Prevention and Control dashboard for 2021/22, can be seen on page 29.

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

- The index case was an admission from the community who was negative on admission, testing positive following a second test.
- Another patient in the bay proved positive and typing confirmed the same strain. Therefore lapse of care from healthcare workers (HCW) between the two cases.

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

Infection prevention and control dashboard 2021/22

Area	Quality Area	Quality Objective	Threshold**	2021-22												
				Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-21	Total
Blood Stream Infection	MRSA BSI	Number of provider-acquired infections	0	0	0	0	1	0	0	0	0	0	0	0	0	1
	MRSA BSI Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA BSI			0	1	1	1	1	3	0	1	1	2	1	0	12
	MSSA BSI Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	E Coli BSI			1	1	1	3	4	2	2	3	1	6	0	1	25
	E Coli BSI Lapses in Care		69	0	0	0	0	0	0	0	0	0	0	0	0	0
	Pseudomonas BSI			1	0	0	1	0	0	0	1	0	0	0	0	3
	Pseudomonas BSI Lapses in Care		7	0	0	0	0	0	0	0	0	0	0	0	0	0
	Klebsiella BSI			1	1	0	0	0	1	1	2	0	0	0	0	6
	Klebsiella BSI Lapses in care		19	0	0	0	0	0	0	0	0	0	0	0	0	0
Bacterium	Clostridium Difficile Infections			2	2	0	5	2	1	2*	3	2	1	0	3	21
	Clostridium Difficile HOHA			2	2	0	2	2	1	2	0	1	0	0	1	13
	Clostridium Difficile HOHA Lapses in care		16	0	0	0	0	0	0	0	0	0	0	0	TBC	0
	Clostridium Difficile COHA			0	0	0	3	0	0	0	3	1	1	0	2	10
	Clostridium Difficile COHA Lapses in Care			0	0	0	1	0	0	0	1	0	0	0	TBC	2
	Hand Hygiene - Trustwide average of scores submitted	Annual Target 90%	90%	95%	96%	95%	97%	95%	96%	98%	98%	95%	98%	99%	100%	97%

**Threshold numbers refer to cases with lapses in care

Reducing Patient Falls

Some patients are at high risk of falling, either as a result of their rehabilitation or condition, and it is recognised that this causes anxiety, loss of confidence and in some cases serious injury to patients.

The length of stay for patients who have fallen whilst in hospital is often increased as staff attempt to improve their mobility and confidence.

The Trust has seen a 5% increase in falls compared to the previous year (900 in 2021/22 compared with 855 in 2020/21).

The Trust has a Falls Prevention Steering group which is a multidisciplinary working group who meet bi-monthly to oversee quality improvement projects and respond to learning identified through incidents and national best practice.

In the prevention of falls the Trust has continued the use of TagCare* and cohorting patients. TagCare is a system of ensuring a group of patients who are deemed to be at high risk of falling are managed collectively by a ward based multidisciplinary team who have line of sight at all times in a bay.

Over the year the rapid incident review template has continued to be developed for falls that result in harm (e.g. fractures) involving the patient where possible. Areas of good practice, or any learning identified, are fed back at the time of the review. Thus far no lapses in care have been identified that could have prevented the falls from occurring; although incidental learning has included compliance with the lying and standing blood pressure and improvements required with documentation.

Members of the Falls Prevention Steering Group have undertaken a baseline assessment against relevant NICE guidelines to inform the falls work plan for 2022/23.

Safer Medicines

The Pharmacy Team continue to provide an enhanced and extended seven day pharmacy service for patients and staff at Yeovil District Hospital. 94.9% of all patients admitted to hospital during 2021/2022 were seen and reviewed by a clinical pharmacist within 24 hours of admission.

A total of 11,498 drug histories were checked by pharmacists during the financial year and 66% were found to have one or more medication related discrepancies which highlights the importance of the medicines reconciliation process.

The decentralised pharmacy discharge service continues to support patient flow across the Trust and improve patient experience at discharge. The average time taken for pharmacy to process discharge summaries at ward level was 45 minutes (awaiting data for March 2022).

In total 5,757 changes to medication were made by pharmacists under the Trust's Enabling Policy ensuring the safe prescribing and administration of medicines to patients.

During 2021/2022, pharmacy staff continued to support the Trust's COVID-19 vaccination programme for staff and eligible adults in the community. The programme was extended during the year to include the vaccination of eligible inpatients.

Since May 2021, YDH pharmacists have been supporting the Somerset COVID-19 vaccination programme providing clinical advice to healthcare professionals and ensuring vaccines are handled in accordance with national policies and procedures.

Pharmacists have also been involved in the review of patients with COVID-19, including non-hospitalised patients, ensuring suitability of choice of treatment and optimisation of therapy.

The Medicines Committee, the Medicines Optimisation Programme and Audit Plan and the Medication Safety Assurance Audit continue to support improvements in medicines safety and assurance.

Numerous of trustwide policies and procedures were developed, reviewed and approved by the Medicines Committee.

Pharmacy conducted a number of medicines related audits including the annual pharmacy intervention audit; this reported a total of 285 interventions made over a 5 day period in November 2021 (including 41 graded as major), equating to approximately 15,000 pharmacy interventions per year.

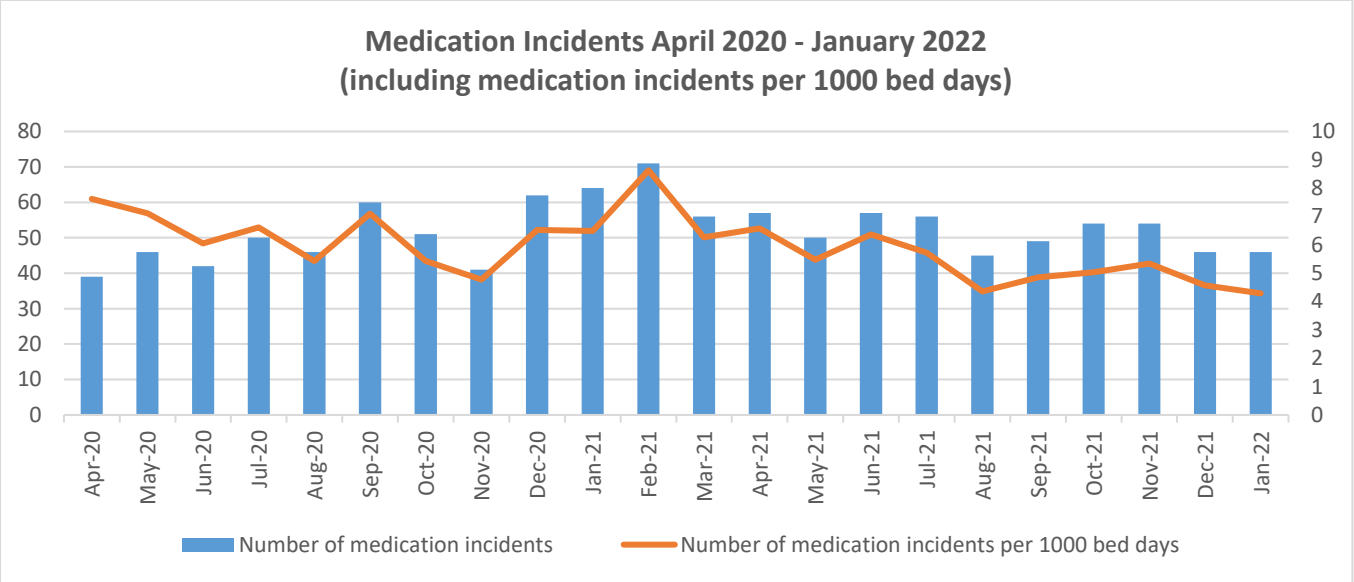
A review of the accuracy of Inpatient Discharge Letters (IDLs) between April 2021 and October 2021 showed that over 10,000 interventions were made by pharmacists when clinically screening IDLs.

Pharmacy delivered a total of £217,286 of financial benefits for the trust during 2021/2022 this combination of financial savings on medicine costs, increased commercial activity and additional income through NHSE and Somerset CCG.

The pharmacy Aseptic Services Unit (ASU) manufactured 6,058 injectable chemotherapy. A total of 2,115 oral chemotherapy prescriptions were dispensed and vial sharing savings of £5,000 were made during 2021/2022.

Medication related incidents continued to be well reported during 2021/2022 with a total of 514 reported via Ulysses (the Trust's reporting platform) between April 2021 and January 2022 (awaiting data for February 2022 and March 2022). There were 12 medication incidents graded as significant i.e. the error caused actual harm to a patient.

All medication related incidents continue to be reviewed by the Medication Safety Officer and discussed by the Medicines Committee. Key prescribing errors or common themes are identified and the required learning from these incidents is established.



The number of pharmacist independent prescribers increased to 9 allowing the team to provide regular prescribing support to the HIV team, Ambulatory Emergency Care (AEC) and to haematology. During 2021/2022, 4,917 medicines were prescribed by pharmacist independent prescribers.

A new highly specialist pharmacist post was created in Critical Care in response to the recommendations and standards specified with the national Guidelines for the Provision of ICU Services (GPICS).

A specialist pharmacist anticoagulation service was in operation until October 2021 as part of a pilot study. The pharmacist in this role was responsible for reviewing inpatients with complex anticoagulation requirements and also working as an advanced practitioner in AEC.

