Yeovil District Hospital NHS Foundation Trust

Quality Account

2018/19
Part One: Statement on Quality from the Chief Executive of Yeovil District Hospital NHS Foundation Trust on Behalf of the Board

1. Our Vision and Values
1.2 Our Corporate Objectives

Part Two: Priorities for Improvement and Statements of Assurance from the Board

2.1 Quality Improvement Priorities
2.2 Statements of Assurance from the Board
2.3 Mortality
2.4 In Hospital deaths per month
2.5 Hospital Standardised Mortality Rate (HSMR)
2.6 Learning from Deaths
2.7 Safety Thermometer
2.8 Never Events
2.9 Pressure Ulcer Prevention
2.10 Reducing Patient Falls
2.11 Escalation
2.12 Safer Medicines
2.13 Healthcare Associated Infections (HCAI)
2.14 Sepsis
2.15 Neutropenic Sepsis
2.16 Recognition and Rescue of the Deteriorating Patient
2.17 Safe Staffing
2.18 Countywide Psychiatric Liaison Service
2.19 Mental Health First Aid (MHFA)
2.20 Mental Health Commissioning for Quality and Innovation (CQUIN)
2.21 Conflict Resolution
2.22 Patient Engagement
2.23 Patient Feedback
2.24 Patient Experience
2.25 Somerset Academy and Somerset Quality Improvement Faculty
2.26 Seven Day Services
2.27 Discharge Improvement
2.28 Recruitment and Retention
2.29 Doctors in training rota gaps
2.30 Staff Survey 2018
2.31 Participation in National Clinical Audit and Confidential Enquiries
2.32 NICE Quality Standards
2.33 Participation in Local Clinical Audits
2.34 Research and Development
2.35 Commissioning for Quality and Innovation (CQUIN) Payment Framework
2.36 Trust Income against Commissioning for Quality and Innovation Payment Framework
2.37 Review of Our Services
2.38 Registration and Compliance
2.39 National and Contractual Quality Standards
2.40 Data Quality
2.41 Payment by Results (PbR) Audit 2018/19
2.42 Information Governance
Part Three: Other Information

3.1 Patient Safety and Quality Improvement
3.2 Patient Safety Incidents
3.3 Serious Incidents
3.4 Duty of Candour
3.5 Learning into actions
3.6 Preventing Venous Thrombo-embolism (VTE)
3.7 Maternity Safety
3.8 Clinical Effectiveness
3.9 National Paediatric Diabetes Audit (NPDA) – Royal College of Paediatrics and Child Health
3.10 Royal College of Emergency Medicine Audits (RCEM)–Royal College of Emergency Medicine
3.11 National Audit of Care at the End of Life (NACEL) – NHS Benchmarking Network
3.12 National Inpatients Survey 2018
3.13 Patient Feedback, Complaints
3.14 Patient Advice and Liaison Service
3.15 Formal Complaints
3.16 Actions agreed from Complaints
3.17 Patient Feedback Indicators / Patient Surveys
3.18 Friends and Family Test
3.19 Freedom to Speak up
3.20 Conclusion and Independent Auditor’s Report to the Council of Governors of Yeovil District Hospital NHS Foundation Trust on the Quality Report

Annexes:
Annex 1 Statement from the Council of Governors
Annex 1.1 Statement from the Somerset Clinical Commissioning Group
Annex 1.2 Statement from the Dorset Clinical Commissioning Group
Annex 1.3 Statement from the Healthwatch Somerset
Annex 2 Statement of Directors’ responsibilities in respect of the quality report
Our Commitment to Quality

Statement from the Chief Executive

Welcome to Yeovil District Hospital ('YDH') NHS Foundation Trust's Annual Quality Account for 2018/19.

We are required to produce this document each year to set out our performance against a range of measures, and describe the ways in which we have worked to provide the best care for our patients. It's been another busy year for YDH: 47,307 people were admitted to our hospital, and 55,715 people attended our emergency department (A&E). More than 65,762 x-rays, MRIs, and other diagnostic tests and scans were carried out, and in our maternity unit, 1,463 babies were born. Whilst winter always brings additional demand for NHS services, this winter proved exceptional both for the scale of the challenge, and the response of our staff. We're proud of the way in which our organisation responded to the complexities – including access for staff and patients – posed by the severe weather.

Technology remains a core enabler of care in our hospital, with the continued roll-out of TrakCare - our electronic health record.

Our patients are already benefitting directly from the implementation of new technology through the use of digital check-in kiosks, which are reducing delays for patients arriving for appointments.

We have maintained exceptional operational performance throughout the year, ending the year as one of very few hospitals in the England to meet the four-hour waiting-times target for A&E, and the referral to treatment waiting-times target. We also maintained the lowest rate for hospital-acquired cases of C-difficile in the South West.

Ensuring a safe and sustainable workforce remains a priority for the organisation, and during the last year the Trust has been thinking globally and working on behalf of other organisations when it comes to the challenge of nurse recruitment. During a visit to Dubai, the YDH team offered posts to just under 700 nurses, who will join the hospital as well as Trusts in Somerset and beyond. At YDH, these new members of our team will help to fill all of our nursing vacancies.

The results of the 2018 Staff Survey show that the Trust continues to improve and we are above average in virtually every area. Our response rate was 71%, which is the highest of any acute trust in the country. The average was 44%.

Our work with primary care continues, both through our Symphony Programme (an NHS England Vanguard which is developing new approaches to care in South Somerset) and Symphony Healthcare Services (SHS), our GP-practice operating arm. At the time of writing, SHS practices are caring for around 60,000 patients in Somerset and beyond.

I hope you find this Quality Account an interesting and informative read. Whilst it is not intended to provide an exhaustive account of the quality improvement work undertaken in 2018/19, it does articulate our priorities and some of the ways in which we maintained and improved patient care, safety and outcomes last year.

On behalf of Yeovil District Hospital NHS Foundation Trust, I confirm that to the best of my knowledge the information contained within this report is accurate.

Jonathan Higman
Chief Executive
1. **Our Vision and Values**

Continuing to provide high quality clinical care and excellent patient experience remains the Trust’s top priority. We are proud of our iCARE principles, initially developed by our nursing staff, and which now underpin all that we do within the hospital; whether it is providing a life-saving treatment, how staff relate to one another or a warm welcome at reception. The iCARE principles arose from a review of complaints, which identified common issues and which formed the basis of our values:

- i: treating our patients and staff as Individuals
- C: effective Communication
- A: positive Attitude
- R: Respect for patients, carers and staff
- E: Environment conducive to care and recovery

All staff are introduced to iCARE at the Trust Induction Day, where the expectations and standards outlined by iCARE are shared. In addition, the iCARE principles are included in staff appraisals, in job descriptions and are reiterated in policies, procedures and training programmes. The main focus however, is to ensure that these values are evident in our daily work and in our care of patients, their visitors and our staff.

1.2 **Our Corporate Objectives**

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

**Our vision**: To care for you as if you are one of our family.

This is underpinned by a set of strategic priorities:

- Care for our population
- Develop our people
- Innovate and collaborate
- Develop a sustainable system

Our strategic objectives are designed to provide focus on quality, sustainability and delivery across all aspects of the organisation and align with our Quality Improvement Strategy and Safety Improvement Plan.
These objectives align with our Quality Improvement Strategy and will be measured by a defined list of indicators. The quality priorities are derived from reviews of national reports, local issues and challenges, patient feedback and public engagement events. Indicators include:

- Learning from deaths
- Hospital Standardised Mortality Ratio (HSMR)
- Summary Hospital-level Mortality Indicator (SHMI)
- Serious incidents (SI's) including maternity safety
- Patient and staff feedback - Complaints and PALs
- Health Care Associated Infections (HCAI)
- Performance against Commissioning for Quality and Innovation (CQUIN)

Performance against these, as well as our focus for 2019/20 are outlined in this report.

2. Priorities for Improvement and Statements of Assurance from the Board

2.1 Quality Improvement Priorities

YDH prides itself on keeping the quality of care at the forefront of service delivery and will ensure the safety, experience and effectiveness of care is of the highest possible standard. The Trust has focused its efforts on the delivery of key priorities during 2019/20 and will continue to drive forward improvements in these areas. The data presented and the priorities identified for future focus are applicable to the Trust subsidiaries and associated services including Day Case UK.

To identify these priorities we held a number of events to engage with staff, patients and their families including promoting the use of a graffiti wall to capture feedback. Events included participation in National Dying Matters Week, a programme of Health and Wellbeing events, and a countywide ‘Always Event’ where the emphasis is on patient and public participation to design service improvements and ensure elements that are most important to the patient are always included.
The Trust utilises Quality Improvement methodology to measure and drive improvements in the experience, safety and effectiveness of care. This approach, devised by the Institute of Healthcare Improvement, is internationally recognised for supporting the delivery of reliable and consistent change. Members of staff from across the Trust have been trained to use these techniques to deliver improvements for the benefit of patients, families and staff. The Trust has adopted this approach to describe its quality aims and drivers to achieve improvement as summarised by the Driver Diagram. A driver diagram is a visual display of a team’s theory of what “drives,” or contributes to, the achievement of a project aim.
Learning from deaths

Safer Care

Mental Health and Holistic Care

Patient Experience

Right care, Right Time, Right Place

Staff Retention and Wellbeing

Leadership and culture

Our community

Person centeredness

Quality improvement and capability and measurement

Learning systems

Suite of projects

- Culture and teamwork
- Step change in doctor involvement
- Transparency and Duty of Candour
- Organisational communication
- Safe staffing levels

- Staff engagement
- Risk awareness and incident reporting
- Problem Based Learning
- Recognising and responding to deteriorating patients

- Shared decision making
- What matters most to you (personalised care)
- Self-care models
- Person centred training
- Improved communication with patient
- End of Life Care

- Focus on trainees and middle management
- Variety of courses and content offerings
- Data analysis capability and leveraging the electronic patient record
- Real time and prospective quality and safety data
- Consultant level data
- Demand/capacity/Flow measures

- Listening to staff
- Supporting staff when things go wrong
- Integrated Learning
- Clinical standards (NICE, department measures)
- Further develop model of ‘accreditation’ of clinical areas
- Collaborative models with partner agencies

- Theatre culture and efficiency
- 7 day standards
- Structured ward rounds/board rounds/Golden Hour
- Flow, efficiency, transitions, discharge and administrative processes inc. Home First
- Clinical Communication and handover
- Acute Kidney Injury, Sepsis, NEWS2 (National Early Warning system)
- Continue focus on safety (falls and pressure ulcer reduction, safer medicines, HCAIs)
## Priorities and Summary of Performance to Date

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Year-end Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority 1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Learning from deaths</strong></td>
<td>Our Summary Hospital-level Mortality Indicator (SHMI) has remained within the expected range compared with other Trusts at 0.9624 (as at September 2018). Our Hospital Standardised Mortality Ratio (HSMR) is lower than expected rage at 88.6. The Copeland Risk Adjusted Barometer (CRAB) observed/expected ratio for deaths following surgery has remained below the normal ratio of 1.0. We have placed greater emphasis on the actions to address learning from mortality reviews and have implemented the following:</td>
</tr>
</tbody>
</table>
| | • Somerset Treatment Escalation Plan (including resuscitation orders)  
• Advanced Communication Training for senior staff  
• New End of Life Care Plan  
• New Endoscopic Retrograde Cholangiopancreatography (ERCP) care pathway to improve post-operative care  
• LeDeR (Learning Disabilities Mortality Review) reviews are completed and learning from county wide steering group is shared at the mortality review group and Clinical Outcomes Committee |
| **Priority 2** | The Trust reported 63 pressure ulcers (grade 2 and above) in 2018/19 compared with 60 in 17/18. However, this year NHS Improvement (NHSI) instigated recommendations to standardise and streamline definitions of pressure ulcers nationally. Previously a 72hr rule from admission was nationally agreed in terms of defining a community acquired pressure ulcer and thereafter defined as healthcare associated pressure ulcer. The new guidance defines that if the pressure ulcer is not identified on admission then it is healthcare associated irrespective of whether these were identified within 72 hours of admission. This change would reflect the minimal increase in numbers. There continues to be a drive trustwide and within the county through collaborative working to standardise best practice, with a focus around the risk assessment and the implementation of preventative measures in terms of reducing the risk of patients acquiring pressure ulcers. There were 762 inpatient falls compared with 813 in the previous year. 0.5% resulted in moderate or severe harm demonstrating a decrease of |
| **Safer Care** | Continuous reduction in avoidable harm (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of NEWS2, compliance with sepsis CQUIN, SI’s and Never Events, safe staffing). |
0.83%. The rate per 1,000 bed days for 2018/19 was 6.83 which compares to 7.01 for 2017/18.

A total of 692 medication incidents were reported in comparison with 729 for the same period in 17/18.

We commenced implementation of electronic recording of NEWS2 (National Early Warning Score) and actively participated in the National Patient Safety Collaborative focusing on systems to improve recognition and management of deteriorating patients.

No Never Events were reported in 2018/19.

### Priority 3

#### Mental Health and Holistic Care

Increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis, older people) (measured by training compliance - Conflict resolution, Eating Disorders, number of Mental Health First Aiders, establishment of Psychiatric Liaison Pathways).

We trained 32 staff to be Mental Health First Aiders to facilitate early recognition and signposting for staff in need of support.

The Trust achieved a 53% reduction in emergency attendances of the cohort of high impact users identified for the Commissioning for Quality and Innovation (CQUIN) 18/19.

We have worked collaboratively with Somerset Partnership NHS Foundation Trust Psychiatric Liaison Team to ensure early assessment and treatment of those in crisis and requiring specialist support. This includes improvements in policy and practice.

There has been an extension to Child and Adolescent Mental Health Services (CAMHS) to improve access over a wider working day and we have appointed a dedicated CAMHS Complex Care Practitioner to improve care co-ordination between acute paediatric services and CAMHS.

300 staff have received training in conflict resolution during the year.

### Priority 4

#### Patient Experience

Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by adoption of Always Events methodology, complaints, PALS concerns, public engagement events and user engagement in identified work streams).

We collaborated with partners to host the first Always Event to be held as a system and focused on improving the experience of discharge. More than half the 50 attendees were patients and users of services. The event has resulted in a number of initiatives to ensure discharge is a more patient-centered process.

The KO41 health and social care data return reported 89 complaint investigation cases throughout 2017/18 and 65 for 2018/19.

We have noted a continued reduction in formal complaints in favour of a more timely response to concerns reported to PALS.

### Priority 5

#### Right Care, Right Time, Right Place

We continue to participate in all relevant
Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care and in line with the Somerset Clinical Strategy, Fit for My Future (measured by involvement and progress with seven day services compliance, improving discharge, Somerset Sustainability and Transformation Partnership (STP) Programme Boards and work streams, Somerset QI Faculty and Somerset Academy programmes of work).

Somerset Sustainability and Transformation Partnership (STP) programmes of work and have been instrumental in shaping future cohorts of the Somerset Academy.

We achieved compliance with the four priority standards for seven day services and are focused on improving delivery of consultant and daily reviews at weekends.

We secured Academic Health Science Network funding to lead the use of NEWS2 and Situation, Background, Assessment, Recommendation (SBAR) across the acute General Practice (GP) referral pathway for patients requiring admission from care home.

We have led the testing and implementation of Clinical Commissioning Group (CCG) Ultrasound Guidance to improve the quality of requests across the system and reduce unwarranted variation.

<table>
<thead>
<tr>
<th>Priority 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Retention and Wellbeing</strong></td>
</tr>
<tr>
<td>Develop a robust approach to staff retention across all staff groups with a focus on celebrating excellence in practice, promotion of wellbeing support and activities, opportunities for development and career progression within Somerset and across providers (measured by recruitment and retention metrics, staff survey results, delivery of workforce strategies and plans).</td>
</tr>
<tr>
<td>We were the top organisation in the National Staff Survey for staff reported wellbeing and achieved a reduction of 3.3% in Registered Nurse turnover. We were second nationally in the NHS Leadership survey by the National Centre for Diversity. We successfully recruited Registered Nurses from overseas to report 0 we vacancies at year-end. We continue to recruit for 11 other NHS organisations in line with the national workforce strategy.</td>
</tr>
</tbody>
</table>

**Priorities for 2019/20**

In reviewing our priorities and progress against 2018/19 plans, we have considered where further improvement is required and engaged with patients, families and staff to identify areas for particular focus. We continue to focus on the following priorities and have aligned these with those identified by the Taunton and Somerset and Somerset Partnership NHS Trusts Alliance.