Over a five month period 352 inpatients prescribed an anticoagulant were reviewed and 11.1% of these patients were identified as being at risk of severe patient harm as a result of inappropriate anticoagulation therapy.

A total of 32 hospital associated venous thromboembolisms (VTEs) were identified and investigated by the pharmacist and learning from these incidents was established. Four patients who had their anticoagulation inappropriately stopped when used for stroke prophylaxis in AF were reviewed, leading to restarting of their anticoagulation and potentially preventing ischaemic strokes in all cases (extrapolated to 10 preventable strokes per year).

A total of 300 patients in Ambulatory Emergency Care (AEC) with potential VTEs were reviewed and treated by the pharmacist leading to a high number of admission avoidances and increased patient flow through ED.

In July 2021, pharmacy began to use PharmOutcomes to refer patients to their community pharmacist on discharge from Yeovil District Hospital as part of the new NHS Discharge Medicines Service (DMS).

Since the introduction of this service, the YDH pharmacy team have referred 1,285 patients to their community pharmacist for a follow-up post-discharge. The 87% of these patients have had a completed medicines review in the community as a result of these referrals.

During 2021/2022, a new Inpatient Discharge Letter (IDL) within Trakcare was launched, replacing the previous yCloud (hospital intranet) document. The new IDL is now in use in all clinical areas within the main hospital.

An YDH outpatient pharmacy was set up within Simply Service Ltd (SSL) in February 2022 replacing Boots Ltd who had been providing the outpatient pharmacy service since 2017. This mitigated a £188,000 cost pressure had the trust renewed the contract with Boots Ltd.

During 2021/2022, the locks on all medicine cupboards across the trust were replaced with a swipe card access system. A new walk in fridge was installed with the pharmacy department replacing a significant number of individual fridges being used for the storage of medicines. In addition, a temperature management system was installed in the Trust's Fluid Store.

Further improvements to the pharmacy service and the provision of medicines optimisation are planned for 2022/2023 and include the following:

- Implementation of ePMA across the Trust.
- Introduction of the electronic ordering of stock medication on the wards.
- Collaborative working with Somerset Foundation Trust (SFT) and the creation of a new Director of Pharmacy post for the merged Trusts.
- 12 month project with Somerset Integrated Care System (ICS) aimed at tackling pharmacy workforce challenges across the county.
- Installation of a new isolator in the pharmacy Aseptic Services Unit (ASU).
- 7 day clinical pharmacy service to Critical Care.

Deteriorating Patient

The Trustwide Sepsis audit has continued and demonstrates positive improvement in the compliance with the Sepsis 6, patient diagnostics and treatment. The number of cases reviewed each month has been reduced to enable more time to focus on improvement initiatives and training on the wards starting with 9A. The members undertaking the audit continue to support staff within the emergency department to develop one consistent approach for managing Sepsis.

The Trust's Resuscitation Team has been working closely with SFT colleagues to align policies and in preparation for the merger.

Concerns continue to be raised regarding the compliance with treatment escalation plans (TEP), in particular the quality and evidence of discussion with patients and next of kin. Work is ongoing with the medical workforce and through a regional treatment escalation plan (STEP) to provide training and support to improve compliance and improve communications with families. A Trustwide Governance session in May 2022 will be dedicated for training for the senior medical workforce.

The Deteriorating Patient Steering Group has noted an increasing number of patients arresting in the Emergency Admissions Unit, this demonstrates the severe acuity level of patients and the pressure of moving people through the emergency department. The Chair agreed to discuss the concerns with the emergency department team to ensure patients are being moved through the Trust appropriately.

Ward based training has recommenced to help ensure staff are able to recognise the signs of deterioration and have the confidence to escalate appropriately.

It is also acknowledged that the lack of visiting, due to the COVID-19 pandemic, may have attributed to the emotional wellbeing of patients, and therefore potential impact on outcomes or recovery.

As a result of an incident occurring in an escalation bed, changes to the environment and practice have been made along with a programme of ward based simulation training.

Maternity safety

Maternity services have evolved and adapted to new ways of working since the beginning of the COVID-19 pandemic. During this time the Team's priority has been to maintain safe equitable care and services for mothers, babies and their families whilst upholding the Trust's iCARE values.

Changes to the antenatal care service provision had reduced the number of face to face contacts women had with midwives and or a consultant obstetrician. During 2021 these appointments have returned to face to face, allowing a more thorough consultation and enabling staff to detect and act upon any concerns more easily.

To reduce risks associated with COVID-19, measures were put in place to ensure protection for staff and women. This consisted of PPE, alongside the recommendation for all staff and women to have the COVID-19 vaccination. Women are also asked to contact the maternity unit ahead of any appointment if they are self-isolating or symptomatic.

Restrictions to postnatal visiting at home were uplifted to ensure women received appropriate timely care, and partners are welcomed to attend all appointments in the perinatal period.

After an initial pause to the maternity transformation programme at the beginning of the pandemic, work has begun to return. During this period the programme has concentrated on continuing to implement the four actions to minimise the additional risk of COVID- 19 for Black, Asian and minority ethnic women and their babies, whilst assisting services to recover from the pandemic by supporting staff wellbeing, with funding for Professional Midwifery Advocate provision and reopening services for women and families.

Work is in progress on developing a perinatal equity strategy covering health outcomes, community assets and staff experience in coproduction with the Maternity Voices Partnership and the creation of a plan to submit to Trust board in June 2022. This outlines the Team's proposals to ensure the building blocks for safe and sustainable transformation are in place and continuity of care becomes the default model of care offered to all women, prioritising those most likely to experience poorer outcomes.

The programme ensures all women with type 1 diabetes are offered continuous glucose monitoring from early in pregnancy as part of their care to improve health outcomes.

Work continues with regional teams to embed maternal medicine networks across the region so women with acute and chronic medical problems have timely access to specialist care and advice.

Coproduction with the Maternity Voices Partnership aims for all women to be offered a personalised care and support plan. This would include an individualised bereavement care plan, underpinned by a risk assessment in line with national guidance. This is in the last stages of development, with a predicted launch in early 2022/23 once training for staff has been undertaken.

As part of the treating tobacco dependency guidance and Somerset Long Term Plan, implementation of new smoke free pregnancy pathways has begun at pace and funding for extra training of maternity support workers to support the programme has commenced.

This supports the embedment of the five Saving Babies Lives Care Bundle 2 elements which include:

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

The Avoiding Term Admissions into Neonatal Unit (ATAIN) quality improvement programme has a National target for less than 5% of term births to result in an admission to a neonatal unit. YDH remains at

4.7% for the last year and cases continued to be reviewed monthly. Transitional care services are also reviewed to minimise separation of mothers and babies.

The Trust has recognised the national challenges to maintain a safe workforce at a time when available midwifery staffing is limited. To invest in staffing the Trust has prioritised the health and wellbeing of its workforce. All staff have a personal line manager whom they can access for direct support.

We also have a dedicated weekly Professional Midwifery Advocate (PMA) available to all staff. Pastoral support has been made available within clinical practice, supported by the midwifery retention support funding. Ongoing funding support for 2022/23 has also been received to maintain this level of care to staff. Newly qualified midwives have a dedicated line manager to ensure they have time and attention to address their needs with allocated time as a group to invest in their training requirements.

In recognition of a reduced midwifery workforce the Trust has introduced Maternity Support Workers to work during the daytime on the postnatal ward and Day Care Assessment Unit. Training has been provided to enable them to support midwives in their duties and allow for a more streamlined process to enable enhanced care of mothers and babies allowing timely discharges ensuring that during periods of escalation mothers and babies are protected.

The Maternity service aims to reduce incidents with a proactive management of risk. All staff have a role in managing risk through compliance with Trust policies and procedures, maintaining competence, identifying and responding to hazards and reporting incidents. A culture of high incident reporting is promoted and learning from incidents is shared through case reviews and discussion at multidisciplinary departmental meetings.

A weekly safety huddle takes place with the Risk Manager, Clinical Director, Head of Midwifery and Matron, to discuss incidents / concerns and identify any immediate learning / need for further investigation.

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

In 2019 the Health Service Investigation Branch (HSIB) a maternity investigation programme was devised as part of a national action plan to make maternity care safer. There was one case reported in the last August 2021.The report is shared for comment with the staff involved and the parents and the final report and recommendations are shared with all staff for learning.

The Trust is successfully meeting the requirements of Year 3 Maternity Incentive Scheme (MIS). The submission date for the current year has been paused, In the meantime the maternity service continues to work hard to demonstrate compliance in achieving the ten safety actions.

Senior midwives and obstetricians were invited to attend a Labour Team away day to improve culture and team building, the event was well attended and enabled staff to connect in a meaningful way. It has allowed staff to find their voice and be heard whilst enabling others to be respectful to listen. Staff reflected back that they had found the day empowering and were enthused to create and maintain a Just Culture within the maternity unit. Training on Civility in the workplace is currently being introduced by our Practice Education Team.

On 30 March 2022 the final Ockenden Report was published with the emerging findings and recommendations from the Independent Review of the Maternity services at Shrewsbury and Telford Hospital NHS Trust. The review of 1592 cases led to Local Actions for Learning (LAfL) in the Shrewsbury and Telford Hospital NHS Trust maternity services. This learning and the recommendations were shared nationally through the report and maternity services across England putting into place 15 ‘Immediate and Essential Actions’ (IEA), to complement and expand upon the 7 IEAs from the initial review in 2020.