<table>
<thead>
<tr>
<th>Priority 1</th>
<th>Learning from Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embed processes where investigation and learning occurs if care concerns have been identified and where these may have led to an adverse outcome for the patient (measured by HSMR, SHMI, SI's, National Audit of Care of the Dying, Mortality and LeDeR reviews).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority 2</th>
<th>Safer Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous reduction in avoidable harm (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of NEWS2, compliance with the Falls, Flu vaccination and Antimicrobial Reduction Commissioning for Quality and Innovation (CQUINs) and incidence of Healthcare Associated and Gram-negative bloodstream infections, SI's and Never Events, safe staffing).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority 3</th>
<th>Mental Health and Holistic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis, older people), ensuring parity of esteem whilst reducing the incidence of violence and aggression against staff (measured by -</td>
<td></td>
</tr>
</tbody>
</table>
Conflict resolution training, CAMHS related incidents, numbers of incidents of violence and aggression, patient experience of those receiving mental health services whilst in an acute setting).

**Priority 4**  
**Patient Experience**  
Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by adoption of Always Events methodology, complaints, Patient Advice and Liaison Service (PALS) concerns, public engagement events and user engagement in identified work streams). Improve the quality of discharge summaries ensuring a patient centred approach to discharge planning and pathways of care.

**Priority 5**  
**Right Care, Right Time, Right Place**  
Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care and in line with the Somerset Clinical Strategy, Fit for My Future (measured by involvement and progress with seven day services compliance, improving discharge, Somerset Sustainability and Transformation Partnership (STP) Programme Boards and work streams, and the Somerset Quality Improvement (QI) Faculty and Somerset Academy programmes of work).

**Priority 6**  
**Staff Retention and Wellbeing**  
Develop a robust approach to staff retention across all staff groups with a focus on celebrating excellence in practice, promotion of wellbeing support and activities, opportunities for development and career progression within Somerset and across providers (measured by recruitment and retention metrics, staff survey results, delivery of workforce strategies and plans). Undertake job planning for Allied Health Professions (AHPs) and Clinical Nurse Specialists in line with NHS Improvement (NHSI) Levels of Attainment and to ensure safe staffing.

Priorities will be monitored and reported to the Governance and Quality Assurance Committee and Trust Board accordingly.

**2.2 Statements of Assurance from the Board**

Progress against the 2018/19 key priorities were monitored via a dashboard presented to the Board and in quarterly quality reports to the Governance and Quality Assurance Committee. The following section outlines the indicators, explaining the rationale for their inclusion and year on year progress against the measures. Further information on some of these indicators is included in Part 3 of this Account.

**Priority 1: Embed processes where investigation and learning occurs if care concerns have been identified and where these may have led to an adverse outcome for the patient (measured by HSMR, SHMI, SI’s, National Audit of Care of the Dying, Mortality and LeDeR reviews).**

**2.3 Mortality**

Throughout 2018/19 the Trust has used the Copelands Risk Adjusted Barometer (CRAB) and Dr Foster to provide outcomes data. The Clinical Outcomes Committee monitors outlier reports and analyses consultant and specialty level data. The mortality data provided by CRAB also informs the regular mortality and morbidity process allowing the team to review records where a risk or trigger has been highlighted.

CRAB analyses data in many ways, using the Trust’s clinical coding information and looking at the reasons for a patient’s death or readmission. The ‘Triggers’ are based on information from the Institute of Health Improvement (IHI) Global Trigger Tool and include:

- Lack of National Early Warning Score (NEWS);
• Shock or Cardiac Arrest;
• Nosocomial Pneumonia;
• Rising Urea or Creatinine;
• Unplanned Transfer;
• Positive Blood Culture;
• Return to Theatre;
• Transfer to Higher Level;
• Fall in Haemoglobin.

The monthly CRAB reports highlight areas or groups of patients where activity is outside of the UK norm for that condition. This indicates that there could be a significantly higher than expected mortality, readmission or complication rate. For teams or procedures where a ‘trigger’ is identified 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.

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

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

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

2.4 In Hospital deaths per month

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 for the timeframe October 2017 – December 2018 is 0.9624 with 1 being the expected norm. (The next data release is not due until June 2019).

The following graph shows risk adjusted mortality data over the last year in patients who have undergone surgery.
15

The normal mortality O/E (observed number of adverse outcomes / predicted number of adverse outcomes) ratio is 1.00. The Trust has remained mainly below this acceptable norm throughout the year with two peaks, one in April and one in December 2018. Drilling down into this data allows the Trust to identify any adverse outcomes and look at these in relation to the volume of procedures performed.

2.5 Hospital Standardised Mortality Rate (HSMR)

The Trust HSMR is 88.6 at the time of reporting and lower than expected range. This favourable position has been ratified 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 patient comorbidities. This situation will be monitored through the Clinical Outcomes Committee on an ongoing basis.

2.6 Learning from Deaths

The National Quality Board published ‘Guidance on Learning from Deaths’ in March 2017 and introduced enhanced reporting of case note mortality reviews. Focus across the Country has been 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 Trust. Data is 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 following graph shows the number of deaths by month and demonstrates national and seasonal trends over the last and this financial year.
During 2018/19 a total of 754 of Yeovil District Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

<table>
<thead>
<tr>
<th>Period</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of deaths</td>
<td>181</td>
<td>182</td>
<td>166</td>
<td>225</td>
<td>754</td>
</tr>
<tr>
<td>No. subject to review using the SJR</td>
<td>51</td>
<td>66</td>
<td>43</td>
<td>7</td>
<td>167</td>
</tr>
<tr>
<td>No. judged to be more likely than not to have been due to problems in the care*</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>% of deaths in the reporting period judged as more likely than not to be due to problems in care</td>
<td>0.55%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0.13%</td>
</tr>
</tbody>
</table>

*This number has been calculated according to the scale contained within the Structured Judgement Review Tool and includes all cases rated 1-3 and includes 1 death as a result of a serious incident.

By 31 March 2019 167 case record reviews and 29 investigations have been carried out in relation to 196 of the in hospital deaths. (26% of all deaths). In no case, was a death subjected to both a case record review and an investigation.

A number of cases are reviewed via speciality Morbidity and Mortality meetings on a monthly basis. These cases are presented at the local Clinical Governance Meetings to share findings and inform improvements in care delivery.

The number of deaths in each quarter for which a case record review or an investigation was carried out is outlined below:
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.

The SJR uses a scale to determine whether care concerns were a contributing factor. The scale is as follows:

Score 1  Definitely avoidable
Score 2  Strong evidence of avoidability
Score 3  Probably avoidable (more than 50:50)
Score 4  Possibly avoidable but not very likely (less than 50:50)
Score 5  Slight evidence of avoidability
Score 6  Definitely not avoidable

In addition, the monthly Mortality Review Group reviews cases where a potential problem in care has been identified and those deaths flagged with four or more triggers identified by CRAB. The Mortality Review Group provides assurance to the Clinical Outcomes Committee which also monitors the outlier reports produced by CRAB. This ensures any issues are identified and enables trust wide learning for improvement.

Serious Untoward Incidents are investigated using methodology based on NHS England’s Serious Incident Framework and using the definition of what constitutes a reportable serious incident.

Learning from Mortality reviews and Serious Untoward incidents throughout the year 2018/19 included:

- The positive impact of active and timely discussion with patients and their families on treatment escalation and resuscitation status. This links with an increased use of Treatment Escalation Plan and Resuscitation Decision Record (TEPDNAR) both within the Trust and in partnership with the community;
- The need to ensure senior staff are equipped with the skills and confidence to have difficult conversations when recognising that patients are likely to be in their last year of life.
The need to ensure patients are placed in wards with appropriately trained and competent staff during times of escalation.

The actions taken in respect of the learning from deaths over the review period included;
- Discussion of cases at local Governance Meetings to inform decision making and learning;
- Commencement of Advanced Communication training for Senior Doctors, Nurses and Specialist staff
- Implementation of a revised End of Life Care plan to ensure symptoms and concerns are recognised and addressed.
- Simulation training with a range of scenarios whereby patients are likely to deteriorate.
- Development of specific care pathways to ensure safe placement of patients requiring post-operative care.

The actions taken have resulted in;
- Planned introduction of the Somerset Treatment Escalation Plan and improved agreements across health care settings to ensure patients receive the appropriate care in the right setting towards end of life;
- Trustwide implementation of an End of Life Care Plan, together with resource folders to improve access to relevant information and staff contacts
- Training of 20 Senior Staff in advanced communications skills are part of an ongoing programme of work

No case record reviews or investigations were completed after 31 March 2018 which related to deaths which took place before the start of the reporting period.

The Coroner can also ask for an investigation relating to the death of a patient. The coroner’s role is to establish the cause of death and ensure that any failure or omission in the management and care of the patient has not contributed to their death. Coroner inquests can result in recommendations within prevention of future deaths notifications; the Trust has not received any of these within the reporting period.

Priority 2: Continuous reduction in avoidable harm (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of NEWS2, compliance with sepsis CQUIN, SI's and Never Events, Safe staffing).

2.7 Safety Thermometer

Developed for the NHS, by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a ‘temperature check’ on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for our patients.

The NHS Safety Thermometer allows the Trust to measure harm and the proportion of patients that are ‘harm free’. Patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps us to measure, assess, learn and improve the safety of the care we provide. The Safety Thermometer allows us to check how many patients in our care have suffered one or more of a defined list of "harms" associated with patient safety. These harms include pressure ulcers and falls. The Safety Thermometer also records if a patient has had a catheter associated urinary tract infection, if they have a Venous Thrombo-embolism (VTE) and if they have been given prophylaxis. The Trust has maintained its Safety Thermometer results above 95% throughout the reporting period with an average of 98% of patients being recorded as harm free in the period 2018/19.
2.8 Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Yeovil District Hospital adheres to the National Patient Safety Agency (NPSA) guidance on the reporting and management of Serious Incidents Requiring Investigation, including Never Events, and the structure and process of a full root cause analysis, as set out in the National Patient Safety Agency guidance, is applied to each case.

The Trust reported no Never Events during 2018/2019.

NATSSIP's - National Safety Standards for Invasive Procedures have now been completed for the Trust and Local Safety Standards for Invasive Procedures (LocSSP's) completed where relevant. These are now available in a number of places on the intranet including the Patient Safety page. These safety standards are embedded in routine clinical practice and are audited on a rolling monthly basis both qualitatively and quantitatively to assure compliance. The Trust is now planning to roll out some of the principles involved in NATSSIP's to a number of other procedures within the trust.

The Trust was also invited to participate in last year’s thematic review by the Care Quality Commission (CQC) into Never Events which was published in December 2018 -"Opening the Door to Change ".

The Trust has a renewed focus on the importance of human factors in team working and focusing on Near Misses to improve quality of care across the Trust.

2.9 Pressure Ulcer Prevention

We continue to follow the national agenda in the reduction of hospital acquired pressure ulcers. This year saw the implementation of NHS Improvement (NHSI) revised definition and measurement document. The purpose of the document is to support a more consistent approach to the definition of pressure ulcers at both local and national levels. This has been successfully rolled out across the Trust within the realms of training and support to the clinical staff.

Following the Trust participation in a national pressure ulcer prevention collaborative led by NHSI, the risk assessment tool was reviewed and replaced with a pressure risk tool, which comprises of six questions in relation to the factors associated with the risk of developing a
pressure ulcer. This facilitates preventative measures to be put in place in a timely manner and had full support from NHSI.

Preventative actions are a key focus in driving improvement and factor within assessment and ongoing care planning. At the end of the year, a total of 63 hospital acquired pressures ulcers (Grade 2 and above) were reported compared to 60 for 2017/18. Whilst this may indicate an increase, the national guidance confirmed a change in definition of hospital acquired pressure damage, thus including all incidents not identified on admission, as being attributable to the Trust. Therefore, this position represents an improvement on previous years’ performance.

2.10 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.

Falls co-ordinators continue to lead a multidisciplinary working group who meet monthly to oversee project work and respond to incidents as they occur. TagCare (a system of ensuring a group of patients who are deemed to be at high of falling are managed collectively by a ward based multidisciplinary team who have line of sight at all times in a bay) and co-horting of patients continues to be used and has become embedded in ward practice, forming part of the daily ward risk assessment and plan of care for high risk patients.

Regular training is offered via short ward based sessions to address preventative practice. In addition, falls training is offered to transition programme candidates (overseas recruits).

We are registered to complete the next phase of National Audit of Inpatient Falls which is focused on hip fractures sustained during an inpatient stay. A repeat internal re-audit of best practice is planned for spring 2019 and will continue to inform the focus of the future Falls work programme in the Trust.

The falls data detailed is extrapolated from the Trust Local Risk Management System (LRMS) which captures all reported incidents of slips, trips and falls. Definitions are in line with national guidance. Levels of harm are calculated using the National Patient Safety Agency (NPSA) risk matrix and in line with national guidance. Data is extrapolated from the LRMS and reported as incidence and rate of falls per 1,000 bed days as detailed below. The rate per 1,000 bed days for 2018/19 was 7.82 which compares to 7.01 for 2018/19.

Overall the number of falls has decreased over the year with the final number for 2018/19 reported as 762 compared with 813 the previous year. This equates to a decrease of 6.2%. The rate of repeat fallers for the year was an average of 13%, compared to 14% in the previous year. Whilst there has been an increase in repeat fallers in the year at times this increase is reflected over the winter months when the Trust was in escalation. Winter plans for 2019/20 will recognise and work to address this increased risk. It is of note that this increase is reflected over the winter months when the Trust was in escalation.
2.11 Escalation

During 2018-19 Financial Year, there were 180 days when escalation beds were in use in the Trust, mainly during April 2018 and between January – March 2019. The ward most commonly used for escalation patients was Jasmine Ward (Open for 100 days in total first in April 2018 and then again during January - March 2019). The use of Jasmine Ward for escalation patients during winter 2018-19 was built into the Winter Plans and staffing planned in advance. Other areas that were used for escalation patients included use of additional opened capacity on Wards 9B, 7A and the Clinical Decision Unit. The opening of the Escalation Area in the recovery area of Day Theatres was minimised in order to reduce disruption to Day Surgery patients and was only open for 25 days mainly in Jan and Feb 2019. There were only 5 Cancelled Operations due to lack of Bed in 2018-19 and these were during the escalation periods in April 2018 and January 2019.

2.12 Safer Medicines

The Trust aims to provide the best possible medicines optimisation and is working together with patients to deliver safer and better outcomes from medicines. We collect meaningful data regarding medication incidents, missed doses, allergy status, medicines reconciliation and high international normalised ratio (INRs) with warfarin. We continue to produce Medication Safety Bulletins which focus on identified risks, with examples of real incidents and clear actions for each healthcare group.

Of the 783 medication incidents reported over the last 12 months, 29.3% reached the patient. While the majority of these errors caused no harm to the patient, the number of incidents reported as “significant” (led to patient harm or required medical intervention) remained low at 2.6% of the total number of reported medication incidents.

The Trust encourages staff members to report all incidents, including those of no harm, to ensure a high level of safety awareness is maintained and to enhance our understanding and learning from near misses.
Although the number of medication incidents reported by YDH staff has increased slightly and the figures remain high during 2018/19 this represents staff groups being encouraged to report all incidents to enhance our understanding and learning.

As stated the number of medication incidents linked to patient harm (or requiring medical intervention) remains low at 2.6%. This compares with data from 2017/18 which shows that 2.0% of all reported medication incidents were linked to patient harm (or required medical intervention).

The Drug and Therapeutics Committee and the Safer Medicines Group were merged during 2017/2018 to form the Trust’s Medicines Committee. This Committee meets bi-monthly with an emphasis on assurance that systems relating to medicines are safe and effective. This assurance is underpinned by the Trust’s new Medicines Optimisation Programme which includes a three year rolling audit plan covering all medication related Patient Safety Alerts to ensure continued compliance with these alerts. The Committee also oversees medicine related incidents, trend analysis and the identification of opportunities for learning; publication of regular medication related safety bulletins; Patient Group Directions (PGDs) and prescribing guidelines; and formulary applications for new medicines.

Pharmacy introduced the Trust’s Medication Safety Assurance Audit, a mock CQC-style inspection concerned with the safe and secure storage of medicines within the Trust. The audit is also used as a tool to monitor for compliance with previous Patient Safety Alerts e.g. the availability of critical medicines and covers all clinical areas which stock medication. A number of key issues have been identified which have been addressed during 2018/2019 including damaged storage cupboards. All findings from the audit are shared with the Ward Matron and are reported to the Medicines Committee for further escalation if needed.

2.13 Healthcare Associated Infections (HCAI)

The implementation and maintenance of robust Infection Control practice remains a key action for the Trust in reducing avoidable Health Care Associated Infections (HCAI). Ensuring Infection Control policies and guidance are in place and implemented, is essential for confidence of all those that use the service and their families. Since 2008 there has been a legal requirement on the NHS and other health and social care organisations to implement the Health and Social Care Act 2008, and to meet the standards The Trust continued to sustain focus and energy on the Infection Control agenda, sharing key learning and best practice against the need for compliance with the HCAI National targets.
NHS Improvement identified the rise in Gram-negative blood stream infections across the healthcare community. This instigated a national ambition to reduce these infections by 50% by March 2021. The Somerset wide multidisciplinary working group has continued to address this and a robust action plan has been followed. Unnecessary catheterisation of patients remained a focus and reduction was seen across the county. As further local target of a 10% reduction across Somerset within the 17/18 financial year was set.

The target for YDH was 19, this year ended with a YDH total of 23 - the same as 2017/18.

The process involves a Post Infection Review (PIR) to identify learning and any focused improvement work required. This is reported under the heading of ‘lapse in care’ Following review of the cases, no lapses in care were identified to date.

This data is reported locally to the Patient Safety Steering Group and Somerset CCG. We are also required to report this nationally via HCAI Data Capture System Mandatory Surveillance run by Public Health England.

2.14 Sepsis

Sepsis recognition and treatment at Yeovil Hospital continues to be an area of high importance. The screening tools and Sepsis 6 pathways that have been implemented are used in all areas and audited monthly. All life support courses delivered to clinical staff incorporate the recognition of Sepsis and the delivery of the Sepsis Six, a bundle of 6 measures that if all done within 1 hr of the recognition of sepsis have been shown to reduce mortality and morbidity significantly. Sepsis Star badges and certificates are awarded to staff that have proven to be instrumental in the delivering of the Sepsis 6 within 60 minutes. Using this simple positive feedback has generated a real eagerness for staff to deliver the treatment required in a timely manner for the benefit of the patients; we are now supplying Sepsis Stars to 16 other NHS Trusts in England.

It has been recognised locally and nationally that some patients present to medical help too late due to a lack of awareness of Sepsis, meaning that despite the best efforts of the staff, sometimes there is nothing that can be done for these patients. In response to this we have commenced a public awareness campaign including the development of the Sepsis Lift in the main lift area, the graphics prompt people to ask the question ‘Could this be Sepsis?’ We are also working with local community services and delivering sepsis awareness sessions in the community.

Another issue that is becoming more apparent since awareness of sepsis has increased is the long term consequences that some patients suffer, these can manifest as physical, psychological or emotional problems, or a combination of them all. With the support of the UK Sepsis Trust and in collaboration with other Trusts we have set up the Somerset Sepsis Support Group that rotates monthly between Yeovil District Hospital, Taunton & Somerset, Weston General Hospital and now Somerset Partnership. These meetings are open to all who have been affected by sepsis and have been well evaluated by those that have attended.

The Trust collaborates closely with other organisations including the Somerset Clinical Commissioning Group Sepsis Working Group, with colleagues from across the county in primary and secondary care, and also links regionally and nationally by way of the South West Sepsis Forum and the National Sepsis Practitioner Forum, and the South West Academic Health Science Network (AHSN).

Please see below for the Sepsis audit results for Q1-Q4.
2.15 Neutropenic Sepsis

Neutrophils respond early to injury or infection. They have a role in both directly killing non-host cells such as bacteria by phagocytosis and activating other parts of the immune system. Cytotoxic anti-cancer chemotherapy is designed to kill neoplastic cells by damaging the DNA irreparably. For most chemotherapy regimens, the neutrophil count falls to its lowest level approximately 5-7 days after administration and can take up to 2-4 weeks to recover, although for some drugs, these timescales are considerably different. Novel biological agents generally have a lower rate of neutropenia but, such problems can still occur.

When neutropenic, the patient is vulnerable to infection this can potentially cause overwhelming sepsis and death. Deterioration can be very rapid, sometimes without an obvious focus for infection. Reported mortality for untreated neutropenic sepsis ranges from 2 to 21% but is poorly reported nationally. Neutropenic sepsis is therefore considered a medical emergency, and as with severe sepsis, there is widespread agreement that early administration of broad spectrum antibiotics is key to successful management.

Patients starting chemotherapy have historically always had a pre-chemotherapy education session which included the signs of Neutropenic Sepsis and what to do if they occurred. From May 2018 Neutropenic Sepsis Alert cards were developed and given to patients along with this session including the warning signs and information for admitting departments. A Neutropenic Sepsis Screening and Action tool has been implemented for both Ambulatory care and the Emergency department over the last 2 months (Q3/4) to help identify and treat these patients more promptly. Our audit results for ‘Door to Needle time’ in suspected neutropenic sepsis have improved month on month during the 2018/19 period with the implementation of the above along
with an increase in staff teaching sessions. In Q1-Q3 we on average achieved 56%, 68% and 77% respectively. This continued to improve with an average result in Q4 of 90%.

2.16 Recognition and Rescue of the Deteriorating Patient

A part time Simulation Fellow post was introduced at Yeovil District Hospital in February 2016/17 with the aim of establishing multi-disciplinary simulation teaching programmes to reduce incidents of failure to detect, communicate or respond to deterioration.

Simulation teaching allows our staff to train in a safe and supportive environment. In situ simulations have the added benefit of testing systems. There has been a dramatic increase in simulation in the medical undergraduate/post graduate programmes. With this increase in demand the Simulation Fellow post was made full time in December 2018.

Simulation at YDH includes the delivery of the following;

- Ward based simulations adult and paediatric;
- Simulation is embedded into F1/F2 doctor teaching on a weekly basis
- Undergraduate teaching programmes, all years
- Real time trauma/emergency simulations in our Emergency Department
- Real time maternal simulations
- Operating department simulations
- Development of end of life simulations to aid our staff with difficult conversations
- A Dr "on-call" Simulation to help our new Doctors familiarise with our systems

In line with the Trust’s strategic priorities to innovate and collaborate we are taking simulation to our primary care colleagues. The programme, funded through a successful bid to Heath Education England, will focus on the deteriorating patient in the community setting. This includes nursing homes and GP surgeries. A key aspect will be the introduction and implementation of NEWS2, which advocates a system to standardise the assessment and response to acute illness. This will aid communication and escalation between all health care providers.

2.17 Safe Staffing

In 2013 the National Quality Board set out key expectations that have provided the Trust with a framework with regards to safer staffing. In July 2016 the National Quality Board published a document to build on this guidance and to support the Five Year Forward View of planning and delivering services in ways that improve quality and reduce avoidable costs underpinned by the following two principles:

- A specific piece of work has been undertaken with junior doctors to improve staffing levels;
- Access to clinical support services and processes for handover to address areas for improvement.

**Right Care** - Doing the right thing the first time in the right setting and ensure that patients get the care that is right for them avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.

**Minimising Avoidable Harm** - A relentless focus on quality based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm and reduce costs associated with litigation.

**Maximising the Value of Available Resources** - Providing high quality care to everyone who uses health and care services requires organisation and health economies to use the resources in the most efficient way for the benefit of their community.
In addition, the Lord Carter Report (2016) and the NHS Five Year Forward View Planning Guidance (2014) make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. Lord Carter’s report recommended a new metric, care hours per patient day (CHPPD), which the Trust now reports on monthly. Carter also recommended a development of a model hospital so that Trusts could learn what ‘good’ looks like from other Trusts and adopt their best practice. Dashboard data is being used to inform the focus on improvement.

As a Trust we are required to ensure that there is sufficient sustainable staffing capacity and capability to provide safe and effective care to patients at all times. During 2018/19, we have undertaken an audit of adult inpatient wards using the Safer Nursing Care Tool and identified the need to increase the whole time equivalent numbers of staff on four wards, 7A (Surgery), 8A (Cardiology), 9A (Respiratory/Endocrinology) and 9B (Gastroenterology). Additional funding has been secured from the STP to staff these wards as indicated by the increased acuity of the patients. Recruitment is underway to fill these additional posts.

The Trust has implemented twice daily acuity scoring on all adult wards to inform safe staffing decisions at the Patient Flow meetings. The SafeCare module of the e-roster (electronic staffing) system has been deployed to ensure robust audit supports professional judgement when making decisions about staffing levels. A Safe Staffing policy has been ratified to support a risk based approach and to ensure director level approval of high cost agency requirements.

Nursing staff are deployed in ways that ensure that patients receive the right care first time in the right setting, with all wards using an e-rostering system which ensures flexible working to meet patients’ needs and making best use of resources across the 24 hour period. Allocation of staff is considered according to the acuity of the patients, staffing levels and skill mix of registered and unregistered staff.

The organisation is committed to investing in new roles and was successful in being a Fast Follower for the Nursing Associate pilot with candidates who commenced in post April 2017. The first cohort of trainees is due to qualify in April 2019 and will join the Nursing and Midwifery Council (NMC) register in June 2019. A further two cohorts are in training. Quality Impact Assessments have been completed, in accordance with National Quality Board and NHSI Developing Workforce Safeguards guidance, where new roles or skill mix reviews have been implemented.

Actions to address nursing gaps include assessment of workload and patient acuity. We use; The SafeCare Model of our e-roster system and senior professional judgement to review the skill mix and requirements to meet the minimum staffing levels. To secure additional temporary staff we also look at the internal redeployment of staff working in other areas but with transferrable skills and knowledge, and escalation, in accordance with the Trust Safe Staffing policy.

Priority 3: Increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis, older people) (measured by training compliance - Conflict resolution, Eating Disorders, number of mental health first aiders, establishment of Psychiatric Liaison pathways).

2.18 Countywide Psychiatric Liaison Service

The Countywide Psychiatric Liaison Service has been in place since the beginning of the financial year. The service is funded by the Somerset Clinical Commissioning Group (CCG). The service has developed iteratively to embed a system and process to ensure rapid assessment, provide appropriate intervention and timely discharge of patients presenting with physical and mental health needs.

YDH contributed to a Rapid Improvement Event facilitated by NHS England that considered Children and Young People experiencing a delay in discharge / transfer of care. This led to a number of work streams such as the development of a draft joint protocol for children and young people who present to the Emergency Department with a mental health need or are known to
children social care and further implementation of the deliberate self harm protocol and guidelines to be used across the county, this work is ongoing.

Additional investment has been made to extend Somerset Partnership’s delivery of on-site CAMHS support to extend opportunities for initial assessment, intervention and appropriate discharge until 20:00hrs Monday – Friday in addition to off-site out of hours support. Challenge remains in recruiting to these posts to ensure a robust and reliable service is provided, locally. In Quarter 4, the Sustainable Transformation Programmes Board approved additional funding for the CAMHS Complex Care Practitioner and the Trust recruited to a Band 6 post for an initial period of one year. The post holder, Paediatric Service and Emergency Department will continue to work collaboratively with Somerset Partnership NHS Foundation Trust to deliver continuous improvements for children and young people with mental health needs. Paediatric staff continue to support the County wide Eating Disorder pathway.

2.19 Mental Health First Aid (MHFA)

In April 2018 the Trust Mental Health Lead carried out the Mental Health First Aid (MHFA) Train the Trainer course which was funded by NHS Improvement. This course provides staff with the knowledge and skills to be competent in dealing with patients and/or staff who are experiencing a mental health crisis.

2.20 Mental Health Commissioning for Quality and Innovation (CQUIN)

A considerable amount of work has continued as a result of the Mental Health CQUIN in the year to develop co-designed management plans for high impact users in the Emergency Department. The Trust achieved a 53% reduction in attendance of this cohort of patients at the end of Quarter 4.

2.21 Conflict Resolution

300 staff received training in conflict resolution during the year.

Priority 4: Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by adoption of Always Events methodology, complaints, PALS concerns, public engagement events and user engagement in identified work streams).

2.22 Patient Engagement

The Trust has a valued and responsive Patient Experience Team who 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, Head of Patient Experience Network, Somerset Engagement and Advisory Group, Somerset Carers Voice group, Somerset Gypsy and Traveller Forum, Equality and Diversity Forum, Learners Engagement for Patient Flow, Sparks Talking Café, Autism and Learning Disabilities workshop, and continues to develop an ever increasing network.

The Patient Experience and Engagement Lead provides a calendar of events, which includes all community support groups and support within the trust. The first Esther café event was held in January 2019 regarding end of life care, where patients and or family members can share experiences with clinical and other staff. Ward Staff and a Governor were able to attend to listen to the relative’s story. Feedback was very positive and staff felt they would be able to alter some of their practice so that it was more patient focussed and everyone identified that communication was key.

The Patient Voice group (a group of volunteers) provides an opportunity for the organisation to test the learning and actions arising from complaints. The Chair of this group works closely with
the Patient Experience and Engagement Manager to agree monthly observations and audit. Information from these observations has provided valuable feedback from patients regarding the quality of discharges from hospital.

2.23 Patient Feedback

The Friends and Family test is captured using an online system called "IwantGreatCare". ‘IwantGreatCare’ this allows the Trust to listen to patients. Feedback is captured at ward and department level and the system has enabled staff to capture feedback at individual clinic level.

During March 2019, the FTT survey was tested with an in house system on one ward, and managed via the SNAP survey software. This was successful, therefore the survey will move to be completely in house as of April 2019, with a focus on encouraging and improving feedback from our patients so that we can make any necessary changes. In addition business cards have been developed allowing patients to complete the survey when they return home, volunteers have agreed to help by distributing these when they are present on the wards. Posters have been developed advertising the survey and encouraging patients to leave any feedback.

2.24 Patient Experience

The Complaints and PALs process has been reviewed in the year. Recognising opportunities for efficiencies. All complainants are now offered an early intervention contact to discuss the concerns early and to agree expected outcomes and time frames for any investigations. This has led to more timely closure of investigations with some cases being closed after the early intervention meetings. All complaint responses now 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 to provide assurance to complainants that by making a complaint, improvements have been identified. These actions are monitored at an operational level via the electronic complaints system by the Ward Sister and Matrons to ensure compliance. The actions and themes are also monitored at the Patient Experience and Engagement Steering Group.

Priority 5: Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care and in line with the Somerset Clinical Strategy, Fit for My Future (measured by involvement and progress with seven day services compliance, improving discharge, Somerset Sustainability and Transformation Partnership (STP Programme Boards and work streams, Somerset QI Faculty and Somerset Academy programmes of work).

2.25 Somerset Academy and Somerset Quality Improvement Faculty

The Trust has actively participated in the development of the next cohort of the Somerset Academy to ensure that delivery of transformative service development, to inform and shape future joint commissioning, is explicitly linked to Sustainable Transformation Programmes priorities and Fit for My Future, the Somerset Health and Care Strategy.

The Somerset Quality Improvement Faculty has been strengthened with additional membership from Primary Care and the Trust has led on a number of Quality Improvement Projects including implementation of a countywide Ultrasound guideline to improve the quality of diagnostic requests and timeliness of provision, and the introduction of NEWS2 and sepsis screening in the GP Emergency Medical Referral pathway. The projects continue at the time of reporting.

2.26 Seven Day Services

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.
There are ten clinical standards for seven day services in hospitals which were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Clinical Standard 2  –  Time to first consultant review;
- Clinical Standard 5  –  Access to diagnostic tests;
- Clinical Standard 6  –  Access to consultant-directed interventions;
- Clinical Standard 8  –  Ongoing review by consultant twice daily if high dependency patients, daily for others.

27 trusts across England were early adopters of the four priority clinical standards and were working towards implementing the standards by April 2017. Yeovil District Hospital was in the second wave of implementation and has been working towards achieving the four priority standards by April 2018. All trusts are expected to meet the priority standards by 2020. This will ensure patients:

- Don’t wait longer than 14 hours to initial consultant review;
- Get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour;
- Get access to specialist, consultant-directed interventions;
- High-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

In spring 2018 the Trust audited 143 sets of notes against the four core standards, the results are shown below:

<table>
<thead>
<tr>
<th>CS2</th>
<th>CS5</th>
<th>CS6</th>
<th>CS8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to first consultant review;</td>
<td>Access to diagnostic tests;</td>
<td>Access to consultant-directed interventions</td>
<td>Ongoing review by consultant twice daily if high dependency patients, daily for others.</td>
</tr>
<tr>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Standard 2 is the only standard measured across the year as follows:

<table>
<thead>
<tr>
<th>Survey</th>
<th>September 2016</th>
<th>March 2017</th>
<th>September 2017</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients reviewed by a consultant within 14 hours of admission at hospital</td>
<td>92%</td>
<td>89%</td>
<td>70%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Note: Methodology changes between September 2016 and March 2017 mean that data may not be 100% comparable between the two surveys. The changes relate to the validation of data entered – the 2017 survey requires each entry that has a validation error to be corrected before it is possible to submit the record.
Work that has been undertaken:

- Budgeting for an eighth general surgeon
- Pathways are under development for emergency surgery ambulatory care and ED
- The scheduling of CEPOD (a permanently staffed operating theatre that can run on a 24 hour basis) sessions has been reviewed
- Working with the Deanery to improve junior on-call at night from August 2019
- Increased use of the Model Hospital to identify areas of variation for length of stay
- Job plans in gynecology were changed to ensure twice daily ward rounds.
- Seven day Gynecology Assessment Unit, embedded ensuring that patients see a consultant or middle grade as part of the admission and a standard operating procedure is being developed to formalise this pathway
- There are ongoing discussions at Somerset Sustainability and Transformation Partnership (STP) level regarding the future provision of paediatric services across Somerset, this includes how seven day services can be sustainably provided

2.27 Discharge Improvement

Throughout the year the Trust has worked collaboratively to improve discharge this work is being managed and monitored by a QI task and finish group. This will continue and is focused around the following workstreams:

- Development of a discharge checklist that is being trialed, the aim is to standardise documentation and ensure all key elements of a successful discharge are considered.
- Development of a patient information leaflet and resource folder with key information, supporting patients and families to prepare for discharge.
- Successful introduction of ward based dispensing, which has demonstrated a significant reduction in the time taken to dispense ‘tablets to take out’
- Increasing the number of non-medical prescribers and nurse transcribers to improve the process and content of discharge summaries
- Discharge summary review of content, and the process for timely completion and sharing with relevant others

Priority 6: Develop a robust approach to staff retention across all staff groups with a focus on celebrating excellence in practice, promotion of wellbeing support and activities, opportunities for development and career progression within Somerset and across providers (measured by recruitment and retention metrics, staff survey results, delivery of workforce strategies and plans).