The Trust has already undertaken a full multidisciplinary review of the initial report in December 2020, by with the Trust’s Safety Board Member, addressing recommendations where an action plan was put in place and immediate actions taken. The response was signed off by the Chief Executive of the Trust and the Chair of the Local Maternity System (LMS) and submitted to the Regional Chief Midwife.

An assurance assessment tool and supporting evidence was submitted in February 2021. More recently the national team undertook an Ockenden 'deep dive review' with every region. The South West deep dive was held in February 2022 and included the current position for the initial seven IEA's. Next steps will include appraising the 15 Immediate and Essential Actions and developing plans as a system to improve safety in maternity services.

3.2 Clinical effectiveness

Clinical audit

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

- Improves the quality of care and patient outcomes;
- Provides assurance of compliance with standards;
- Identifies and minimises risk, waste and inefficiencies.

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

National clinical audit

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

The Sentinel Stroke National Audit Programme 2021/22

The Sentinel Stroke National Audit Programme (SSNAP) is national healthcare quality improvement programme, measuring the quality and organisation of stroke care across the NHS. The clinical audit collates data for stroke patients in acute hospitals, equating to around 85,000 patients submitted on a yearly basis. Each quarter the hospital is graded (from A-E) based on the care they have provided. These grades and the corresponding statistics are available to the public.

The Stroke Pathway is very complex, with involvement from a wide range of MDT members and expertise. In October to December 2020 Stroke Services within the Trust were downgraded in their overall SSNAP rating to a 'C' following large scale service impacts from COVID-19. The Stroke Service Enhancement Programme (SSEP) was formed to address the problems along pathway, with the aim of improving our SSNAP score to an 'A' rating, but also the outcomes of patients and their experience.

The Stroke Team started with two projects that were felt to be key to patient safety; screening for malnutrition within 24 hours of admission and ensuring patients were given the correct consistency of diet or fluids.

Correct consistency of diet or fluids

This aim of this project is to improve health outcomes by decreasing the number of patients on Ward 7B that are given an incorrect consistency of diet or fluids to 0 by December 2021.

This project was started with the introduction of staff awareness training during "dysphagia awareness month". It was felt that by raising awareness of the levels of diets and fluids, and what they should look like, potential safety incidents could be avoided.

To do this the Stroke Specialist Speech and Language Therapist provided sessions on the ward showing staff how to thicken fluids and the ability to feel the difference between the different levels. Alongside this our specialist dietician provided examples of different meals for staff to experience.

Staff really engaged with the training sessions, and visualisations of the diet and fluids. More staff awareness led to more reporting and photos of incorrect diets before being sent back to the kitchen instead of given to a patient. This initially rose the number of incident forms submitted to 2 in October 2021, but by December 2021 this had reduced back to 0.

Unfortunately the Team have not achieved the overall target during the year due to further impacts of COVID-19, including the closure of the ward on which the projects were based. Therefore the projects were put on hold until a more appropriate time. The YDH SSNAP Score was also downgraded once again in October-December 2021.

However, the Team hope to relaunch the Stroke Service Enhancement Programme shortly when hospital pressures subside and they are settled into a new ward environment with revamped objectives and new members.

National Audit of Care End of Life: Third round of the audit (2020/21) bespoke dashboard for Yeovil District Hospital Report

Audit Aim: To review the quality of care given at end of life.

Report findings: A summary against the key indicators is shown below:

	March 2020		March 2022	
	National	YDH	National	YDH
Communication with the dying person	7.8	7.8	7.9	8.2
Communication with family	6.9	5.7	7.0	6.6
Involvement in decision making			9.5	10.0
Individualised plan of care	7.2	6.2	7.7	6.5
Needs of families and others	6.0	6.6	5.6	6.3
Families experience of care	7.0	7.4	6.5	6.9
Governance			9.7	10
Workforce	7.4	6.9	8.1	9.4
Staff Confidence			7.5	7.7
Staff support			6.4	7.0
Care and confidence			7.3	7.7

YDH score higher than national average | YDH score same as national | YDH score lower than national average

All areas which relied on surveys of families or staff showed YDH performed better than the national average, including family feedback and staff feedback. The Trust has seen an improvement under 'workforce' since the start of the weekends on call.

Areas for improvement:

- To conduct a review on the Trust's current end of life care plan and the current tool for documentation of assessment and care at end of life.
- Improve education for staff around the importance of communication around food and fluids and the side effects of medication at end of life.

National Audit of Learning Disabilities

Audit Aim:

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

Report findings:

Staff: Although there was a poor response from staff the Trust did exceed the National average in areas such as quality of care, which was seen as a positive with staff. Unfortunately, it is not possible to base an improvement

program on the results from staff as the numbers were low. The Trust has identified that a different approach is needed to encourage more staff to engage in future surveys.

Patient: Around 50 patients responded to the survey, generally the responses were positive and in some cases exceeded the national response. There were areas identified for improvement including explanations given regarding appointments. Concerns raised regarding families ability to visit will be addressed as visiting returns to pre-pandemic arrangements. A high proportion of respondents (74%) said that they were seen quickly in an emergency.

Local clinical audits

Radiographer Abnormality Detection Systems (Red Dot) Audit, 2022

Aim:

> To establish how accurately the current Red Dot scheme is being used at YDH to identify acute abnormalities. (The Red dot scheme is where radiographers mark a radiograph (usually a red dot sticker) that they believe show an acute abnormality to alert emergency doctors to the possible presence of an abnormality).

Objectives

> To collect and compare images and associated reports from PACS to establish use of RD along with accuracy.
> To investigate any impact of RD accuracy by time of day, age of patient, and area of interest.

Conclusion:

> When used the red dot scheme is applied with 94% accuracy, however it is acknowledged that there is some improvement required in its consistent use.

Recommendations:

> Refresher on A&E protocols – clavicle, turned laterals etc.
> Sessions focused on anatomy and technique as identified by high rates of false negatives (Adult shoulders & ankles, paediatric elbows).
> Reporting Radiographer led sessions – focus on pathologies (e.g. pubic rami, avulsion and occult fracture identification) and importance of radiographic technique to aid in diagnosis.
> Inclusion of red dot scheme and rationale in preceptorship and induction of new radiography staff to ensure competency.
> Access online resources - E-Learning for Healthcare modules & Norwich Image Interpretation.
> PACS teaching sessions – how to best use PACS as a diagnostic tool.
> Preliminary Clinical Evaluation terminology posters – useful terms to be used in Preliminary Clinical Evaluation/sticky note comments.
> Re-audit in May 2022 to evaluate impact of recommendation and readiness for implementation of PCE scheme

Early management of paediatric forearm fractures in ED, 2021

Aims:

> All units managing children's forearm fractures should have protocols to enable early, definitive manipulation and casting without necessitating admission. The aim of the this project is to identity the compliance of managing paediatric forearm fractures with the BOAST (British Orthopaedic Association Standards for Trauma and Orthopaedics) guidelines and creating a pathway which would allow for early manipulation of forearm fractures in ED to avoid, or reduce, unnecessary paediatric admissions.

Objectives:

> Identity the compliance of managing paediatric forearm fractures using BOAST guidelines.
> Create a pathway which would allow for early manipulation of forearm fractures in the emergency department to avoid and reduce unnecessary paediatric admissions.

Conclusion:

> To enable early manipulation and casting without necessitating admission is at 35.9% compliance.
> The time from admission to first x-ray averaged 39.5 minutes.
> 71.9% of patients had a documented assessment of the limb including CRT and neurological status.

Recommendations:

> Discuss in the Trauma meeting to arrange a pathway in emergency department (after discussing with the emergency department) for paediatric forearm fractures. This includes increasing availability of registrars to

manipulate within the department to provide monitored space to perform MAU (manipulation under anaesthesia) under sedation.

- To collaborate with the emergency department to make a Trakcare capsule which would auto populate with a standardised clerking for said patients.
- Re-Audit in May 2022.

PICC line management, 2022

Aim:

- To identify the management and identification of complications, incidence on infection rate and documentation.

Objectives:

- Identification of complications.
- Identification of incidence on infection rate.
- Identification on documentation.

Conclusion:

- Successful placement of PICC was possible in 108 patient's first attempt (99.1%), with inability to pass the line in 1 patient (0.9%).
- There was no immediate complications following insertions.
- The compliance in record maintenance and documentation failure was at 11.1%.
- The most common reason for PICC removal was completion of therapy (74%).
- The simple insertion technique and low incidence of serious complications making PICCs reliable and cost-effective.