2.28 Recruitment and Retention

In August 2017 we began working on an extensive action plan with the target of reducing our turnover. The work covered many actions in the following headings: Culture and Leadership, Personal and Career Development, working environment, Engagement and communication, recruitment and Health and Wellbeing. This has led to a 3% decrease in our turnover within 12 months.

The chart below details quarterly turnover rate for Registered Nurses and Midwifery staff at Yeovil District Hospital NHS Foundation Trust and our region/sector average. The grey solid line is our planned improvement trajectory.
2.29 Doctors in training rota gaps

In August 2018 there were 7 vacant training posts (Rota Gaps): 7 x F2 doctor posts. In September 2018 this increased to 10 vacant training posts adding 2 x ST4 Paeds, 1 x ST3 Gastro.

Rota gaps occur due to the Deanery being unable to fill their posts nationally and supply Doctors to the Trust.

When the deanery completes their national recruitment any posts they fail to fill are highlighted to trusts for them to complete recruitment at trust level.

In order to make the posts at YDH more attractive we are redesigning rotas and ensuring those recruited at trust level are able to access the same training opportunities.

2.30 Staff Survey 2018

The results of the 2018 Staff Survey show that the Trust continues to improve and we are above average in virtually every area. Our response rate was 71%, which is the highest of any acute trust in the country. The average was 44%.

We are also the best Trust in the country for staff health and wellbeing, and we are in the top 20% of NHS Trusts for a number of other important areas:

- Diversity and inclusion
- Support from managers
- Staff morale
- Safety of the hospital environment
- Bullying and harassment
- Staff Engagement
Headline results show us that:
- 65% look forward to coming to work (average 58%)
- 79% are able to suggest improvements (average 74%)
- 78% feel supported by their manager (average 69%)
- 78% feel valued (average 71%)
- 95% feel YDH takes positive action on H&WB (average 89%)
- 70% recommend YDH as a place to work (average 60%)
- 74% would recommend YDH as a place to receive care (average 68%)

However, there are some things we still need to improve on:
- 21% experienced violence from patients (average 15%)
- 79% have had an appraisal (average 87%)

We are determined to continually improve and make Yeovil Hospital an ever better place to work, and to support this we have put in place many organisational development programmes. Two key programmes have focused on developing Health & Wellbeing initiatives, and investing in our leaders to help them improve their management skills and become even better at supporting and developing their people.

The survey results have been shared with staff, and we are involving them in developing improvement plans to make Yeovil Hospital a fantastic place to work and receive care.

2.31 Participation in National Clinical Audit and Confidential Enquiries

During 2018/19 there were 39 national clinical audits and 5 national confidential enquiries that covered relevant health services that Yeovil District Hospital provides. During that period Yeovil District Hospital participated in 95% of relevant national clinical audits and relevant 100% national confidential enquiries of those in which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Yeovil District Hospital participated in and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to the audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>National Clinical Audit Title and Provider Organisation</th>
<th>Cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Ischaemia National Audit Project (MINAP) National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>National Heart Failure Audit National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease Programme/IBD Registry Inflammatory Bowel Disease Registry</td>
<td>730 – in process of populating registry retrospectively</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) Royal College of Physicians</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme British Thoracic Society</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia British Thoracic Society</td>
<td>All eligible patients</td>
</tr>
<tr>
<td>Non-invasive Ventilation – Adults British Thoracic Society</td>
<td>All eligible patients</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme NHS Blood and Transplant</td>
<td>100% minimum requirement</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT) UK National Haemovigilance</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>National Diabetes Audit – Adults (NDA)</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>Organisation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>National Pregnancy in Diabetes Audit (NPID)</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>National Paediatric Diabetes Audit (NPDA)</td>
</tr>
<tr>
<td>Royal College of Paediatrics and Child Health</td>
<td></td>
</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>Cystic Fibrosis Trust</td>
<td></td>
</tr>
<tr>
<td>National Audit of Seizures and Epilepsies in Children and Young People</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>Royal College of Paediatrics and Child Health</td>
<td></td>
</tr>
<tr>
<td>National Neonatal Audit Programme</td>
<td>Continuous audit of all eligible patients</td>
</tr>
<tr>
<td>Royal College of Paediatrics and Child Health</td>
<td></td>
</tr>
<tr>
<td>NHS England</td>
<td>Seven Day Hospital Services</td>
</tr>
<tr>
<td>University of Bristol Norah Fry Centre for Disability Studies</td>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
</tr>
<tr>
<td>British Society for Rheumatology</td>
<td>National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis</td>
</tr>
<tr>
<td>Royal College of Psychiatrists</td>
<td>National Audit of Dementia</td>
</tr>
<tr>
<td>NHS Benchmarking Network</td>
<td>National Audit of Care at the End of Life (NACEL)</td>
</tr>
<tr>
<td>Royal College of Obstetricians and Gynaecologists</td>
<td>National Maternity and Perinatal Audit (NMPA)</td>
</tr>
<tr>
<td>MBRRACE-UK, National Perinatal Epidemiology Unit</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
</tr>
<tr>
<td>Intensive Care National Audit and Research Centre</td>
<td>National Cardiac Arrest Audit</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>National Joint Registry (NJR)</td>
</tr>
<tr>
<td>Healthcare Quality Improvement Partnership</td>
<td>National Ophthalmology Audit</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>National Oesophago-gastric Cancer Audit</td>
</tr>
<tr>
<td>Royal College of Gynaecologists</td>
<td>National Bowel Cancer Audit</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>National Lung Cancer Audit</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>National Prostate Cancer Audit</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>National Breast Cancer in Older People</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>National Audit of Breast Cancer in Older People</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine</td>
<td>Vital Signs in Adults Audit</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine</td>
<td>VTE Risk in Lower Limb Immobilisation</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine</td>
<td>National Audit of Breast Cancer in Older People</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine</td>
<td>National Prostate Cancer Audit</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>National Bowel Cancer Audit</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>National Oesophago-gastric Cancer Audit</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>National Lung Cancer Audit</td>
</tr>
<tr>
<td>Royal College of Physicians</td>
<td>National Prostate Cancer Audit</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>National Breast Cancer in Older People</td>
</tr>
</tbody>
</table>
During 2018/19 the Trust was eligible to enter data into the following 5 NCEPOD studies:

<table>
<thead>
<tr>
<th>Study Name</th>
<th>Cases Included</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer in Children and Young Adults</td>
<td>0</td>
<td>Awaiting report</td>
</tr>
<tr>
<td>Perioperative management of surgical patients with diabetes</td>
<td>6</td>
<td>Report disseminated for review</td>
</tr>
<tr>
<td>Pulmonary Embolism Study</td>
<td>3</td>
<td>Awaiting report</td>
</tr>
<tr>
<td>Acute Bowel Obstruction Study</td>
<td>6</td>
<td>Awaiting organisational questionnaire to complete</td>
</tr>
<tr>
<td>Long-term Ventilation Study</td>
<td>0</td>
<td>Awaiting organisational questionnaire to complete</td>
</tr>
</tbody>
</table>

### 2.32 NICE Quality Standards

All new guidance issued by the National Institute for Health and Care Excellence (NICE) is reviewed by the Clinical Governance audit team before being distributed to clinicians for assessment of Trust compliance.

NICE Quality Standards are designed to drive quality improvement and are derived from NICE Guidance and other evidence sources accredited by NICE.

The following table shows the quality standards issued and the Trust’s position in respect of compliance with those that are applicable.

<table>
<thead>
<tr>
<th>Guidance</th>
<th>Number published – Total No.(No. during 2018/19)</th>
<th>Fully Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Standards</td>
<td>161 (16)</td>
<td>61</td>
</tr>
</tbody>
</table>

Quality Standards that are partially compliant include:

**NICE Quality Standard 33 – Rheumatoid Arthritis**

National audit results highlight the following two areas for improvement: People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, are referred to a rheumatology service within 3 working days of presentation. People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral.

**NICE Quality Standard 56 – Metastatic Spinal Cord Compression (MSCC)**

Local audit results highlight the following area for improvement: Adults with suspected MSCC who present with neurological symptoms or signs have an MRI of the whole spine and any necessary treatment plan agreed within 24 hours of the suspected diagnosis. Patients admitted out of hours, over the weekend, are transferred to another hospital.

**NICE Quality Standard 104 – Gallstone Disease**

There is full compliance with this standard except in the following area when it is sometimes not met: Adults with acute cholecystitis have laparoscopic cholecystectomy within 1 week of diagnosis.
Action Plan – Measures to meet recommendation ambulatory care, acute surgical pathway and the appointment of an eighth consultant.

**NICE Quality Standard 105 – Intrapartum Care**

Local audit results highlight the following area for improvement: Women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes.

Action Plan – Review information provided at booking. Create a handout / text message / internet link about the local provision for the four places of birth and about our key outcomes to women which is updated every quarter.

**NICE Quality Standard 125 – Diabetes in Children and Young People**

There is full compliance with this standard except in the following area when it is sometimes not met: Children and young people with type 1 diabetes who have frequent severe hypoglycaemia are offered ongoing real-time continuous glucose monitoring with alarms.

Action Plan: Continuous glucose monitoring if recommended has to be funded by patient. Negotiations are taking place jointly with Musgrove Park Hospital to produce funding criteria in line with the NICE Guidelines.

**2.33 Participation in Local Clinical Audits**

A total of 101 local clinical audits and surveys were registered in Clinical Governance during 2018/19. The reports of 39 (39%) completed local clinical audits were reviewed by the provider in 2018/19 and Yeovil District Hospital intends to take the following actions to improve the quality of healthcare provided.

**Re-audit of CT Reporting Time in Head Injury**

The aim of the audit is to determine the time duration from the CT scan acquisition to the provisional or final report available on the Primary and Acute Care Systems (PACS) and whether it is in accordance with NICE guidelines. NICE recommends – a provisional radiology report should be made available within 1 hour of the scan being performed.

Key findings:
- Out of the 79 CT reports, 76 were reported within one hour which corresponds to 96.2% following the NICE guidelines.
- There is significant improvement in the reporting time as compared to previous study 88% though the target was not achieved.

Action plan:
- Presenting this audit in clinical group meeting
- Discussions with all CT reporting radiologists
- Re-audit in 3-6 months’ time

**Re-audit of thyroid U scoring and subsequent fine needle aspiration cytology (FNAC)**

The aim of the audit is to determine whether ultrasound reporting and treatment meets the British Thyroid Association (BTA) guidelines 2014 that recommend all thyroid ultrasounds include a U-score. U1 - U2 should not have FNAC. U3 - U5 nodules should have FNAC.

Key findings:
- There is significant improvement in the quality of ultra-sounding (US) Thyroid reporting by 100% mentioning on U scoring as compared to previous data of 82% and there is subsequent FNA procedure for 98% of the cases with indeterminate nodules.
Action plan:
- Email this re-audit to all the radiologists and sonographers who are performing US thyroids
- Presentation and discussion in upcoming clinical governance

**Cystistat/Ialuril Audit**

The aim is to review the pathway of care for this group of patients to ensure best practice by increasing self-care and education before invasive treatments are considered and ensure regular reviews. This should provide a cost saving due to reduction of expensive intravesical treatments currently being offered as first line treatments.

Recommendations:
- All Patients referred to the Clinical Nurse Specialist should be seen for lifestyle advice and education before starting invasive treatments
- A local agreement should be made as to what first line treatments are available before starting second line treatments such as cystistat and ialuril
- Patients should be reviewed at least yearly by a urologist to agree that treatment should continue and discuss alternative options
- All patients should be offered the option of self-administration if appropriate

Action plan:
- Present findings to urology team for feedback and to agree new pathway
- Re audit in 12 months
- Provide a patient education document at diagnosis to empower patients to self-manage their condition

**Emergency Admission Audit**

The aim is to assess compliance with national guidance on medical review of Emergency admissions in Obstetrics and Gynaecology departments within a specified time period. To oversee the development of standards and care pathways for patients with emergency care needs and to ensure uniform adoption of best practice.

Key findings:
- The performance level in the management of emergency admissions in Obstetrics and Gynaecology at YDH has significantly improved following the implementation of changes in the clinical practice, which reflects enhanced service provision and better patient outcome

Action plan:
- Further audit required to ensure the target of 100% is met by March 2020

**Delirium and sedation on the Intensive Care Unit Audit**

The aim is to review current practice on the Intensive Care Unit with local guidelines.

Key findings:
- Areas for improvement were identified including training and review of protocols

Action plan:
- Education of nursing and medical staff:
- Importance of appropriate sedation
- RASS to be prescribed on morning round
- RASS documented every hour
- Increasing frequency and documentation of sedation hold
- Importance of CAM-ICU
- Update of delirium and sedation protocols:
- Change sedation to include pain scores / remove cooling / to start music therapy
- Ensuring easy access of protocols on ICU and via intranet
- Re-audit in 2019
Appropriateness of usage of Computerised Tomography Pulmonary Angiogram (CTPA) investigation of suspected pulmonary embolism Audit

The aim of the audit was to assess, when being used as the primary imaging investigation, whether CTPA was being used appropriately and also to look at the diagnostic yield of CTPA scans in terms of pulmonary embolism and alternative diagnoses. Key findings and actions taken:

- Discussing with the referring doctors the results of this audit, especially ED doctors (since most requests are from the ED team);
- Presenting the Audit results in the Hospital’s Physicians Clinical Governance meeting if possible and making them aware of the importance of adhering to the referral protocol and clear documentation on the request cards;
- Ensure all patients should have chest radiographs prior to justifying a CTPA request;
- Clear documentation of whether local referral protocol is being adhered to.
- Discussion of which is the best way to achieve this.
- Where receiving referral – ask clinician about the WELLS score (VTE Risk tool) and D-dimer (blood test) if available and document on the requesting card.

Safety and efficacy of Apremilast in treating psoriatic arthritis Audit

The aim of the audit was to assess the safety and efficacy of Apremilast in treating psoriatic arthritis (NICE Technology Appraisal Guidance 433).

Key findings and actions taken:

- Identify patients with psychiatric co morbidity before starting Apremilast;
- Inquire about their physical and psychological wellbeing while being on Apremilast during clinical consultation;
- Ensure drug compliance by reducing delay in drug delivery;
- Audit presented at Rheumatology Multidisciplinary team meeting.

The safety of Xen implant for managing advanced glaucoma Audit

The aim of the audit was to ensure clinical safety and efficacy of a new treatment used in the department for advanced glaucoma. (NICE Interventional Procedures Guidance 575).

Key findings and actions taken:

- The Xen audit showed that the procedure was safe and reliable with good outcomes compared to comparative data. No actions required. Abstract submitted and accepted by the College of Ophthalmologists at their annual conference.

Royal College of Psychiatrists – National Audit of Dementia

The aim of this third round audit is to improve the quality of care received by people with dementia in general hospitals. In the audit report the following areas were highlighted for improvement: assessment, nutrition, discharge, documentation and communication. As a result of the audit, and an increase in patients being admitted to hospital with impaired cognition or a diagnosis of dementia, the following actions have been taken:

- Redesign of the acute admission clerking proforma to include a delirium screen and a frailty scoring system;
- Development of a Dementia strategy and workplan to ensure ongoing improvement and monitoring by the Dementia Steering Group;
- Additional improvements to the built wards and departments to deliver a more ‘dementia friendly’ environment;
- Targeted training on Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DOLS).
In addition, the Trust has supported the development and provision of a Psychiatric Liaison Team who are based in the hospital and provide an immediate service for the assessment, intervention and management of patients in crisis. The team is employed by Somerset Partnership Trust but work collaboratively with the hospital to deliver clinical intervention, education and training and policy development to improve the care and treatment of patients with mental health needs. This is an important development and a key focus for delivery, in line with the Quality Priorities across the county for 2018/19.