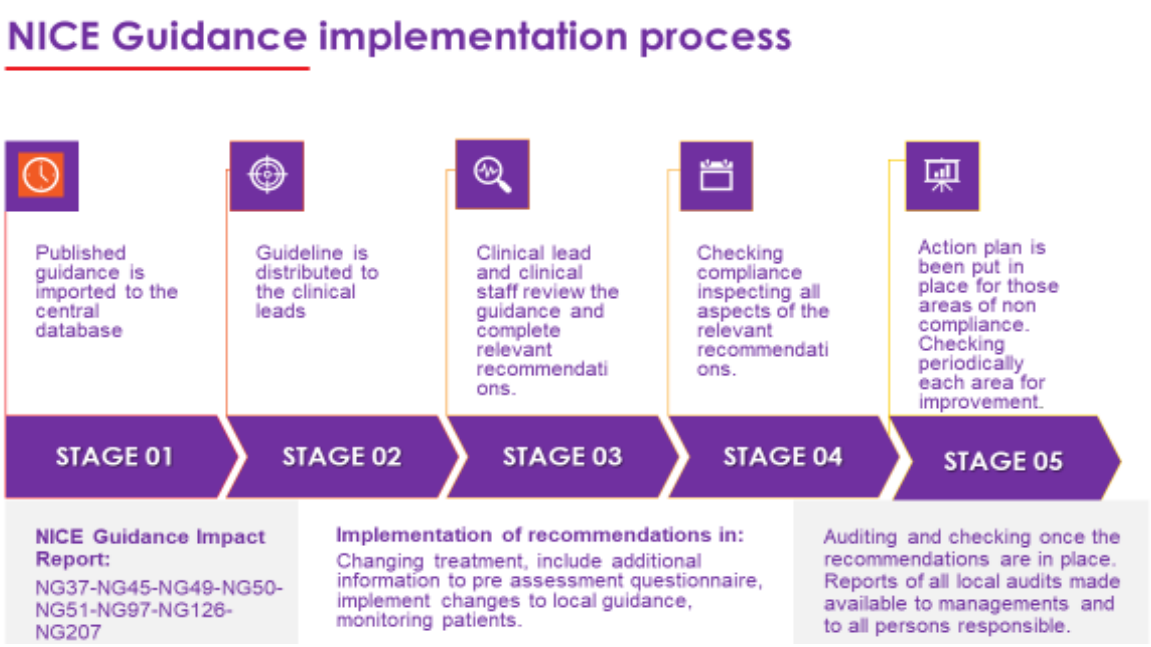
Recommendations:

- Review and update the existing guidelines.
- Identify any gaps in training and education in the use of PICC line management.
- Extend the role of insertion teams to include education, re-audit and standard setting, to allow improvements in infection rates and longevity.

Management and Implementation of Best Practice Guidance from the National Institute of Health and Care Excellence (NICE)

There is an effective process for monitoring NICE guidance, this includes the completion of baseline assessments for all the relevant guidance to identify areas of compliance and improvement opportunities.

There 153 NICE guidance relevant to the Trust; 126 of these have been reviewed in full and 69 assessed as fully compliance.



As a result of the review of NICE guidelines the following changes in practice have been implemented during 2021/22.

- The Gynaecology Team have confirmed changes to practice in line with the latest recommendations for the management of ectopic pregnancy.
- After reviewing the latest recommendations the preoperative team have updated their practice regarding routine urine tests for patients undergoing elective orthopaedic surgery.
- There has been a change in pharmacological treatment for people with liver cirrhosis and ascites.

Learning from deaths

Dr Foster

(Data from Telstra Health UK) Throughout 2021/22 the trust has sought external assurance through the Dr Foster Health Care Intelligence Portal (Telstra Health UK). This system provides access to a wide range of key hospital quality and efficiency data providing an analysis of the patient's hospital journey from the Emergency Department to inpatient and outpatient activity. This tool provides multiple ways to analyse and assess hospital activity data which allows us to provide more effective and accurate decision making as we are able to better understand trends, emerging patterns and variations in patient outcomes.

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

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

- In-hospital mortality
- Emergency Department attendances
- Inpatient and outpatient admissions
- Length of stay
- Excess bed days
- Readmissions

The monthly Dr Foster reports provide an overview of outcomes for the trust highlighting areas or groups of patients where activity is not as anticipated given the mix of patients for that condition. This indicates that

there could be a significantly higher than expected mortality, readmission or complication rate. The mortality data provided by Dr Foster provides Cumulative Sum (CUSUM) alerts allowing the trust to interrogate the data and review patient records where an alert occurs.

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

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

Summary Hospital-level Mortality Indicator (SHMI)

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

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. Data includes hospital deaths and those occurring 30 days after discharge. Our latest published SHMI covering 12 months October 2020 to September 2021 is 94.9, with 100 being the expected norm.

Hospital Standardised Mortality Rate (HSMR)

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

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

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

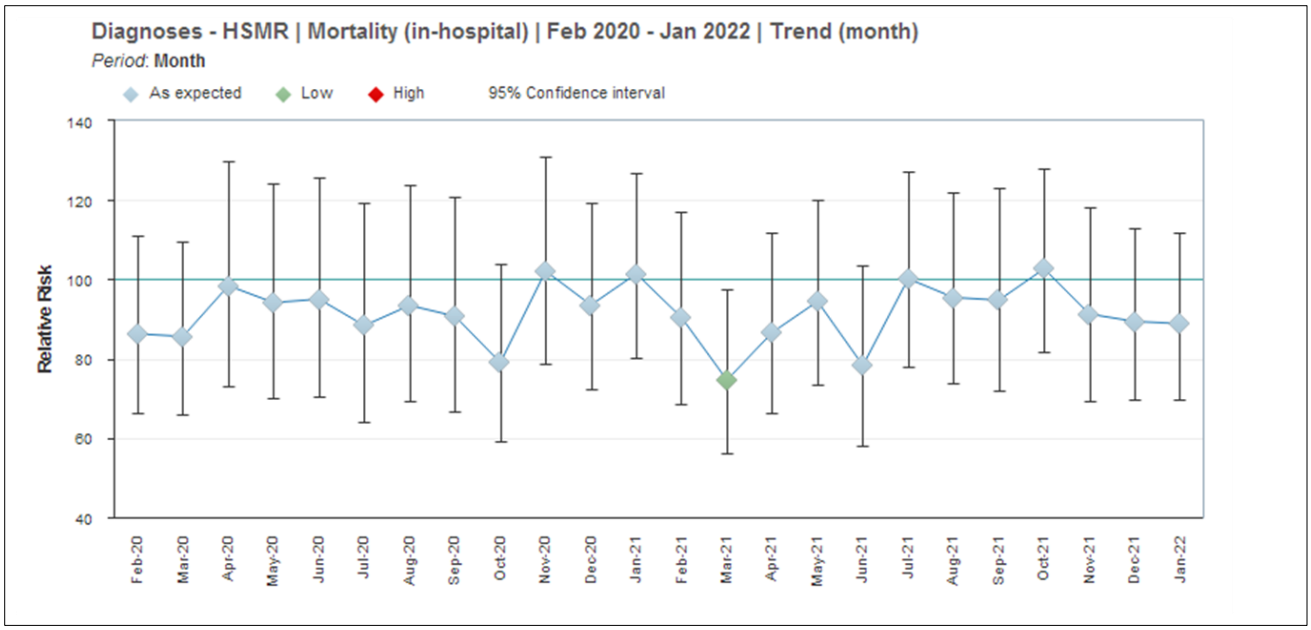
Other key differences in methodology include: HSMR is adjusted for more factors than the SHMI, most significantly patients receiving palliative care being excluded from the HSMR calculations. A further difference is seen in the fact that SHMI data includes post-discharge deaths, up to 30 days after discharge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

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

The trust HSMR is reported at 93.5, rolling year as at November 2021, which is a positive outcome and statistically lower than anticipated. This favourable position has been ratified and monitored throughout the year and it is believed to be due to a combination of factors including the good practice of identification and management of patients at the end of life and efficient coding of existing patient comorbidities.

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

The chart below shows the HSMR trend over the last 2 years.



Diagnoses – HSMR

Standardised review of deaths

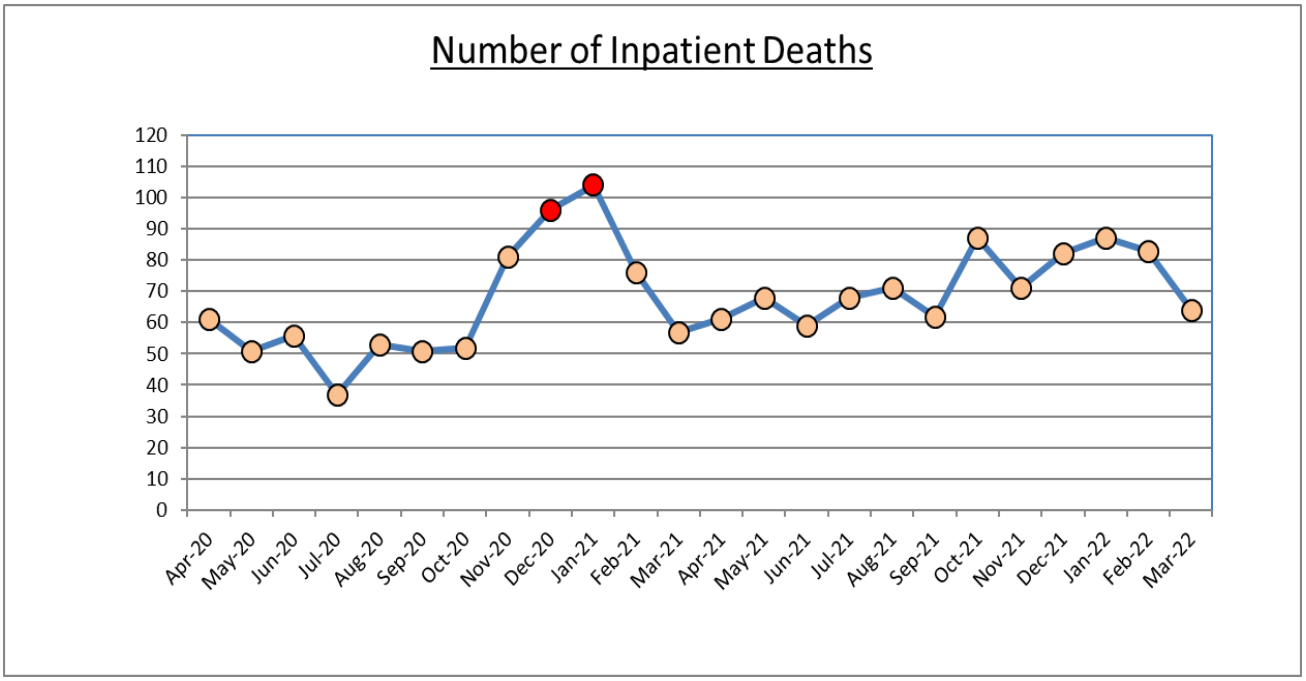
The National Quality Board 'Guidance on Learning from Deaths' published in March 2017, introduced enhanced reporting of case note mortality reviews. The National focus remains on standardising the review of deaths using a Structured Judgement Review (SJR) tool developed by the Royal College of Physicians. This tool has been adopted throughout the trust, with formal mortality reviews recorded on a central data base to enable learning to take place across all areas of the Hospital. Links to the trust's bereavement data ensure that all in hospital deaths are captured with an initial records review highlighting where a full formal Mortality Review or other investigation should be completed.

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

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

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

The chart below shows the number of deaths by month and demonstrates national and seasonal trends over the last and this financial year.



Inpatient deaths 2021/22

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

3.3 Patient experience

Patient engagement

Our Patient Experience Team have continued to engage with partner organisations in the local community to gain insight and feedback from the local population. The Team ensures representation at the County wide Complaints Managers Meeting, Somerset Engagement and Advisory Group, South West improving Patient Experience Network, Carers Strategic Partnership Board Meeting and continues to develop an ever increasing network, although engagement opportunities were reduced due to the COVID-19 pandemic. We work collaboratively with our colleagues at Somerset Foundation Trust to identify areas for improvement as a collective, such as work to support carers and accessible information.

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

Patient Feedback and National Surveys

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

Some of the commendations we have received:

> Nurse on the night shift was so lovely. She really cared for my daughter and we both felt in really safe hands.

> Thank you to all the staff who treat everyone with care and dignity despite the enormous pressures. A big thank you to the doctor in charge and nurse who managed to insert a cannula on first attempt. It usually takes lots of attempts and use of ultra sound machine so brilliant job

- The surgical team were fantastic! Nurse looked after me amazingly, and the whole team, from entering to leaving the hospital were very kind. Thank you NHS !
- Very efficient a new effective procedures to ensure emergency admission for broken hip identification in A&E. Surgery following in the morning. COVID-19 aware and compliance. Ever very helpful.
- Excellent caring and friendly staff. Always clean and COVID-19 aware. Excellent care from all staff lead by the sisters.
- The service was very good, they repaired and adjusted my hearing aids whilst I was there, fantastic service, and all with a very chatty— smiley nurse. 10 out of 10 and a big thank you. 👍👍
- Really do not think that anything can be improved. Was seen at appointment time and had very good discussion with Consultant who sent me to have blood tests, I couldn't believe that it was all done so quickly - no waiting around. VERY Impressed.
- The service was fast and efficient. I didn't have to wait too long to be seen, and considering I had to first see a consultant, then go on to the mammogram area, then on to ultrasound, the wait in each area was very reasonable. I got out sooner than I was expecting, and felt very safe inside the hospital with the COVID-19 measures in place. All of the staff were really happy, professional and friendly too.

The Patient Experience and Engagement Lead continues to work closely with department managers to help encourage staff members to ask patients to complete the survey. Following launch of the quick response (QR) code, we also launched a pilot text service, where patients are texted on discharge. This was trialled in Therapy Outpatients and was a huge success. The response rates have significantly improved, this is now being rolled out into other areas, to enable us to gain more information of the experiences from patients.

The Trust's Patient Engagement Lead has been working closely with Somerset CCG and Healthwatch to complete a survey looking into the increase in attendances to the Emergency Department. This was completed over a period of a week in September 2021 and was a combined piece of work with SFT. The key findings were:

- 72% of people were visiting with a new injury or illness.
- 68% of people sought treatment or advice from other services before coming to the emergency department.
- 50% of people were referred to the Emergency Department by another service, 23% of these came from primary care and 17% from NHS 111.
- 30% of people attended because they were unable to access treatment from another service. 17% of people came to the Emergency Department because they were unable to access treatment from their GP and 6% came because they were unable to access treatment at their Minor Injury Unit.
- 8.8% of people's visits to the emergency department related to the injury or illness that they are on a waiting list for.
- 8.5% of people who were discharged from hospital treatment in the last three months were visiting the Emergency Department in relation to that treatment.
- 21 of the 44 people who are on the waiting list for elective treatment were visiting as a result of their current condition this is almost 50% of those responses which seems more significant than comparing it against the total 283 overall responses.
- There were a significant number of attendees (24) from the TA6 postcode given that there is the MIU in Bridgwater. 15 of these were told to come to the Emergency Department (this is likely to refer to SFT).

Key observations:

- 68% of respondents were under the age of 55.
- Where people had tried Minor Injury Units, there was a lack of consistency services, this appears to have influenced their attendance at the Emergency Department instead.

- When busy, people have to queue outside the Emergency Departments and as a result some people turned and walked away.
- Inability to access GP appointments was a reoccurring reason for attendance. This included knowing they wouldn't get an appointment or having to wait too long in a phone queue. People were also seeking a face-to-face appointments that primary care was unable to offer.

2020 Children and Young Peoples Survey

Yeovil District Hospital participated in the Children and Young Peoples National Survey, which is commissioned by Care Quality Commission. A total of 125 people returned a completed questionnaire, giving a response rate of 25%.

The top five scores, rated significantly 'better' than the national average were:

- Parent/Carer – If your child used the hospital WiFi to entertain themselves, was it good enough to do what they wanted
- If you used the hospital WiFi, was it good enough to do what you wanted?
- Did you like the hospital food?
- Were there enough things for you to do in hospital?
- Parent/Carer – Were there enough things for your child to do in hospital?

The bottom five scores, rated 'worse' than national average were:

- Parent/Carer - Were the different members of staff caring for and treating you child aware of their medical needs?
- When you left hospital, did you know what was going to happen next time with your care?
- Parent/Carer – Were you given any written information (such as leaflets) about your child's condition treatment to take home with you?
- Parent/Carer – If you had been unhappy with your child's care and treatment, do you feel that you could have told hospital staff?
- When you spoke to hospital staff, did they listen to what you had to say?

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

2020 Urgent and Emergency Care Survey

Yeovil District Hospital participated in the 2020 Urgent and Emergency Care National Survey, which is commissioned by Care Quality Commission. A total of 473 people returned a completed questionnaire, giving a response rate of 38.99%.

The top three scores, rated significantly 'better' than the national average were:

- How long did you wait before you first spoke to a nurse or doctor?
- Did a member of staff explain why you needed these test(s) in a way you could understand?
- After leaving A&E, was the care and support you expected available when you needed it?

The Trust were not rated 'worse' than the national average for any of the questions.

These results were celebrated as the survey was carried out at a particularly difficult time throughout the COVID-19 pandemic.

2021 Maternity Survey

Yeovil District Hospital participated in the 2021 Maternity National Survey, which is commissioned by Care Quality Commission. 212 people were eligible for the survey, of which 132 returned a completed questionnaire, giving a response rate of 62%.

The Trust was placed first out of 66 trusts for the Maternity Survey, which was a fantastic achievement that was celebrated.

The top five scores, rated significantly 'better' than the national average were:

- Care after birth; If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?
- The start of your care in pregnancy; Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- Care after birth; Did you see or speak to a midwife as much as you wanted?
- Staff caring for you; Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- During your pregnancy
- Were you given enough support for your mental health during your pregnancy?

The bottom five scores, rated 'worse' than the national average were regarding the following questions:

- Care in hospital
- Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?
- Care after birth; In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?
- Staff caring for you; Did the staff treating and examining you introduce themselves?
- Staff caring for you; If you raised a concern during labour and birth, did you feel that it was taken seriously?
- Care after birth; Did a midwife or health visitor ask you about your mental health?

Health and Wellbeing Hub

There has been an increase in people visiting the hub and our Health and Wellbeing Lead has supported people requiring information, support or signposting. Dementia, Cancer and Long COVID have been the most common themes of enquiry over the last year. There is a vast amount of information available on all of these long term health conditions which is given or emailed to our patients, family members and carers to assist them. The Lead has also been working on projects such as a loan Information Technology service which Spark (a company who provide information, advice, training and support to the voluntary and community sector in Somerset) run in the community for our patients to have access to an iPad for virtual clinics. A new storage / display unit has also arrived which will store the cancer service leaflets, for which the team is currently working with all the cancer support workers and nurses to make sure the right leaflets are included.

The Lead continues to liaise with the village agents and social prescribers in the community to learn of any support groups that are running again as they are starting to hold face to face consultations. Support groups in the community are slowly commencing again and The Health and Wellbeing hub features on the Somerset District council website for our patients in the community to access.

The Team continue to use social media as a platform to share any support groups or information that can help patients, carers and families regarding long term health conditions.

Cancer support drop in clinics have been started, where one of the cancer support workers attends the hub to offer advice and support for our patients with cancer. The Health and Wellbeing Lead has been liaising

with the hair loss clinic at the hospice, to gather information for any patient that may need to use this service and the Lead regularly attends the hospice to meet with patients when required.