National Cardiac Arrest Audit (NCAA) (Quarter 3 April 2018 December 2018)

Rate of cardiac arrests - ward

The following graph presents the reported number of in-hospital cardiac arrests attended by the team where the location of arrest was ward per 1,000 hospital admissions for adult, acute hospitals in NCAA.

NCAA report for quarter 3 (Apr to Dec ’18) Compared to 2017 figures in brackets.

For a total of 34,254 (33,712) admissions:
- There were 31 (62) calls for in-hospital cardiac arrests
- The number of in-hospital cardiac arrests per 1000 admissions has significantly improved, approximately 0.9 (1.8)
- 42% (61%) were age 75+ - much improved, mean age is on a downward trend.
- We have had more arrests in the more acute areas than NCAA expects:
  - ED – 5
  - ICU – 11 (recognising the deteriorating patient early & transferring to ICU)
- Less on the wards than expected – 13
- Survival to hospital discharge is currently 26.7% (26.4%)

2.34 Research and Development

The number of patients receiving NHS services provided or subcontracted by Yeovil District Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1260. 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 Peninsular Clinical Research Network.

There are presently 86 studies open and recruiting, inclusive of randomised clinical trials, observational studies, 21 on follow up and 1 sponsored and led by the Trust. These studies are
distributed over many clinical specialties and we provide support to our clinical colleagues to assist with the running of these studies and the development of new innovative ideas. We have used the nationally recommended systems and protocols to manage these studies and to ensure results are passed into practice in a timely manner. This ensures that our clinical staff are aware of the latest possible treatment opportunities and give patients the best possible outcomes.

We are in receipt of a NIHR Research for Patient Benefit Grant for £245000 for Professor Nader Francis to run a multicentre study looking at volatile biomarkers in colorectal cancer which is a Trust Sponsored study and aims to recruit 600 patients nationally which is currently recruiting well.

We have 2 medical research fellows that assist Prof Francis in running the grant and submitting abstracts and future grants. We are in receipt of funding from the South West Pen to host a non-medical research fellow post to assist with patient recruitment and to develop their own research idea and disseminate research within the Trust. A specialist dietician was successful in her application and continues to develop her interest in Nutrition post Critical Care and has presented her work nationally and had developed international collaborations within this area.

We actively encourage patient involvement and celebrated with an afternoon tea event in September that saw patients and Trust staff talk about their research experiences in a relaxed forum and was well supported and the feedback was excellent. The research team attend patient groups and give talks about research opportunities at regular intervals and we have patient representation at our trial management and steering groups. The team are working hard with the Head of Volunteers to develop a role suitable for patients to promote research within the Trust. We also attend Trust induction to ensure all new staff are aware of the research department and the team and how they can get involved.

We are working hard with our colleagues in Musgrove Park Hospital and Somerset Partnership to run research studies that span the whole patient's journey within Somerset to enable them to access research at every opportunity. We also have developed close collaborative working with the Symphony Health Service GP practices in Somerset to ensure patients can access research that may cross secondary and primary care.

We have recruited across a broad portfolio of studies in many specialities and are giving patients many opportunities to participate in new treatments and for our staff to be part of a high performing research active organisation. We sponsor innovative multicentre studies and strive to ensure the Trust is represented globally and we are national award winners for our research contributions. We are in the NIHR top ten small acute trusts league table recruiting into research and this is a great accomplishment for a small district general hospital and our patients and staff.

2.35 Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of Yeovil District Hospital income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between Yeovil District Hospital and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The CQUIN framework is used by commissioners to agree core quality assurance goals as part of a quality improvement based service contract.


As directed by NHS England a 2 year contract and CQUIN schedule was agreed at the beginning of 2017. This saw 1.5% of the 2.5% available allocated to national CQUIN schemes, and the remaining 1% made available to support engagement with Somerset Sustainability and Transformation Partnership (STP) as well as being linked to the achievement of a providers control total.
The system rewards excellence by linking a proportion of income to the achievement of specific goals. It is vital that the Trust delivers the required standard to improve the quality of care and patient experience and to ensure the income opportunity is achieved. In 2018/19 the service improvement delivered by the implementation of the CQUIN indicators included:

- A suite of indicators focusing on the Health and Wellbeing of NHS Staff, visitors and patients. Focusing on the physical activity and mental health initiatives as well as a step change in the health of the food offered on the premises;
- A focus on sepsis screening for patients in Emergency Department and Inpatient settings as well as ensuring that antibiotic reviews were undertaken within 3 days in addition to continuing to drive the reduction in antibiotic consumption;
- Collaborating across organisations to improve services for people with mental health needs who present to the Emergency Department by improving the care pathway;
- Supporting the GP Forward View by improving GP access to consultant advice on referrals into secondary care, as well as the transition to e-referrals;
- Supporting the proactive and safe discharge of patients by promoting better patient flow and access to other care settings across health and social care providers by working collaboratively.
- Improving the uptake of flu vaccinations for frontline clinical staff within Providers.
- Reduction in antibiotic consumption per 1,000 admissions
- Personalised Care and Support Planning

2.36 Trust Income against Commissioning for Quality and Innovation Payment Framework

A proportion of Yeovil District Hospital Foundation Trust’s income is conditional on achieving quality improvement and innovation goals agreed between the Trust and its commissioners. Any person or body who entered into contract, agreement or arrangement for the provision of relevant healthcare services, through the Commissioning for Quality and Innovation payment framework is eligible to invoice for CQUIN.

The income Yeovil District Hospital Foundation Trust receives is conditional on achieving national and locally agreed goals, this equated to £2,100,000 in 2014/15, £2,060,000 in 2015/16, £2,308,595 for 16/17, £2,330,277 for 17/18 and the following for 2018/19:

Breakdown of Planned 18/19 CQUIN:

| NHSE - Military | £7,328 |
| NHSE - Dental (half year only as service transferred) | £10,353 |
| NHSE - Specialist Commissioning | £79,498 |
| Somerset CCG | £1,927,569 |
| Dorset CCG | £353,675 |

**Total Planned CQUIN** | **£2,378,423**

CQUIN for 18/19 has to be agreed with CCG and is discussed as part of the Contract Performance meetings.

The CQUIN achievement for 2018/19 has been fully achieved for Dorset and Somerset CCG’s. NHSE specialised commissioning achievement is yet to be determined.

The CQUIN programme for 2018/19, set as part of the 2 year contract signed in 2017/18 will continue to focus on supporting the Sustainable Transformation Plan and relevant National CQUINs.
2.37 Review of Our Services

During 2018/19 Yeovil District Hospital NHS Foundation Trust provided 43 NHS services. Yeovil District Hospital NHS Foundation Trust has reviewed all of the data available to it on the quality of care in all of these NHS services. Services include those provided by subsidiary organisations.

The income generated by direct provision of NHS services was approximately 85.6% of total income.

2.38 Registration and Compliance

Yeovil District Hospital is required to register with the Care Quality Commission and its current registration status is Requires Improvement, the Clinical Services review was graded Good overall.

Yeovil District Hospital has the following conditions on registrations – none.

The Care Quality Commission has not taken enforcement against Yeovil District Hospital during 2018/19.

Yeovil District Hospital has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Service Ratings

Services ratings are described in the following tables:

**2016 Inspection Summary**

<table>
<thead>
<tr>
<th>Services</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Medical care</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Critical care</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity and gynaecology</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Outpatients and diagnostic imaging</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

A series of improvement work was undertaken in response to the comprehensive inspection including focus on the following areas:

- Aspects of infection control across the Trust;
- Improving quality assurance for the use of resuscitation equipment across the Emergency department, maternity services and children services;
- Increasing compliance with staff appraisals;
- Strengthening arrangements for End of Life Care in line with National Standards;
- Increased compliance with Level 3 Children’s Safeguarding in targeted staff groups/departments;

All actions have been taken and completed in response to the recommendations from the CQC and work is ongoing to maintain compliance.

**2019 Inspection Summary**

The most recent inspection was undertaken in December 2018 and January 2019. This is the first time we have been rated under new assessment criteria, which includes an assessment of our core clinical services (see table above) – undertaken by CQC – and a Use of Resources assessment – carried out by NHS Improvement. Both these ratings are amalgamated to provide a single, overall rating for the organisation.

We are pleased to report that our core clinical services have been rated as ‘Good’ overall. However, our ‘Use of Resources’ rating is ‘Inadequate’ which results in an overall rating for the Trust of ‘Requires Improvement’.

The overall assessment of all core hospital services is ‘Good’ – the second best rating available from CQC – we are delighted that two of our services achieved the highest possible ‘Outstanding’ results in certain areas. See the table of results above. For our urgent and emergency services, which were previously rated as ‘Requires Improvement’ by the CQC, the rating of ‘Good’ across every element of this latest inspection is further enhanced by an assessment of ‘Outstanding’ for the responsiveness of their care. These excellent results were mirrored in our maternity services, which were previously rated as ‘Requires Improvement’ by the CQC, with ‘Good’ ratings across the board and an ‘Outstanding’ for caring.

The core clinical services report details significant improvement across all domains with areas for improvement focused on the safe domain. The Trust has committed improving nursing documentation to reflect risk assessments undertaken and appropriate care plans in place and will continue to work with our Children Social Care and CAMHS colleagues to provide a safe and appropriate care pathway for children and young people experiencing emotional health concerns.

In relation to the actions required for the Use of Resources report, in summary we are required to demonstrate better oversight of our financial Governance and develop more robust plans for addressing and reducing the elements of the deficit which are within our control.

The key areas identified as requiring improvement within the clinical core services include:
• Improve storage in some areas of confidential patient records.
• Ensure all mandatory training is meeting trust targets.
• Complete and escalate early warning scores appropriately.
• Check resuscitation equipment every day or as is required by trust policy.
• Maintain fully accurate records of patient care and complete fluid balance charts in line with trust policy. Complete resuscitation paperwork in line with trust policy and national guidance.
• Improve processes for mental capacity assessment and ensure documentation is completed in line with trust policy and national guidance.
• Include decisions about resuscitation and treatment escalation plans to ensure these are completed in line with trust policy and national guidance.
• Review processes for safe administration of medicines through a syringe driver, including infection prevention and control measures.
• Safeguard children and young people at all times by monitoring and assessment to reduce the risk from self-harm.
• Seek support to ensure there is good awareness of the opportunities to access and use benchmarking data to drive improvement.

The trust has developed a comprehensive action plan as a result of the report which was received on May 8th 2019 and this will further inform our Quality Priorities. This action plan is subject to review and monitoring via the Governance and Quality Assurance Committee to ensure progress is evident.

2.39 National and Contractual Quality Standards (See table below)
<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Source</th>
<th>Latest Date Range</th>
<th>This Years Value</th>
<th>Last Years Value</th>
<th>Best Performance (National)</th>
<th>Worst Performance (National)</th>
<th>National Average</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational Health</strong></td>
<td>Overall patient Experience of Hospital Care</td>
<td>NHS Digital</td>
<td>Aug17-Jan18</td>
<td>79.5</td>
<td>76.6</td>
<td>88.9</td>
<td>71.8</td>
<td>78.4</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Responsiveness to patients' needs</td>
<td>NHS Digital</td>
<td>Aug17-Jan18</td>
<td>69.1</td>
<td>66.3</td>
<td>85.0</td>
<td>60.5</td>
<td>68.6</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Staff Sickness</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>3.4%</td>
<td>3.0%</td>
<td>2.4%</td>
<td>5.5%</td>
<td>4.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Staff Turnover</td>
<td>Trust</td>
<td>Apr18-Mar19</td>
<td>15.6%</td>
<td>17.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>NHS Staff Survey Response rate</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>72%</td>
<td>58.0%</td>
<td>72.0%</td>
<td>33.0%</td>
<td>45.0%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Palliative Care Coding</strong></td>
<td>SMHI</td>
<td>NHS Digital</td>
<td>Oct17-Sept18</td>
<td>52.3%</td>
<td>29.8%</td>
<td>58.6%</td>
<td>11.2%</td>
<td>33.6%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PROMS: Hip Replacement - EQ VAS</td>
<td>NHS Digital</td>
<td>Apr17-Mar18</td>
<td>No Data</td>
<td>71.9%</td>
<td>-</td>
<td>-</td>
<td>68.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PROMS: Hip Replacement - EQ SD Index</td>
<td>NHS Digital</td>
<td>Apr17-Mar18</td>
<td>No Data</td>
<td>90.2%</td>
<td>-</td>
<td>-</td>
<td>91.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PROMS: Hip Replacement - Oxford Hip Score</td>
<td>NHS Digital</td>
<td>Apr17-Mar18</td>
<td>No Data</td>
<td>95.4%</td>
<td>-</td>
<td>-</td>
<td>98.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PROMS: Knee Replacement - EQ VAS</td>
<td>NHS Digital</td>
<td>Apr17-Mar18</td>
<td>100.0%</td>
<td>48.7%</td>
<td>-</td>
<td>-</td>
<td>59.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PROMS: Knee Replacement - EQ SD Index</td>
<td>NHS Digital</td>
<td>Apr17-Mar18</td>
<td>100.0%</td>
<td>73.2%</td>
<td>-</td>
<td>-</td>
<td>83.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>PROMS: Knee Replacement - Oxford Knee Score</td>
<td>NHS Digital</td>
<td>Apr17-Mar18</td>
<td>100.0%</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>94.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Readmissions in 28days: 0-15yrs</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>9.4%</td>
<td>8.4%</td>
<td>-</td>
<td>-</td>
<td>9.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Readmissions in 28days: 16yrs+</td>
<td>NHS Digital</td>
<td>Apr18-Mar20</td>
<td>9.3%</td>
<td>8.4%</td>
<td>-</td>
<td>-</td>
<td>9.0%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Effective</strong></td>
<td>MSA Breaches</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Complaints rate</td>
<td>Trust</td>
<td>Apr18-Mar19</td>
<td>5.4</td>
<td>7.3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Staff - Friends and Family Test</td>
<td>NHS Digital</td>
<td>2018</td>
<td>74.0%</td>
<td>68.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Maternity - Friends and Family Test</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>96.0%</td>
<td>94.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Inpatients and Daycases - Friends and Family Test</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>94.6%</td>
<td>94.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Emergency Dept - Friends and Family Test</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>94.0%</td>
<td>92.6%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Caring</strong></td>
<td>VTE Risk Assessment</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>94.4%</td>
<td>92.1%</td>
<td>100.0%</td>
<td>95.7%</td>
<td>95.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Safety alerts</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Never Events</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Emergency C. Section Rates</td>
<td>Trust</td>
<td>Apr18-Mar19</td>
<td>15.8%</td>
<td>17.9%</td>
<td>-</td>
<td>-</td>
<td>16.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Rate of C. difficile infection per 100,000 beddays</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>4.9</td>
<td>7.8</td>
<td>-</td>
<td>-</td>
<td>12.1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>MRSA bacteraemias</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>0.8</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Rate per 1000 bed days - Patient safety incidents</td>
<td>Trust</td>
<td>Apr18-Mar19</td>
<td>43.2</td>
<td>45</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Percentage of Patient Safety Incidents that resulted in severe harm or death.</td>
<td>Trust</td>
<td>Apr18-Mar19</td>
<td>0.082%</td>
<td>0.09%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Safe</strong></td>
<td>Clostridium (C.) difficile – meeting the C. difficile objective (All)</td>
<td>NHS Digital</td>
<td>Apr18-Mar19</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Certification against compliance with requirements regarding access to health care for people with a learning disability</td>
<td>Trust Board Declaration</td>
<td>Apr18-Mar19</td>
<td>Compliant</td>
<td>Compliant</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>62 day wait for first treatment from urgent GP referral: all cancers</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>80.0%</td>
<td>83.8%</td>
<td>-</td>
<td>-</td>
<td>85.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>62 day wait for first treatment from consultant screening service referral: all cancers</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>83.1%</td>
<td>94.4%</td>
<td>-</td>
<td>-</td>
<td>90.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>31 day wait from diagnosis to first treatment: all cancers</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>97.5%</td>
<td>97.8%</td>
<td>-</td>
<td>-</td>
<td>96.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>31 day wait for second or subsequent treatment: surgery</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>94.6%</td>
<td>95.6%</td>
<td>-</td>
<td>-</td>
<td>94.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>31 day wait for second or subsequent treatment: anti cancer drug</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>97.6%</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>98.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Two week wait from referrals to date first seen: all cancers</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>91.7%</td>
<td>95.2%</td>
<td>-</td>
<td>-</td>
<td>93.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Two week wait from referrals to date first seen: breast symptoms</td>
<td>CWT RETURN</td>
<td>Apr18-Feb19</td>
<td>93.7%</td>
<td>95.2%</td>
<td>-</td>
<td>-</td>
<td>93.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>18 week maximum wait from point of referral to treatment (incomplete pathways)</td>
<td>UNITY RETURN</td>
<td>Apr18-Mar19</td>
<td>90.5%</td>
<td>93.3%</td>
<td>-</td>
<td>-</td>
<td>92.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Maximum 6-week wait for diagnostic procedures</td>
<td>WEEKLY SITREP</td>
<td>Apr18-Mar19</td>
<td>99.7%</td>
<td>99.0%</td>
<td>-</td>
<td>-</td>
<td>99.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Maximum waiting time of 4 hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>WEEKLY SITREP</td>
<td>Apr18-Mar19</td>
<td>97.3%</td>
<td>96.9%</td>
<td>-</td>
<td>-</td>
<td>95.0%</td>
<td>-</td>
</tr>
</tbody>
</table>
Yeovil District Hospital considers that SHMI data is as described for the following reasons:
- SHMI has remained within the expected range

Yeovil District Hospital has taken the following actions to improve and or maintain this indicator, and so the quality of its services, by:
- Share indicator and expected range with the Board
- Monitor at the Clinical Outcomes Committee
- Triangulate with HSMR at Clinical Outcomes Committee
- Move to utilising Dr Foster data

Yeovil District Hospital considers that PROMS data is described for the following reasons:

In 2018 there was a decision to move to amplitude as the PROMS provider - this provides an electronic version of the PROMs data collection but is not restricted to the mandatory requirements of Hips and knees. The data for PROMS was not available for a 6 month period as there were issues with the data interface. These issues are now resolved and we are now collecting all PROMS data for Trauma and Orthopaedics as required.