The Westland's gym group that the Health and Wellbeing Lead set up for patients with long term health conditions continues to prove a huge success and we go into the new year with a grant from Macmillan to fund the gym for patients with long term health conditions to attend for a year. This will consist of 12 patients in each session for 10 weeks to build their confidence and strength. This is the only fitness support group out in the community for Yeovil. Due to the Westland's gym support group being a big success, the hospice has asked us to start a friendship/bereavement support group in the community which will be developed throughout 2022.

Complaints and PALs

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

All PALS communications are graded as either an enquiry (easily and quickly resolved) or a concern (which needs an investigation). The PALS service received 2013 concerns/enquiries during 2021/22, which is a significant increase from 1027 in the previous financial year:

- Quarter 1 = 426
- Quarter 2 = 531
- Quarter 3 = 500
- Quarter 4 = 556

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

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

Due to the COVID-19 pandemic complainants have not been offered face to face early intervention meetings, to discuss the concerns and to agree expected outcomes and timeframes for any investigations. However, the Complaints Lead has been telephoning the complainant ahead of them receiving the formal acknowledgement letter to introduce themselves and discuss the concerns, the complaints process and the timeframes involve.

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

There were 49 formal complaints received during 2021/22:

- Quarter 1 = 11
- Quarter 2 = 19
- Quarter 3 = 14
- Quarter 4 = 12

The mandatory KO41 health and social care data return was suspended by NHS digital in quarter 4 of 2019/20 due to the COVID-19 pandemic, but was restarted in Quarter 3 of 2020/21. The submissions for quarter 3 and 4 for 2021/22 where not required to be submitted until 20 May 2022, therefore the report is not available to provide comparative data at the time of writing this report.

Learning and actions

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

- Senior Sister to discuss with nursing team, the importance of ensuring effective communication with families and carers
- Palliative Care Team to organise staff training which will include shadowing the team and scenarios regarding end of life communication

- Training to be carried out with staff to ensure the importance of effective communication
- Staff to be reminded of the importance of accurate and adequate information being provided in letters, as for a number of reasons patients may not remember conversations at the time of consultation. Staff should also use voice recognition to help prevent any errors in letters. To share complaint at our clinical governance meeting to aid learning
- Review the patient experience and journey of an emergency ophthalmology patient to ensure that patients feel safe and informed. Explore the opportunity of assigning an ophthalmology nurse to liaise with wards for our patients ensuring medications are appropriate
- The Emergency Department to review and update the Standard Operating Procedure to include the IOP measurement of the patient and pass this information on to the Bristol Royal Infirmary (BRI). Although not applicable in this case, it could provide alert to a possibility of suprachoroidal haemorrhage earlier
- Arrange customer service training with the hospital's training academy for staff on Ward 7B
- Review referral pathway from Dermatology to Plastics to ensure there is enough capacity within the plastic surgery service to ensure that patients are seen urgently i.e. within 2 weeks
- Ultrasound scan before caesarean section for breech: local guideline amended as per national guideline, circulated to all staff via email and pre-operative theatre checklist is being updated to include scan prior to breech caesarean section

End of life service

During 2021/2022, 889 patients died at Yeovil District Hospital.

How we care for those who are dying is indicative of the culture of a hospital and wider society. Providing person-centred care to patients at the end of life, and continuously working towards achieving a 'good' death and improve the bereavement experience of those that are left behind.

The pressures of the COVID-19 pandemic continued through 2021/2022 placing challenges in the provision of end of life care throughout the Hospital with restrictions for visiting and a shortage of available nursing home beds. Despite this, developments have happened that allowed end of life care to develop further throughout the year.

A weekend and bank holiday service was established in April 2021 and successfully maintained throughout the year, and is now set to become an established part of the service. This service has allowed for advice to be given throughout a weekend by the team, patients of concern to be followed up proactively and, if need be, visits made to support patients and their families. This has included 21 patients visit to assist with complex symptom control and symptom advice which prior to this service would not have happened.

To assist teams in the identification of patients approaching the final year of life we have introduced the Supportive and Palliative Care Indicator Tool (SPICT), an evidence based palliative care tool. The fractured neck of femur team and the dementia have team have so far been trialling the use of this tool to help in the identification of patients who are approaching the end of their lives and have found it beneficial.

This identification is essential to help patients' plans and ensure what matters to them remains at the centre of care. Over the next year the plan is to role this out further across the hospital.

An audit and review of care after death was conducted, and although it showed no major areas of concern in the care provided it did show areas for improvement and what needed or further development is.

The end of life steering group continued to provide oversight throughout the year with meetings held every quarter looking at the key performance indicators. These key performance indicators show a continual gradual improvement in the use of the end of life care plan as well as assessment of spirituality.

The monitoring of discharges has also been part of the key performance indicators. The past year has seen the specialist end of life discharge team been incorporated into the palliative care team. Despite the pressures of a lack of available nursing home beds, same day discharges have still been managed and most patients continue to reach their preferred place of care.

Complaints and PALS and incidents have been monitored throughout the year. As in previous years concerns in communication remain a continual theme. To work on improving this a programme of individual communication simulations for all trained nurses has been started.

This involves working on a one to one basis with nurses and undertaking with them a simulated 'end of life' phone call providing an individual feedback. This will be an ongoing programme of work, which will likely need to be continued indefinitely, it has received positive feedback from staff with qualitative evidence of improved care. Further developments are needed to improve working with medical teams as well.

The National Care of the Dying Audit of Hospitals (NCDAH) has been cancelled the previous year. Past results have shown showing YDH above the national average in 9/11 domains. These included areas based on feedback from relatives, as well as in feedback about levels of support from healthcare professionals across the hospital. Areas where YDH fell below the national average was in documentation and communication about areas of care such as food and fluids as well the side effects of medication prescribed. A plan is being developed to improve this area of care and in particular looking at how we teach and use of the end of life care plan.

The bereavement service, in which all relatives of patients who have died are called with 4 weeks of the death, which was started during the pandemic is continued and has become an established part of care.

Do not attempt resuscitation decisions (DNACPR) and the use of the Somerset treatment and escalation plan (STEP), have continued at times to be an area of concern, not just in YDH, but across Somerset.

The End of Life and the Palliative Care Teams are working together in the county wide programme to improve this area of care.

Key Successes of 21/22:

- Establishment of an out of hours on call service.
- Introduction of the SPICT tool.
- Establishment of a simulation training programme for nurses.

Key Priorities for 22/23

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

- Further development of simulation training including for medical teams.
- Review of the teaching and use of the end of life care plan.
- Review of care after death.
- Further development out the SPICT tool.
- Involvement in improvement work around the use of the do not resuscitate and escalation decisions.

Dementia Team

The Dementia Team's role includes inpatient care, assessment, family liaison, staff, patient and carer education, and multidisciplinary working with a variety of other specialist teams.

During 2021/22 the Dementia Team have implemented a number of improvement initiatives to help support the care of the Trust's patients with dementia.

This has included:

- The recruitment of two new Health Care Activities assistants who are clearly visible on the wards in yellow tunics.
- The role of the Dementia Link Nurse role is to be relaunched after a pause due to COVID-19.

- The work the Team have done to raise awareness has significantly increased the number of referrals and therefore patients who have been able to benefit. This has been supported by a Senior Health Care Assistant who actively identifies patients on the wards.
- The Team have been key in supporting virtual visits with the volunteers.
- A condensed version of the 'This is Me' document is being implemented to be used in addition to the full document in the patients' notes. These shorter documents will be more accessible behind each bed space.
- Dementia specific training for staff is ongoing and delivered as regularly as possible due to the restrictions of the pandemic. As the ability to provide training programmes improve these will include a continued focus on caring for patients with a delirium, cognitive impairment or dementia.
- An inpatient diagnostic pathway for dementia has been developed and will be introduced early in 2022/23.
- The Team have been actively involved in a quality improvement project to improve accurate pain identification and assessment across the hospital.

Orthotics and the Diabetic MDT clinic

The Trust has appointed an Orthotist with a specialism in Diabetes care. The role of an Orthotist within this service is to prescribe and design orthoses and / or footwear for the healing or prevention of ulceration, which has the potential to require long term treatment from multiple services and increases risk of amputation.

The new has implemented numerous changes, these include:

- Development of new systems to allow full monitoring of patients who are in the system, and pre-appointment ensuring all footwear and/or orthoses are supplied within the shortest possible time
- Sourcing of a new footwear supplier who has proved to be reliable and able to deliver footwear and orthoses of an improved quality within shorter time-frames
- Working on pathways to improve patient safety whilst they are awaiting footwear/orthoses to be completed
- Excellent communication with the rest of the MDT ensuring treatment plans are understood, agreed upon and implemented
- Leadership and training of the wider Orthotics team to expand knowledge, provide resilience and further capacity for this group of patients.

3.4 Recruitment and selection

Throughout 2021/2022 the Trust has grown to support 43 Trusts and private organisations recruiting international nurses, midwives, mammographers and radiographers.

The Team has also been working with the Scottish Government supporting the set-up of their International Recruitment Programme to ensure they have the correct procedures and policies in place to be successful. This has resulted in us recruiting nurses and radiographers for 6 Scottish NHS Boards. The OSCE (Objective Structured Clinical Examination) Team is also working with NHS Scotland Academy to develop their OSCE training programme as there is no central provision for this.