Yeovil District Hospital considers that 28 day re-admissions data is described for the following reasons:
- 0-15 years of age – within expected range
- 16 or over – within expected range

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:
- Regular audit of emergency readmissions to determine avoidability
- Increased focused and support on community services and social care to improve discharge processes including Home First.

Yeovil District Hospital considers that responsiveness to the personal needs of its patients data is described for the following reasons:
- Need for improvement in shared planning and decision making about treatment options and use of the Somerset Treatment Escalation Plan
- Need for improved communication about discharge arrangements

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:
- Introducing revised documentation to improve written records of discussions with patients
- Introduction of a new End of Life Care Plan

Yeovil District Hospital considers that VTE data is described for the following reasons:
- A change in data capture systems following implementation of TrakCare

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:
- Re-establishing mechanisms for data capture
- Re-establishment of a VTE Working Group
- Review and update of Trust policy in line with NICE guidance
- Weekly monitoring of performance
Yeovil District Hospital considers that C diff data is as described for the following reasons:

- Significant focus on prudent antibiotic prescribing and rapid isolation of suspected cases

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Continued focus on robust infection control practices
- Rapid isolation of suspected cases

Yeovil District Hospital considers that the percentage of patient safety incidents that resulted in severe harm or death is as described for the following reasons:

- Increased focus on improving rates of reporting to determine risks without harm, thus allowing for earlier mitigation
- Implementation of NEWS2, digital capture of patient vital signs, review of Deteriorating Patient policy
- Increased suite of simulation training modules in relation to deterioration

Yeovil District Hospital will take the following actions to improve this indicator, and so the quality of its services, by:

- Continued focus on risk management awareness and training
- Audit of feedback and prompts to managers from the incident reporting system to provide assurance of actions taken

The auditors carried out work on two mandated indicators, specified by NHSI in its guidance.

- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

The auditor has verified that our work on the two mandated indicators has concluded that there is sufficient evidence to provide a limited assurance opinion in respect of maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers and percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

The Trust continues to take the following actions to validate this position:

- Implementation of ERS has reduced the number of errors on clock start dates. For those areas which do not have electronic referrals and there is a manual process, the validators review and check the correct dates are entered.
- Monthly Audit in place to audit sample areas for clock stops. This is reviewed by the RTT group and training/correction is addressed.

In addition and during the transfer of our Oral Max Fax service to another local provider, the RTT pathway accuracy was audited by an external party who was satisfied that the Trust had utilised the RTT recording guidance appropriately.

2.40 Data Quality

An external clinical coding audit was undertaken by NHS Digital Approved Clinical Coding Auditors) on behalf of YDH which examined the clinical coding accuracy of 199 spells (200 FCEs) for activity between Nov 1st 2018 and 11th Jan 2019. The areas
reviewed were known high activity areas for the trust including: Trauma & Orthopaedic, geriatric medicine and a random sample of 1+ Length of Stay (LoS). This audit will also be used to satisfy the clinical coding audit needs of the Data Security and Protection Toolkit.

Table 1: Summary findings from the audit (Provisional)

<table>
<thead>
<tr>
<th>Area</th>
<th>Spells tested</th>
<th>Pre-audit value</th>
<th>Post-audit value</th>
<th>Net change</th>
<th>Net change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>199</td>
<td>£376,511</td>
<td>£378,506</td>
<td>£1995</td>
<td>0.53%</td>
</tr>
</tbody>
</table>

The error rate resulted in a potential net financial undercharge of £1995 to the commissioners for the sample audited. The coding accuracy achieved the mandatory Data Security and Protection Toolkit level overall with both secondary diagnoses and secondary procedures reaching the higher advisory levels.

Table 2: Data Security and Protection Toolkit levels of attainment (Provisional)

<table>
<thead>
<tr>
<th>Acute Trust</th>
<th>Primary diagnosis correct</th>
<th>Secondary diagnosis correct</th>
<th>Primary procedure correct</th>
<th>Secondary procedure correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory</td>
<td>&gt;=95.0%</td>
<td>&gt;=90.0%</td>
<td>&gt;=95.0%</td>
<td>&gt;=90.0%</td>
</tr>
<tr>
<td>Mandatory</td>
<td>&gt;=90.0%</td>
<td>&gt;=80.0%</td>
<td>&gt;=90.0%</td>
<td>&gt;=80.0%</td>
</tr>
<tr>
<td>Yeovil</td>
<td>94.00%</td>
<td>95.81%</td>
<td>93.68%</td>
<td>93.01%</td>
</tr>
</tbody>
</table>

The hospital accuracy levels are only 1% and 1.32% for primary diagnoses and primary procedures respectively off of achieving the highest advisory attainment level. Compared to the 2017/18 audit this has highlighted an improvement in both of these areas with primary diagnosis accuracy increasing by 2.63% and primary procedure accuracy increasing by 1.75%. The secondary diagnosis accuracy has also improved from 2017/18 increasing by 7.34% to now reach the advisory level. The secondary procedure accuracy has fallen from 2017/18 by 1.91% but still meets the advisory level.

Audit findings have been 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.

The completion of clinical coding remains at 99%+ coded by day 3 which has historically been highlighted as a potential cause of the increased error rate in diagnostic coding. As a result of this the department recruited for a further qualified coder to help maintain coding turnaround timeframes whilst improving accuracy who was appointed to post in Apr 2018. In part this new position has helped evidence an increase in accuracy in three of four areas.

The action plan from the 2017/18 audits has proved successful showing a significant improvement in the secondary diagnosis accuracy in part due to the additional post and regular internal audit highlighting and addressing issues as they arise.

2.41 Payment by Results (PbR) Audit 2018/19

Yeovil District Hospital NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during the reporting period by the Audit Commission.
Yeovil District Hospital submitted records during 2018/19 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included a valid NHS number was:

- 99.8% for admitted patient care;
- 99.9% for outpatient care;
- 99% for Accident and Emergency Care.

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

- 99.4% for admitted patient care;
- 98.2% for outpatient care;
- 99.4% for Accident and Emergency Care.

2.42 Information Governance

Yeovil District Hospital Information Governance Assessment Report overall score for 2017/18 (version 14.1) was 77% and was graded Green – Satisfactory.


We are continuing to work on the DS&P Toolkit and will make our final submission 31 March 2019 for year 2018/19.

On 25 May 2018 General Data Protection Regulations (GDPR) were released. With guidance from the Information Commissioners Office we have undertaken the following work:

- Reviewed and updated our Information Governance training,
- Reviewed all contracts to establish the lawful basis for processing personal information,
- Updated Privacy Notices for patients and staff
- Created a data base to record any data subjects exercising the right to stop processing their data
- Meeting Subject Access Requests within 1 month with no charges made.
- Reporting incidents via the DS&P matrix within 72 hours and following further investigation processes where required.
- Implementing a Data Protection Impact Assessment (DPIA) Policy to support the review of new processes and technologies
- Appointed a Data Protection Officer
- Reviewed working practices to ensure lawful international transfers

We continue with this ‘work in progress’ to ensure we meet GDPR/DPA standards and compliance
3. Other Information

3.1 Patient Safety and Quality Improvement

The Trust demonstrates its ongoing commitment to Patient Safety and continues to participate in the South West Academic Health Science Network (AHSN) events to support the National Patient Safety Collaborative.

The Trust uses the LIFE system to effectively monitor and manage Quality Improvement (QI) plans. Life is a purpose built Healthcare QI tool and has everything needed to run a QI project in one place. It is used by hundreds of health and social care organisations across the globe to facilitate quality improvement work and makes it easy for teams to collaborate on QI projects.

The Trust also uses the SCORE survey to measure the safety culture of teams and departments. This anonymous and private survey allows individuals and teams to gain an important perspective on the Trust’s current patient safety culture, identifying areas of strength and areas for improvement. The SCORE survey is not a benchmarking exercise but gives teams the chance to influence change for themselves. To date, Therapies, Pharmacy and Maternity have taken part in the survey with positive outcomes.

We all recognise that healthcare carries some risk and while everyone working in the NHS works hard every day to reduce this risk, harm still happens. Whenever possible, we must do all we can to deliver harm free care for every patient, every time, everywhere. We must be open with our patients and colleagues about the potential for things to go wrong and for people to get hurt, and most of all, we must continuously learn from what happens in order to improve.

Our Patient Safety Improvement plan incorporates national recommendations, including safe staffing levels, and local priorities that reflect our patients’ needs. We implement and monitor the Patient Safety Improvement Plan through our Harm Free and Patient Safety Groups and by progress against CQUIN targets:

- Medicines Committee;
- Recognition and Rescue Group (Deteriorating Patients, Sepsis);
- Pressure Ulcer Steering Group;
- Falls Prevention Group;
- Maternity Safety

We tackle our proposed projects by using appropriate quality improvement methods, such as Plan Do Study Act (PDSA) cycles, on a project by project basis. What is common to the success of all quality improvement approaches is that they require deep engagement and collaboration. Board oversight is provided by the Governance and Quality Assurance Committee.

Patient Safety

3.2 Patient Safety Incidents

There were 8,295 incidents reported in 2018/19, this is a 5.6% increase from the number of incidents reported in 2017/18 (7,855). Of these, 4,795 were patient safety incidents.
Of the 4,795 patient safety incidents, and in line with national guidance, 340 were classed as a near miss, 3,675 were no harm, 634 were no harm, 137 were moderate harm, 9 severe harm and one death.

The Trust routinely reports all patient safety incidents to the National Reporting and Learning System (NRLS) and adheres to the national policy on incident reporting and investigation. Overall the Trust has seen a rise in incident reporting, demonstrating improvement in safety culture and a reduction in incidents resulting in harm.

The Trust has a positive approach to incident reporting and actively encourages staff to report near misses and patient safety incidents. However, during the year, the frequency of incident reporting has decreased by 1.9%. Changes have been made to the electronic incident reporting system in response to staff feedback, this position will be monitored by the Patient Safety Committee.

All reports are reviewed by a senior manager with comprehensive investigations conducted into the more significant incidents. The aim is to ensure that lessons are learned and then shared widely to reduce the likelihood of a recurrence.

The following chart shows the Patient Safety incident data for 2018/19 and shows the different levels of harm reported.
3.3 Serious Incidents

A total of 35 investigations were commissioned in 2018/2019. Of these, 10 required a Comprehensive Root Cause Analysis (Level 2 investigation) and 10 met the definitions of a Serious Incident Requiring Investigation, in accordance with national definitions and guidance, and were reported to Somerset Clinical Commissioning Group. 9 Serious Incidents met the threshold for Duty of Candour which was complied with accordingly.
3.4 Duty of Candour

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

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

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

The Trust realises the importance of learning lessons from problems that have occurred. Whenever an incident is reported in the hospital a thorough investigation is carried out and reports are made outlining areas for improvement. This information is shared with
all grades of staff at a quarterly Trust-wide meeting. Topics in the last year have included:

**Never Event  Peripherally inserted central catheter (PICC) line- Incident took place 2017/18**
- PICC care training available for all nurses on a twice monthly basis, as well as the facility to undertake ward base training.
- Who Surgical Check list has been amended to include CVP lines, dialysis lines and PICC lines.
- Sherlock insertion system to be used with all PICC line insertions.

**Information Governance raised through incidents resulting in SI**
- Maternity service has changed a number of practices to ensure information is protected. This includes ensuring outpatient notes are kept within a locked trolley.

**Patient Safety Alerts through NHS Improvement Alerts**
- Teaching regarding the use of SI incident reporting system and highlighting high level of reporting in organisations is usually linked with low levels of harm how to use the system and recent patient safety alerts that have relevance Trust Wide.
- Collaborative working with Primary care and secondary care to ensure patient have bowel management.

**NEWS 2 introduction into the Trust to help identify deteriorating patients**
- NEWS 2 has been rolled out across the Trust with our updated VitalPac system, we are still using paper copes in the Emergency Department, Theatre and Ward 10.
- On-line training has been provided for all clinical members of staff to provide the introduction of this update to assist with identifying and recusing deteriorating patients.

**Review multidisciplinary risk assessments for younger people presenting in ED with mental health issues raised through SI**
- Clear Joint CAMHS, YDH and Children’s Social Care management plan required for all patients to include, level of supervision required, proportionate restraint procedures and behaviour contracts with patients and carers
- Improved knowledge of policies and procedures such as ligature risk management, patient observation, deliberate self harm protocol and joint complex patient protocol
- Additional training and support/supervision for all staff managing young patients with increased and unpredictable risks in an acute settings, to include de-escalation and therapeutic interventions

**Learning from Deaths**
- Positive impact of active and timely discussion with patients and their families on treatment escalation and resuscitation status.

**3.6 Preventing Venous Thrombo-embolism (VTE)**

We have continued to work on improvements to reduce harm to patients. The national emphasis on preventing venous thrombo-emboli has continued. A thrombosis can be a blood clot in the deep vein of the leg - Deep Vein Thrombosis or (DVT) and the more serious blood clots in the lung - Pulmonary Embolism or PE. These can form through slowing of blood flow and we know that patients having surgery and those whose mobility is reduced are at particular risk.
To aid with preventing this potential complication we can take several actions. We can give medication to thin the blood, use stockings or mechanical pumps to improve blood flow and encourage our patients to be as mobile as possible.

Every patient should be assessed within 24 hours of admission regarding their individual risk of a thrombosis and the appropriate measures put in place. There are exclusions such as those patients undergoing some types of day case procedures and most patients attending the Emergency Department. We have identified a greater potential risk for patients attending the Emergency Department with Lower limb injuries requiring a plaster that limits their mobility and developed an additional risk assessment and management process for this group of patients.

Compliance with VTE Risk assessment is a key patient safety measure and a nationally reported key quality indicator with a National Target of 95%. The Trust has achieved an overall year end position of 94.8%. This is an increase on 17/18 data due to the work that has been undertaken following the change in electronic data capture with the implementation of Trakcare. Q3 and Q4 17/18 did meet the 95% target and work is continuing to ensure this level of performance is maintained.

We audit compliance with the prophylaxis and management of these patients and if a pulmonary embolism or deep vein thrombosis develops during their admission, or within 90 days of their discharge an investigation is undertaken to identify why this happened. We use the learning from our investigations to improve the care for future patients and are currently looking at the policy including review of existing exclusion criteria.

3.7 Maternity Safety

Birth numbers are slightly down this year to 1405. Compared to the financial year 17/18 this represents a 5% drop in birth numbers. Whilst the regional dashboard data for 2018/19 is not yet available, data for other parts of Somerset suggests that elsewhere in the county the decrease is more marked than at YDH which is suggestive of a normal and expected fluctuation in birth rate.

The home birth team continues to be very successful with an overall rate of 5.6%. Work has now commenced on further strengthening and developing the midwife led pathway as we move towards opening our alongside midwifery led unit which will further increase the percentage of “out of hospital” births.

The service works to the Saving Babies lives care bundle which includes action around the monitoring of small for gestational age babies – the (GAP/Grow programme). Staff have undergone advanced training and an annual perinatal institute funded study day is provided to ensure that all staff assessing fetal growth during pregnancy have had the appropriate level training. Governance structures around this issue have been strengthened with the establishment of a GAP working party – a new policy has been written and all cases are incident reported with a missed case rolling audit to identify learning. Intrauterine growth retardation is associated with smoking in pregnancy and the number of women who continue to smoke at delivery (11.6%) remains equal to those smoking at booking (11.6%). This suggests that women who smoke at booking continue to do so throughout their pregnancy. Smoking cessation services are offered on an opt out basis to smokers. Data suggests that 82% are offered carbon monoxide monitoring at booking and 79.9% taking up this offer, but it has recently been found that women who have miscarried in early pregnancy are included in the denominator data. This has now been rectified. There is therefore a lot of preventative work including an increased focus...
on public health measures taking place and innovative approaches to reaching those most at risk in order to reduce the number of small for gestational age babies, however, demographic issues continue to provide a challenge to achieving a sustainable decrease in low birthweight babies.

The caesarean section has remained stable since last year with just a 0.3% decrease. A recent review has found that there were an increased number of caesarean sections where maternal choice was at least one of the indicators. There has been recent professional debate over the fact that maternal request for Caesarean section is accepted by NICE guidance to be an indication providing that the woman is fully informed of the risks and benefits. If it is the woman’s choice to opt for caesarean section and she has given full and informed consent it is difficult to argue that her choice should not be met. On a positive note there has been a 2.4% decrease in the rate of emergency caesarean sections.

Other clinical areas of concern are our ongoing post-partum haemorrhage rate which had made an initial improvement but has slipped again. Measures recently undertaken to readily identify excessive bleeding include scales in the labour rooms to weigh swabs etc. to get an even more accurate measurement of blood loss and plans to introduce a new method of risk assessment in the form of an obstetric bleeding strategy. The rate of third and fourth degree tears following normal deliveries has steadily increased throughout the year. The underlying cause of this could be multi-faceted. Episiotomy rates, birth positions, water birth and a “hands off” approach during birth can all be contributory factors. A multi-disciplinary task and finish group is to be established to work on a reduction strategy including the introduction of episiotomy skills in the preceptorship package, encouraging midwives to develop episiotomy skills by undertaking them under the direction of a doctor when an instrumental delivery is about to be performed and a senior second midwife in the room at delivery to support if an episiotomy should be required. A reflective practice form is to be introduced to be completed by any practitioner who conducts a delivery which results in a 3rd and 4th degree tear.

Year to date rates are showing an encouraging downturn in neonatal morbidity and mortality a total of 4 still births and 1 neonatal death. This compares favourably with 2017/18 when there were 7 stillbirths and 2 neonatal deaths. Of the stillbirths this year, one was due to a cord prolapse at home and the other three were intrauterine deaths prior to onset of labour. One of these cases has been reviewed using the perinatal mortality review tool. There were no issues or concerns with the antenatal care provision. The panel is yet to sit and review the other two cases (1071 births in quarters 1-3 the stillbirth rate is 0.28% which is better than the current national average of 0.41%.

3.8 Clinical Effectiveness

We have a number of processes for understanding effectiveness and monitoring to ensure the care we provide follows national best practice. We have reviewed our work in this area and set revised priorities for delivering improvements.

The Trust’s Clinical Outcomes Committee oversees the compliance and delivery of best practice with a focus of effective outcomes for patients. The committee reviews new guidance from the National Institute of Clinical Excellence and assists clinical teams to assess their compliance with the guidance, identify any gaps and work towards improved practice.
National and Local Audits undertaken within the Trust are reported to the Clinical Outcomes Committee which has developed a specialty based approach. Outcomes from the audits and the resultant action plans are reviewed and new policies, protocols and guidance relating to clinical standards agreed.

All published audit reports are reviewed by the clinical teams and the publication date is reported to the Clinical Outcomes Committee. The reports of 30 national clinical audits were reviewed by the provider in 2018/19 and Yeovil District Hospital intends to take the following actions to improve the quality of healthcare provided.

3.9 National Paediatric Diabetes Audit (NPDA) – Royal College of Paediatrics and Child Health

The aim of this audit is to improve the care, outcomes and experiences of children and young people with all types of diabetes treated within NHS Paediatric Diabetes Units (PDU) until the age of 24 years.

The audit highlighted 68.85% young people, aged 12 years and older, in Yeovil District Hospital received all seven care processes between April 2016 and March 2017 compared to 43.5% across England and Wales. (48% young people, aged 12 years and older, in Yeovil District Hospital received all seven care processes between April 2015 and March 2016 compared to 35.5% across England and Wales). It is not possible to make direct comparison rates of the seven care processes reported before April 2015 as this was the first time the audit presented the information for children and young people with Type 1 diabetes only.

Action Plan:
- Online data submission is now available in clinics to improve complete data collection
- A business case to recruit a designated clinical psychologist for Yeovil District Hospital has been approved to improve access and supervision
- To improve education regarding eye screening and kidney screening
- To ensure all eye screening results are included in the audit
- To improve urine screening and ensure all results are included in the audit

3.10 Royal College of Emergency Medicine Audits (RCEM)–Royal College of Emergency Medicine

The aim of these audits is to identify current performance in Emergency Department against RCEM clinical standards, show the results in comparison with other departments and also across time if there was previous participation.

Procedural Sedation in Adults audit
The four fundamental standards were not met up to the national average:

- Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status (2017/18 – 0%, 2015/16 - 0%)
- Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities (2017/18 – 30%, 2015/16 - 55%)
- Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse (2017/18 – 30%, 2015/16 - 9%)

- Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG (2017/18 – 6%, 2015/16 - 12%)

Action Plan:
- Sedation proforma amended and made into a single proforma with clear guidance
- Safety checklist introduced
- Introduce an ED sedation kit box (containing drugs and equipment, sedation proforma and safety checklist)

3.11 National Audit of Care at the End of Life (NACEL) – NHS Benchmarking Network

The aim of this audit is to assess the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. (This is the first audit round. The second round of the audit will take place in 2019 and will again include an organisational level audit, case note review and the NACEL Quality Survey).

The audit highlighted three areas where the Trust performed below the national average:
1. Communication with families and others
2. Individual plan of care
3. Workforce / specialist palliative care provision

These areas had been identified as points of concern prior to this audit and the following actions are in place:
- Development of a new end of life care plan – rolled out across the trust from January 2018, addressing points 1 and 2
- Development of a programme to look at 7 day working for palliative care – addressing point 3
- Development of a communication skills programme for all staff – addressing point 1

Patient Experience

3.12 National Inpatients Survey 2018

The findings from the 2018 Inpatient Survey were received from the Picker Institute in February 2019.

This annual survey asks the views of adults who had stayed at least one night as an inpatient during the month of July 2018. Patients are asked what they thought about different aspects of the care and treatment they received. The purpose of the survey is to understand what patients think of healthcare services provided by the Trust, and the questionnaire reflects the priorities and concerns of patients based upon what is most important from the perspective of the patient.

A total of 1,250 patients were sent the questionnaire. 1,199 were eligible for the survey, of which 627 returned a completed questionnaire, giving a response rate of 52%.
The 2018 survey has highlighted the many positive aspects of the patient experience, including:

- Admission: did not have to wait long time to get to bed on ward which saw a 5% improvement;
- Hospital: not bothered by noise at night from other patients saw a 6% improvement;
- Discharge: was not delayed saw a 5% improvement;
- Hospital: not bothered by noise at night from staff saw a 4% improvement;
- Hospital: got enough help from staff at mealtimes saw a 4% improvement.

When reviewing the Trust’s results against the Picker Average (results compared with the 81 other trusts that commissioned Picker to run the survey), the Trust scored better than average for the following questions:

- Admission; did not have to wait long time to get to bed on ward;
- Hospital: not bothered by noise at night from staff;
- Hospital: food was very good or good;
- Hospital: offered a choice of food;
- Hospital: got enough to drink;
- Care: staff helped control pain;
- Care: staff helped within reasonable time when needed attention.

However, the Trust is below the national average in several areas’ relating to patient experience:

<table>
<thead>
<tr>
<th>Question</th>
<th>Average %</th>
<th>YDH %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned admission date not changed by hospital</td>
<td>79</td>
<td>70</td>
</tr>
<tr>
<td>Hospital: staff completely explained reasons for changing wards at night</td>
<td>81</td>
<td>72</td>
</tr>
<tr>
<td>Nurses: did not always know which nurse was in charge of care</td>
<td>81</td>
<td>77</td>
</tr>
<tr>
<td>Care: right amount of information given on condition or treatment</td>
<td>80</td>
<td>76</td>
</tr>
<tr>
<td>Procedure: told how to expect to feel after operation or procedure</td>
<td>88</td>
<td>84</td>
</tr>
<tr>
<td>Discharge: patients given written/printed information about what they should or should not do after leaving hospital</td>
<td>63</td>
<td>56</td>
</tr>
<tr>
<td>Discharge: told purpose of medication</td>
<td>91</td>
<td>88</td>
</tr>
<tr>
<td>Discharge: given clear written/printed information about medicines</td>
<td>85</td>
<td>78</td>
</tr>
<tr>
<td>Discharge: told of danger signals to look for</td>
<td>64</td>
<td>58</td>
</tr>
<tr>
<td>Discharge: family given enough information to help care</td>
<td>76</td>
<td>70</td>
</tr>
<tr>
<td>Discharge: told who to contact if worried.</td>
<td>79</td>
<td>70</td>
</tr>
</tbody>
</table>

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

3.13 Patient Feedback, Complaints

During the year, both the Complaints and PALS teams have further developed their processes to ensure a robust management of formal complaints, PALS enquiries and concerns. The process now includes an early intervention contact, where expected outcomes are discussed and agreed prior to commencing any investigations or reviews.
All complaint response letters now also include whether the complaint has been upheld, partially upheld or not upheld. Where appropriate, formal complaints responses include an action plan to address issues identified during our investigations, the actions are implemented by senior members of staff and taken to the departmental peer reviews and to the Patient Experience and Engagement Steering Group.

Complaints and PALS concerns and enquiries are outlined in the graph below:

3.14 Patient Advice and Liaison Service

The PALS service received 333 PALS concerns/enquiries during the first quarter and 317 during quarter 2, 293 during quarter 3, and 327 during quarter 4.

Whilst previously, conciliation meetings were largely conducted as a result of a formal complaint process, a significant number of conciliation meetings now occur as a result of
PALS enquiries and bereavement concerns raised when families are collecting a death certificate from the bereavement service. It is clearly evident that when relatives or patients have concerns, it is recognised that this is more effective in terms of resolving concerns as early as possible.

All PALS contacts are graded as either an enquiry (easily and quickly resolved) or a concern (which needs an investigation). Departmental Managers make initial contact with enquirers, where appropriate, and the PALS team now provide verbal or email responses to concerns unless specifically requested to be more formally in a letter. The last quarter has seen a significant increase in concerns compared to enquiries as shown in the above Graph. The Patient Experience and Engagement Steering Group will review any factors relating to this and monitor any actions required.

3.15 Formal Complaints

There were 17 formal complaints received during Quarter 1, 19 during Quarter 2, 15 during Quarter 3, and 14 during Quarter 4.

![Formal Complaints Review By Financial Year](image)

Whilst efforts are made to meet agreed deadlines for response, a number of complainants have received holding letters, providing an explanation as to why the complaint response may have been delayed. It remains evident that if an explanation is given to a complainant as to a delay then the majority of complainants are content with this process. All complainants continue to be offered a meeting, either at the outset of the complaints process or after a response have been received. The mandatory KO41 health and social care data return reported 89 compliant cases throughout 2017/18 and 65 for 2018/19.

The Head of Clinical Governance and Assurance and the Medical Director play a key role in conciliation and early intervention meetings which has made them very effective and provides opportunities for shared learning across departments and at Trustwide level. Clinical input is also enormously beneficial and valued by complainants attending such meetings.
3.16 Actions agreed from Complaints

- Review content of patient information leaflet with regard to risks of Transobturator Tape procedure and expectation of any anatomical changes following procedure at Gynaecology Governance Meeting.
- Update the maternity booking pack to inform women that they will be asked for their relevant medical history when they ring the Labour Ward.
- When time specific medication is required in specific month and an outpatient clinic slot is not available, staff must escalate this to the Patient Services Manager or Operational Support Manager.
- Ward sister to work with the therapy team to trial new falls alarms system and audit effectiveness.
- Matron to arrange additional training for nursing staff on; the correct application and management of brace to support upper arm fracture.
- Tissue Viability Team to provide additional training in wound care and include documentation in new staff induction programme.
- Enhanced End of Life training programme (since Autumn 2018) being rolled out Trust wide to include; holding difficult conversations.
- Reiterate the need for staff to follow up with the Radiology Department to clarify any likely delay and reasons - inform patient and relatives and document in records.
- An appropriate care plan to be put in place should a particular patient be readmitted, ensuring there is a multidisciplinary approach taking into consideration her physical and mental health needs.

3.17 Patient Feedback Indicators / Patient Surveys

Patient Voice is a voluntary group which supports the organisation with obtaining feedback, often using observational audit. The group have a yearly schedule to survey patients on key subject areas. During the beginning of the year, the focus was relating to basic care which involved observations of the environment and key factors in care such as communication, being able to reach call bells and drinks, noise and cleanliness on the wards. The findings are discussed at the monthly Patient Voice meeting and at ward peer reviews to aid any learning or necessary changes, a report is also provided to the Patient Experience and Engagement Steering Group.

3.18 Friends and Family Test

The Friends and Family Test (FFT) is collected from the inpatient wards, emergency department, maternity unit and outpatient clinics for national submission each month. 10,130 responses were collected throughout the year.

During March 2019, the survey was tested in house on one ward, and managed via the SNAP survey software. This trial was successful; therefore the survey will be managed completely in house as of April 2019, with a focus on encouraging and improving feedback from our patients so that we can make any necessary changes. Business cards have been developed allowing patients to complete the survey when they return home, volunteers have agreed to help by handing these out when they are present on the wards. Posters have been developed advertising the survey so that patients are encouraged to leave any feedback.
The following charts show the responses to the friends and family test for each area of submission (Emergency Department, Inpatient Wards, Maternity and Outpatient Clinics).
The other questions included in the Iwantgreatcare survey look at whether the patients felt they were treated with dignity and respect and felt involved enough in decisions made about their care, whether they received timely information about their care and treatment, whether the hospital was clean and whether they were treated with kindness and compassion by the staff. The report then provides an average score for the five questions.

As a consequence of the feedback from patients and their families, a number of areas for improvement were identified that aligned with the Quality Priorities for 2018/19. These included:

- Publication of a Patient and Public Engagement Strategy
- Increase the percentage response rate for the Friends and Family Test – we had experienced a 1.8% decrease. By bringing this survey process back into the organisation we will be able to focus on encouraging and improving feedback from our patients so that we can make any necessary changes. In addition to increasing numbers of responses, we will focus on supporting patients to give honest feedback.
- We have worked collaboratively with Somerset Clinical Commissioning Group, Somerset Local Authority, Taunton and Somerset and Somerset Partnership NHS Foundation Trusts to host the first Always event nationally focused on system improvements. The event saw 50 attendees including patients, carers, voluntary agencies and health and social care staff to consider what a good discharge from hospital (Acute, Community and Mental Health) should always look like. This has generated a number of patient-centred improvement projects and a countywide steering group has been established to provide oversight.

This programme of improvement work will take place throughout 2019/20 with oversight provided by the Yeovil District Hospital NHS Foundation Trust Patient Experience and Engagement Committee. Board level assurance will be via the Governance and Quality Assurance Committee.

3.19 Freedom to Speak up

The following table identifies the concerns that have been raised via the Freedom to Speak up Guardians. Staff can raise concerns either face to face, by email or on the Trust intranet. This gives them the opportunity to raise a concern anonymously if preferred. The Guardians also hold a weekly drop in session.

Feedback and outcomes are given directly to staff who make themselves known. If a concern is raised anonymously, where possible, and when appropriate, the outcome and improvements made as a result are published in the Trust news bulletin.