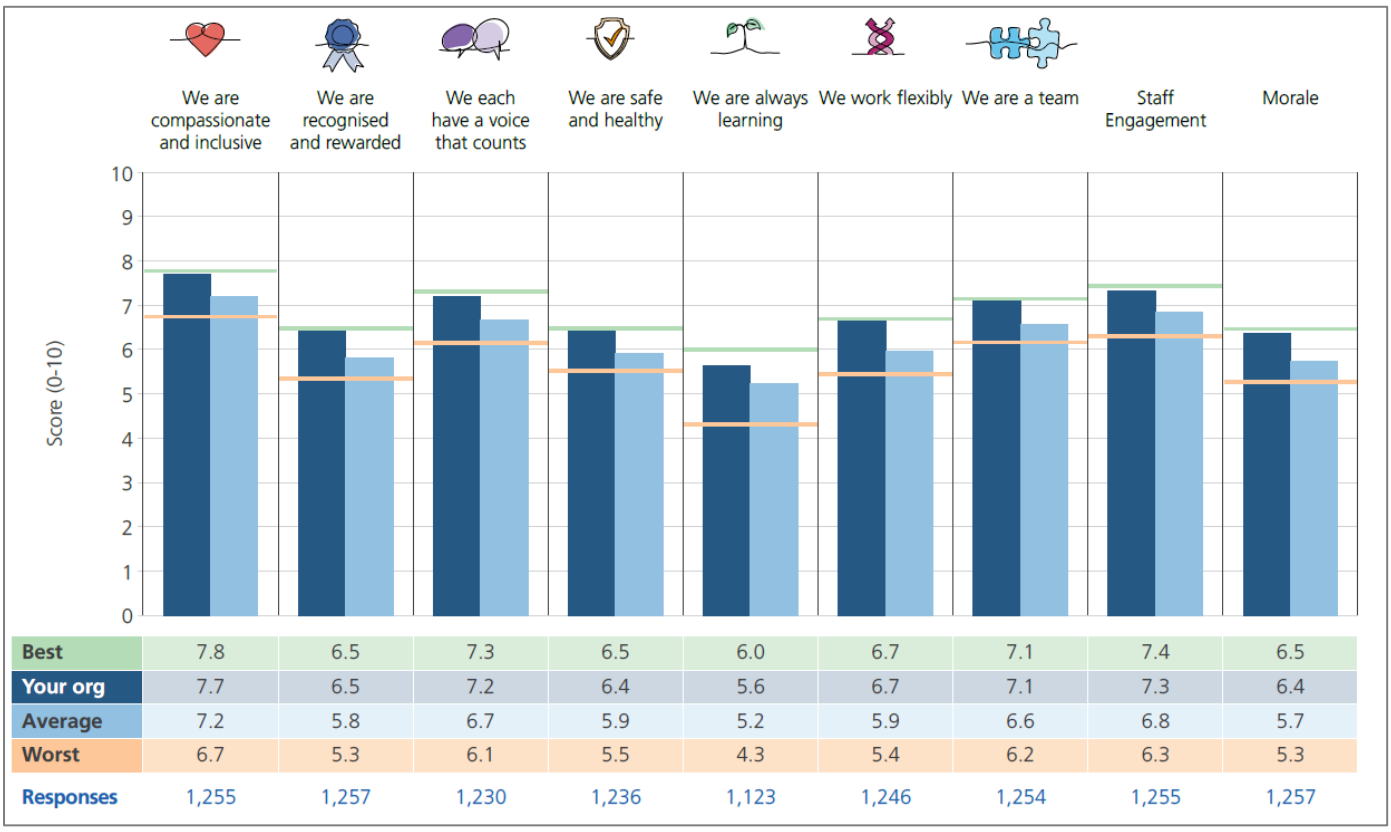
The Trust been awarded the NHS Pastoral Care Quality Award for its work supporting the pastoral care of international healthcare professionals. We are one of only three trusts to receive this award.

Work continues with NHSEI advising on policy changes and supporting trusts who are new to international recruitment, and also working with the Department of Health in the setup of government country agreements.

Staff survey 2021

The 2021 NHS Staff Survey was completed between September and December 2021 with a 57% response rate. This year was the first year that the staff survey was completed and nationally aligned to the themes of the People Promise.

A summary of the results is shown below:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.7	6.5	7.2	6.4	5.6	6.7	7.1	7.3	6.4
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,255	1,257	1,230	1,236	1,123	1,246	1,254	1,255	1,257

This highlights the overwhelmingly positive feedback from the Trust's staff. In every theme the Trust scored higher than the benchmark group average and in three were consistent with the best.

The Trust is really encouraged that the results have remained so positive despite so many challenges, however as expected, morale has decreased slightly, but feedback is overwhelmingly more positive than comparators.

In July 2021 the Trust implemented a quarterly pulse survey to continue to regularly ask staff about their wellbeing and hear feedback on how engaged they are feeling. This has been invaluable in ensuring the Trust continues to listen and develop support that is based on evolving needs.

This feedback continues reflect positive attitudes about work and levels of engagement, staff consistently recommend the trust as a place to work and receive treatment.

The past year has continued to be challenging operationally for every team and a sense of fatigue has been felt across the NHS in general and recognised in national feedback. The Trust no exception and this is apparent in staff survey feedback. The Trust has worked hard to ensure it's staff feel supported, cared for and listened to and whilst we won't always get this right every time, these results show we have been able to maintain this.

The Trust's managers and leaders have been vital to this success and have responded to the ongoing challenges of the pandemic, where continued hybrid working, less face to face contact and engaging and communicating with the team have been common,

Positive areas

The areas where we benchmark very well are:

> Opportunities for flexible working

- Team working – feeling valued by your team, effective working with other team
- Line managers – interested in your wellbeing, feeling valued by your manager
- Taking positive action on wellbeing
- Access to learning and developing – support for career development
- Acting on concerns.

Areas for improvement

The areas that we must improve are:

- Ensuring that all colleagues have an annual appraisal. 77% of colleagues reported that they have had an annual appraisal in the last 12 months compared with 80% in our comparator group of trusts.
- Of those staff who reported experiencing harassment at work, 56% of respondents said this was on the basis of ethnic background; 22% reported harassment on the grounds of gender; and 21% reported harassment on the basis of age.

Future priorities and targets

Looking forward to the coming year we will be working to improve by:

- Continuing with wellbeing support for colleagues
- Encourage and support good management practice
- Inclusion – build on the work we have already done to ensure all colleagues feel valued and belong
- Work to eliminate incidences of harassment
- Support team working and team effectiveness
- Improve appraisal completion to support colleagues' development.

3.5 Statement regarding junior doctor rota gaps

The health and wellbeing of the junior doctor workforce is a key priority the Trust aim is to ensure that not only do are there safe and compliant rotas which work for the service, but also rotas that have input from the doctors who are working them, this ensures a well-rounded approach to rota design.

Currently the Trust's rota patterns are created through an electronic system, Allocate e-rota, this ensures that rotas are compliant, however the full rosters are downloaded on to excel spreadsheets and managed this way over the year through the medical rota team, ensuring that the management of rosters is centralised allows the teams to understand the challenges that others are facing and sharing of best practice across all rotas.

Challenges this year have predominately been from the impact of staff absences due to the unpredictability of COVID-19 peaks and variances, absences have been mainly due to staff testing positive, symptomatic staff awaiting PCRs, or being close / household contacts which lead to initial isolation periods of 10 days.

A key rule for the Trust as governed by Health Education England (HEE), and the Director of Medical Education (DME), was that trainees cannot be moved between specialties to cover rota gaps without prior approval from HEE and our DME, this has meant that our trainees have been protected from movement from their allocated specialities.

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

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

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

Junior doctors are encouraged to raise issues and improvement ideas relating to the rota design through a number of channels, such as, through the rota team directly, who have an open door policy, through their senior or through the junior doctor forum.

In order to address rota gaps the Trust plans include:

- Advertising for vacant posts in a timely manner, ahead of the position being vacant.
- Recruitment of temporary locum doctors, for example we have had additional staff in during the pandemic and winter period to limit the impact on our staff.
- Review of skill mix within certain departments, for example the appointment of Advanced Clinical Practitioners (ACPs) and Physicians Associates who are able to undertake duties which may normally be covered by our medical workforce.
- Consideration of recruiting innovative junior doctor Trust roles, for example roles which include a leadership/ quality improvement/ other non-clinical elements to the role.

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

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

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

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

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

	August 21	December 21	April 22
WTE vacant training post (rota gaps)	4	1	2

Rota gaps 21/22

3.6 Statement regarding encouraging staff to speak up

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

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

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

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

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

Freedom to Speak up Guardians do not get involved with investigations or complaints, but help to facilitate the process of raising a concern where needed, ensuring policies are followed correctly and the process of any actions are fair. Feedback and outcomes are given directly to staff who make themselves known and any submitted anonymously will get a return via an auto system unable to show the email address to the Guardians.

Staff can contact the Freedom to Speak up Guardians using a dedicated email address, through the Guardians own email, face to face request or via the portal. All discussion are placed on the portal and can only be seen by the Guardians. The portal supports the anonymised quarterly returns to the NGO.

Concerns are placed into categories and activity is generalised and reported to Board, maintaining anonymity. They discuss patterns, trends and look for solutions and remedies to increase staff support and influence a Culture of 'speaking up'.

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

This year the new portal was created and has improved the reporting and recording mechanism, whilst increasing the anonymity of staff. This enables a Guardian to get back to an individual within 2 working days, either anonymously through the auto return or directly if requested.

We have supported many staff to speak up and successfully improved concerns linked too many categories including safety, process, behaviours and services.

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

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

Annex A: Statement from Council of Governors

The governors of Yeovil District Hospital Foundation Trust recognise the enormous efforts made by all the skilled and dedicated staff to maintain patient safety and standards while trying to keep business as close to normal as possible throughout the pandemic. We are extremely grateful for all that has been achieved through this very difficult time - and usually with a smile.

The governors were very pleased to see the results of the staff survey, again based on a very high rate of return. Staff are pleased to work for the Trust, have confidence in their managers, and feel supported in their work and their well-being.

Throughout the year, governors have been kept fully informed of the work towards the potential merger with Somerset Foundation Trust. We have considered the strategic business case for merger and, working with colleagues from SFT, have had the opportunity to look at a range of work streams and to question the non-executive directors regarding due diligence in the process.

ALISON WHITMAN
Lead Governor

Annex B: Statement from the Somerset Clinical Commissioning Group

July 2022

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Yeovil District Hospital NHS Foundation Trust Quality Account 2021/22

Thank you for sharing the final draft of your Quality Account 2021/22 for the Trust. Please find below the statement of Somerset Clinical Commissioning Group (CCG) for inclusion in your Accounts.

The Quality Account has been shared with key members across the CCG and this response is on behalf of the CCG.

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

NHS Somerset Clinical Commissioning Group is the lead commissioner of health services from the Trust. We welcome the opportunity to provide this statement and comment on your Quality Account 2021/22.

Firstly, we wanted to compliment the Trust on the accessible summary of quality metrics included at the beginning of your Quality Account. This gives a great 'at a glance' overview of how the Trust is performing with regard to both quality and performance.

COVID-19 Pandemic

The Trust should be commended for the continued provision of safe and effective services during Wave 3 of the Covid pandemic, which saw heightened levels of pressure on acute hospital well along with staff sickness. It was reassuring to read that all infection, prevention and control measures remained in place. It was also encouraging to see the Trust were able to continue with participation in national audits during Covid.

As we enter 2022/23, our priorities are focussed on the restoration of planned care services but to also ensure our patients remain safe and well whilst they wait for their planned treatment. As a Somerset system, we acknowledge the great work that is taking place in perioperative care to ensure patients are as fit and well for surgery as they can be. We also recognise the impact that waiting for treatment can have on patients' lives, their families, and their livelihood. It is for this

reason, we are taking into consideration and any underlying health inequalities for those who are waiting for treatment.

Do not attempt cardiopulmonary resuscitation (DNACR) and Treatment Escalation Plans (TEP)

We acknowledge the amount of good work that is taking place across the Trust to learn from deaths and take forward quality improvement initiatives. It was noted in the Quality Account that community DNACRs and TEPs do not always inform the decision to admit or in-patient management plans. We also recognise the support and training you are providing to staff to improve end of life care, as well as the provision of additional on-call support.

It was fantastic that end of life and palliative care specialists have been combined to provide same day discharges despite pressures on nursing home sector. Planning for end of life is a priority for all of us as Somerset system partners and the CCG is keen to work with the Trust to ensure patients have the care and support around them to them to end their life in their chosen place.

Patient Safety

Whilst the current process is to report all incidents via the Trust's incident reporting system, Ulysses, and the reporting staff member identifies whether it is deemed a patient safety incident. Once the Patient Safety Incident Response Framework (PSIRF) is published in early July 2022, it will be good to work as a Somerset system on our quality improvement approach to patient safety incidents and implementation of PSIRF over the next year.

Infection, Prevention and Control

The Quality Account sets out the good compliance against hand hygiene audits and highlights those areas where we as a Somerset system need to focus on reducing community acquired infections. We are taking this quality improvement approach forward through the Somerset Infection Prevention and Control Committee, of which the Trust is an active member.

People with a learning disability

It was good to see the mention of the National Audit of Learning Disabilities (LD Improvement Standards) within your Quality account. It was positive to read the identified areas of focus over the last couple of years. The survey consisted of three parts - Organisational, Staff and Patient feedback. It is good to read the Trust exceeded the National average in some areas, but the staff survey uptake was poor. This could be an area for development in 2022/23.

As a CCG, we have updated our contracts and included the Learning Disability Improvement Standards - https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/ These standards will help us to provide a holistic organisational and system wide approach to improving services for people with Learning Disability and autism.

Safeguarding

We noted the lack of safeguarding practice within the quality Account. The Trust have made significant contributions to the Somerset safeguarding agenda and it would have been good to see some of this work evidenced within the Quality Account.

Patient and Staff Experience

As a Trust you must be proud of the fact that 100% of expectant and birthing parents recommend maternity services to a friend or family member. It was great to see that parents have such a positive experience, particularly as we work through the actions following the publication of the most recent Ockenden report.

We also noted that the Trust has one of the highest response rates for staff survey in the country. We acknowledged that some staff say they feel harassed at work. It would be good to see an action plan that sets out the work the Trust is doing to address this important area.

We believe that the information published in your Quality Account provides a fair and accurate representation of Yeovil District Hospital quality initiatives and activities over the last year.

The Quality Account demonstrates a high level of commitment to quality in the broadest sense and we support the positive approach taken by the Trust and look forward to 2022/23 where we work together as an Integrated Care System on our collective quality priorities.

Yours sincerely

Kathy French
Interim Director of Quality and Nursing
NHS Somerset Clinical Commissioning Group

Annex C: Statement from Dorset Clinical Commissioning Group

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Chief Nurse
Yeovil District Hospital NHS Foundation Trust
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Re: Quality Account 2021/2022

Thank you for asking NHS Dorset Clinical Commissioning Group (CCG) to review and comment on your Quality Account for 2021/2022. Please find below the CCG's statement for inclusion in the final document:

Dorset Clinical Commissioning Group welcomes the opportunity to provide this

statement on Yeovil District Hospital NHS Foundation Trust's Quality Account. We have reviewed the information presented within the Account and can confirm that the report is an accurate reflection of the information we have received during the year as part of limited monitoring discussions due to the COVID-19 pandemic during 2021/2022.

Yeovil District Hospital NHS Foundation Trust's quality and safety priorities for 2021/22 were to continue to focus on preparing and managing the infection prevention and control responsive to the COVID-19 pandemic and the restoration of services, including the recovery of all elective activity. Dorset CCG acknowledges the challenges that responding to the Covid-19 pandemic has presented to quality improvement. It is positive to see, despite this, progress was still made in the identified areas.

The commissioners support the quality priorities from 2021/2022 being carried forward into 2022/2023 and welcome the opportunity to review any additional quality improvement priorities identified as part of the merger transformation programme. We look forward to receiving regular further updates on the progress in these areas, whilst recognising that the NHS faces a challenging backdrop from increased demand alongside recovery of services from the impacts of the Covid-19 pandemic. Dorset CCG/ ICB remains committed to work with Yeovil District Hospital NHS Foundation Trust, over the coming year to ensure all quality standards are monitored.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

Vanessa Read
Director of Nursing and Quality

Annex D: Statement from Healthwatch

Yeovil District Hospital Draft Quality Account 2021/22
Response from Healthwatch Somerset

Healthwatch Somerset welcomes the opportunity to comment on the Yeovil District Hospital NHS Foundation Trust Quality Account for 2021/22. Healthwatch Somerset exists to promote the voice of patients and the wider public with respect to health and social care services. We work with the health and care system to ensure that patients and the wider community are appropriately involved in providing feedback and this is taken seriously when decisions are made about future services.

Like the rest of the country the last two years with Covid has impacted on planned future developments and the hospital is faced with a backlog of patients either awaiting treatment or for consultations. Staff have been under considerable pressure and Healthwatch was pleased to note that they are being supported through the health and well-being hub. This care of staff has been recognised with the Trust being given the NHS Pastoral Award for care of its international staff.

Healthwatch was pleased to see, that despite the pressures on the hospital, there is a clear focus on learning from past incidents. We noted that there has been a significant increase in pressure ulcers compared with previous year. In response to this the Pressure Ulcer Steering Group now meets monthly to review cases and have re instituted staff training. Reasons for this increase in pressure ulcers appear to have been the increased acuity of patients coming into hospital and staffing shortages.

Healthwatch carried out a survey of patients on the impact of longer waits for treatment, as in the rest of the country, this remains a challenge. We noted this has been exacerbated by the lack of ability to discharge patients into appropriate intermediate care provision. Patients waiting more than 104 weeks for treatment are now contacted by the hospital to check if additional support is needed and reassure them they are still on the list.

Nationally there was an unprecedented increase in attendances at A&E departments. In conjunction with the CCG, Healthwatch carried out a survey of patients waiting in A&E to understand the reason for their visit, if not a genuine emergency. We note that The Trust also carries out surveys amongst various users of its services to find out what was good and what needs to be improved.

We noted that Pharmacy services have been developed to include working with community pharmacists to manage medication post discharge. This is of benefit to patients, as they have easy access to community pharmacies for help and advice.

We are pleased to see that the Trust continues to actively engage with its patients, carers and community. The Health and Well-being hub is used to support patients, their carers and families. There appears to be good links with community services. Cancer support drop-in clinics are held regularly and links with Hospice benefit patients, such as how to manage hair loss that may occur through treatment. The Health and Wellbeing department have liaised with a local company and have set up a gym group for patients with a long-term health condition.

We are happy to support the Trust in ensuring that the voices of patients and the community are heard.