Guardians support staff and due to the open culture, no staff who have raised a concern have suffered as a result. Guardians are very happy to attend meetings with staff if that is required. This has resulted in a positive outcome on a number of occasions.
<table>
<thead>
<tr>
<th>April 2018 to present</th>
<th>Nature of concern</th>
<th>Raised by</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-functioning equipment</td>
<td>Nurse</td>
<td>Matron confirmed that a replacement had been ordered.</td>
</tr>
<tr>
<td>2</td>
<td>Inappropriate conversations taking place in lifts</td>
<td>Anonymously</td>
<td>Reminder included in Trust wide news bulletin</td>
</tr>
<tr>
<td>3</td>
<td>Incorrect adherence to uniform policy</td>
<td>Anonymously</td>
<td>Staff involved were reminded</td>
</tr>
<tr>
<td>4</td>
<td>Incorrect process of admitting a patient</td>
<td>Patient’s wife who is also a staff member</td>
<td>Procedure was clarified with the team involved.</td>
</tr>
<tr>
<td>5</td>
<td>Alleged bullying</td>
<td>Pharmacy assistant</td>
<td>Department dealt with this in line with Trust policy.</td>
</tr>
<tr>
<td>6</td>
<td>Unacceptable culture within a clinical team</td>
<td>Medical staff</td>
<td>Lengthy investigation with action plan in place as a result</td>
</tr>
<tr>
<td>7</td>
<td>Lack of cutlery available at ward level</td>
<td>Nursing staff</td>
<td>Additional supplies provided in an ongoing way.</td>
</tr>
<tr>
<td>8, 9 and 10</td>
<td>Change of annual leave entitlement</td>
<td>Clerical staff</td>
<td>Handed over to Human Resources who provided an explanation</td>
</tr>
<tr>
<td>11</td>
<td>Non-adherence to No smoking Policy</td>
<td>Nursing staff</td>
<td>Reminder of the importance included in Trust wide news bulletin</td>
</tr>
<tr>
<td>12</td>
<td>Difficulty in obtaining correct fillings for jacket potatoes at ward level</td>
<td>Anonymously</td>
<td>An improvement in the system was communicated via the Trust wide news bulletin</td>
</tr>
<tr>
<td>12</td>
<td>Poor care and alleged discrimination of staff</td>
<td>Nursing staff</td>
<td>Meeting with staff member and Matron to resolve these issues</td>
</tr>
<tr>
<td>13</td>
<td>Non-adherence to No smoking Policy</td>
<td>Nursing staff</td>
<td>Second reminder of the importance included in Trust wide news bulletin</td>
</tr>
<tr>
<td>14</td>
<td>Possible misuse of Trust funds</td>
<td>Anonymously</td>
<td>Director of Nursing provided a response</td>
</tr>
<tr>
<td>15</td>
<td>Discrimination and lack of support within a team</td>
<td>Nursing staff</td>
<td>Currently ongoing</td>
</tr>
<tr>
<td>16</td>
<td>Lack of support</td>
<td>Nursing staff</td>
<td>Currently on going</td>
</tr>
</tbody>
</table>
3.20 Conclusion and Independent Auditor's Report to the Council of Governors of Yeovil District Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Yeovil District Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Yeovil District Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2018/19 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, May 2019;
- feedback from governors, May 2019;
- feedback from local Healthwatch organisations, May 2019;
• the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
• the national patient survey, February 2019;
• the national staff survey, December 2018;
• Care Quality Commission Inspection, December 2018;
• the 2018/19 Head of Internal Audit’s annual opinion over the trust’s control environment, dated April 2019; and
• any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Yeovil District Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Yeovil District Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

• evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
• making enquiries of management;
• testing key management controls;
• limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
• comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
• reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.
Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Yeovil District Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

May 2019
Annex 1 - Statement from the Council of Governors

Statement from the Council of Governors

The Council of Governors receives regular reports on all aspects of quality, including patient safety, clinical outcomes and patient experience. Governor observers attend the Governance and Quality Assurance Committee, the Risk Assurance Committee and Patient Experience and Engagement Group. Governors are also invited to attend the full Board of Directors meeting on a rotational basis and are welcome to attend all Part 1 Board of Directors. At all these meetings, representatives are actively encouraged to participate and contribute their views, and to report back to the full Council of Governors. On this basis, the Governors are confident that the provision of high quality care is a core aim of Yeovil District Hospital and that appropriate measures are in place to monitor standards. The Governors welcome this year’s generally positive Quality Accounts which confirm that YDH learns from the data collected and adapts policy accordingly.

Once again, Yeovil District Hospital has achieved high performance of key standards, particularly with regard to four-hour waits and referral to treatment times – this has placed the Trust amongst the best performing trusts in the country.

Yeovil District Hospital worked towards achieving the priorities set for 2018/19, with focus on:

- safety and quality of patient experience, including maternity and patients with dementia
- safer care which reduces avoidable harm
- learning from deaths
- mental health
- staff retention and wellbeing

Work towards improvement has involved the inclusion of staff, patients and carers in identifying areas to develop and in finding solutions. The introduction of TagCare has led to a reduction in harm to patients at high risk, there have been no ‘never events’ reported, infection control figures have continued to improve compared to previous years and to other organisations. The Governors are encouraged to note that the Trust continues to maintain high Safety Thermometer results, with an overall average of 98% of patients being recorded as harm free.

The Council of Governors acknowledge the recent report from CQC. Governors are delighted to see the improvements in judgements across so many areas of the hospital, in particular the outstanding results for Urgent and emergency care and for Maternity. Governors would like to congratulate all the staff involved in achieving these outcomes, of which they should be very proud and which mean that the overall assessment for core services is ‘Good’. The overall rating for the Trust of ‘Requires Improvement’ is disappointing but Governors are aware of the financial pressures under which the Trust is working and the plans to address these, and are confident that these will lead to a more positive position in the near future.

The Governors continued to monitor the Local Indicator of “Proportion of Overnight Discharges 10pm – 7am”. The data showed that overnight discharges had small fluctuations throughout the year with a yearly average of 3.6% of total discharges taking place between 10pm and 7am, though some patients self-discharge. In 2019/20, the
Council of Governors will monitor the number of patients who attend the accident and emergency department and only receive advice and guidance, with no further treatment.

The Governors received regular information on system working within Somerset, with Yeovil District Hospital working more closely with Taunton and Somerset NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, the County Council and NHS partners in Dorset. The Governors note that the Trust’s priorities for the coming year are in line with those of Taunton and Somerset and of Somerset Partnership, which pay due regard to the use of the Trust’s facilities by Dorset residents and that improvements being made are in accordance with ‘Fit for My Future’.

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

The Council of Governors welcomes the ongoing improvement shown by the results of the 2018 Staff Survey, which this year had a response rate of 71%, the highest in the country. The results illustrate further improvements in the health and wellbeing of staff, diversity and inclusion, staff morale and staff engagement – to the extent that scores for staff feeling valued (78%), staff recommending YDH as a place to work (70%), and staff recommending YDH as a place to receive care (74%) are all well above the national average.

The Council of Governors continues to actively monitor and receive updates on the recruitment of staff, both for medical and nursing staffing groups. Governors were delighted that, as a result of the overseas recruitment programme, there were no reported nurse vacancies this year and YDH have also been able to help other trusts to address this difficult issue. Work to address medical vacancies is ongoing and Governors will be keen to see more progress with this over the coming year.

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

Annex 1.1 - Statement from the Somerset Clinical Commissioning Group

NHS Somerset Clinical Commissioning Group is the lead commissioner of health services for the Yeovil District Hospital NHS Foundation Trust (YDH) and we welcome the opportunity to provide this statement and comment on the Trusts Quality Account.

The Quality Account format can be a difficult read and a summary navigating the reader about how the Trust has identified their priorities would be helpful. The data presented gives an accurate position of the YDH local and national quality priorities and quality improvement work undertaken within 2018/19 as well as reporting on the required content as set out by NHS Improvement’s Quality Account reporting requirements.

Throughout 2018/19, there have been robust arrangements in place between YDH and the CCG to agree, monitor and review the quality of services through the Clinical Quality Review meeting and the Contract Review Group meetings.

The Trust is to be congratulated for its excellent staff survey results, the latest independent NHS staff survey ranked the Trust the best in the country (out of 230 NHS organisations surveyed) for staff health and wellbeing. The survey offers staff the opportunity to anonymously share their experiences and opinions of their job and their employer to identify
any areas for improvement. The Trust also ranked in the top 20% for areas such as diversity and inclusion, support from managers, staff morale, safety of the hospital environment, bullying and harassment and staff engagement.

The Care Quality Commission (CQC) undertook an inspection visit at Yeovil Hospital between 4 December 2018 and 17 January 2019; the report was published on Wednesday 8 May 2019. While this overall quality rating remains unchanged, inspectors noted clear progress in a number of areas since its previous inspection. Yeovil District Hospital, the trust’s main centre, was rated as Good for being effective, caring, responsive and well-led. The hospital was rated requires improvement for being safe. The CQC published the trust’s Use of Resources report at the same time, which is based on an assessment undertaken by NHS Improvement. The trust has been rated as Inadequate for using its resources productively. The combined rating for the trust, taking into account CQC's inspection for the quality of services and NHSI's assessment of Use of Resources, is Requires Improvement.

YDH has launched numerous quality improvements during the year; these include focusing on the effectiveness of ward rounds, improving patient discharge pathways and deteriorating patient simulation training. It is notable that the Trust has participated in the full range of national and local clinical audits and that this has resulted in actions to improve quality. Our review will detail comments on the three key areas patient experience, patient safety and clinical effectiveness.

**Patient Experience**

The Trust continues to embed the principles of iCARE (Communication, Attitude, Respect, and Environment) throughout the organisation and encourages all members of staff to take individual responsibility to help deliver its vision and values. On the NHS website, YDH has a score of 4 out 5 stars with comments from a variety of the services and particular comments about receiving “Compassion, Care, Communication with a Capital C......

YDH received a 47% response rate in the National Adult Inpatient Survey which was higher than the national average of 41%. The Trust has shown an improved performance compared to the previous year with the majority of questions asked showing increased scores. Of note, the following areas had a significantly higher score than the previous year:

- Waiting time to get a bed
- Doctors’ explanations that were easy to understand
- Adequate amount of nursing staff for their care
- Feeling emotionally supported
- Patients asked for their views
- Being given information about how to complain about their care

The Trust has maintained a consistent performance with Patient Led Assessments on the Care Environment (PLACE) with improved scores in Food, Dementia and Disability. YDH have been using magnetic boards behind patient beds as an update for individual and family involvement, “ask me about my discharge”, “when am I going home?”, “What is happening to me?”, a summary card for involvement and a variety of mechanisms to empower patients/families to be better involved and engaged with their care, treatment and discharge planning. This is helping to support timely and effective discharge from hospital.

The Trust has acknowledged the importance of hydration and nutrition in recovery from illness or surgery and to maintain good health and have therefore made hydration a priority
area for improvement by implementing quality improvement projects such as flashing cups to remind patients to drink. The Trust participated in International Nutrition and Hydration week and has plans for further improvement in 2019/20.

Yeovil Hospital also took part in the national 70 day #endPJparalysis challenge, which aimed to give patients back one million days of their precious time that would otherwise be spent in a hospital bed. Each day the hospital helped those patients who were able to get up and dressed, swapping hospital gowns and pyjamas for everyday clothes to help them get back on their feet and stay active during their time in hospital. Families and friends were encouraged to support recovery and independence by making sure their loved ones had clothes and all their independence aids with them in hospital adding to their sense of wellbeing and identity.

**Patient Safety**

The Trust continues to work closely with the CCG and other stakeholders in Somerset to improve infection prevention and control through shared learning. A key component in the Trust’s reduction of infection is through good hand hygiene by all clinical staff. The Trust consistently scored above the local threshold of 90% throughout 2018/19 with an overall compliance of 95% at the year end.

The Trust should be commended for having no provider-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA-bacteria) bloodstream infections in 2018/19. There were also no Trust attributed cases of Clostridium difficile Infection (CDI).

Screening people for blood stream infection, known as sepsis, has been above 98% in the Emergency Department and 92% on the inpatient wards. Antibiotic administration within one hour has been variable throughout the three quarters with 81.2% overall for ED and 90.9% for inpatients. The CCG acknowledges that sepsis remains a priority for the Trust and compliance will continue to be monitored in 2019/20 through the quality contract meetings.

**Clinical Effectiveness**

This year Yeovil Hospital has seen its highest number of patients signing up to take part in clinical trials. The Trust is celebrating recruiting 1,000 patients in just 10 months, giving patients the opportunity to help shape the future of how patients and their conditions are treated. The Clinical Research team at Yeovil Hospital is renowned for being very active despite its small size, participating in local, national and international trials. The team is currently running more than 120 studies, including more than 70 new research trials this year.

The Trust commenced implementation of the second version of the National Early Warning Score (NEWS2) in March 2019 and has actively participated in the regional Deteriorating Patient Safety Collaborative which has been focusing on implementing systems to improve recognition and management of deteriorating patients. The Trust successfully won a bid for funding from Health Education England to provide Simulation Training in the wider community and is currently working with partners in Primary Care to improve the pathway for deteriorating patients in the community setting to acute care through the use of NEWS2 and SBAR. After the initial pilot, the Trust aims to spread the project to nursing and care homes.

The Trust continues to work with commissioners and other stakeholders in delivering the National Home First discharge project which, in Somerset, is funded through the Joint Commissioning Board (Somerset Local Authority and the CCG). The Home First service
The aim is for patients to be discharged and assessed in either their own home or a bedded facility which is more akin to their usual surroundings. The project aims to support frail, vulnerable people, post-discharge, this is delivered either at home with assessment and support, with community hospital enablement or care home enablement. In its first year, Somerset's Home First initiative has helped 2,000 people leave hospital earlier, avoiding 7,500 nights in hospital and saving £2m. This is a great example of joined up working from health and social care with better outcomes for patients.

Quality Improvement Priorities for 2019/20

The CCG supports the Quality Improvements identified by the Trust for 2019/20 and closer alignment of the priorities across the Somerset Health System with Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust, the key priorities are aligned to national work programs and include:

- Learning from deaths
- Safer Care
- Mental Health and Holistic Care
- Patient Experience
- Right Care, Right Time, Right Place
- Staff Retention and Wellbeing

It is clear that the Trust has demonstrated many areas of effective improvement in patient safety and quality initiatives. The CCG recognises the Trust’s continued commitment to working in partnership with commissioners, the public and other key stakeholders and we look forward to again working with the Trust in the forthcoming year.

Please contact me at the address above if you wish to discuss the CCG comments or statement further.

Yours sincerely

Sandra Corry
Director of Quality, Safety and Engagement
Annex 1.2 - Statement from the Dorset Clinical Commissioning Group

In 2018/19 Yeovil District Hospital pursued achievement of key quality priorities and has demonstrated consistency with quality, safety and performance throughout the year by the provision of information at meetings and through reporting mechanisms. We can confirm that we have no reason to believe this Quality Account is not an accurate representation of the performance of the organisation during the year.

NHS Dorset CCG recognises the areas of strength described in the Quality Account, such as, learning from a Never Event that took place in 2017/2018 which has resulted in an increase in the accessibility and availability of Peripherally Inserted Central Catheter (PICC) care training for nurses and the introduction of an amended Surgical Check list for procedures such as central venous catheter lines, dialysis lines and PICC lines. In addition, no Never Events have been reported for 2018/2019.

In the report it demonstrates how learning from deaths has continued to have a positive impact, particularly related to supporting timely discussions with patients and their families regarding treatment escalation and resuscitation status for their relative.

The Quality Account highlights that the National Early Warning Score 2 (NEWS 2) has been implemented across the Trust, this has included the on-line training required for all clinical members of staff. Dorset CCG supports the national programme around recognising and treating the deteriorating patient. The collaborative work related to NEWS 2 across the health and social care system in Somerset is recognised as a proactive approach.

The CCG are supportive of the focus of the quality priorities for 2019/2020, the emphasise demonstrated in the priorities are on patient safety, clinical effectiveness, patient experience and staff retention and wellbeing. The six 2019/2020 priorities are the same as the ones from 2018/2019 and include, learning from deaths, safer care, patient experience and staff retention and wellbeing. They were chosen following a review of priorities and progress and a consideration of where further improvements could be made or embedded. The specific focus of these priorities was selected following engagement with patients, families and staff. The CCG will continue to work with Yeovil District Hospital and Somerset Clinical Commissioning Group over the coming year to ensure all quality standards are monitored as set out in the reporting requirements of the NHS Contract and local quality schedules.

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

Yours sincerely

Vanessa Read

Director of Nursing and Quality
Annex 1.3 - Statement from Healthwatch Somerset

Healthwatch Somerset welcomes the opportunity to comment on the draft Yeovil Hospital NHS Foundation Trust Quality Account for 2018-19. Healthwatch Somerset exists to promote the voice of patients and the wider public with respect to health and social care services. Although Healthwatch Somerset has not been directly involved in the development of quality priorities this year, we note that the topics were developed through wide consultation with staff, governors and patient representative groups. This included meetings with Healthwatch Somerset to review progress against the individual quality improvement priorities. As in previous years the priorities were based on the Trust’s review of quality performance and the identification of areas for improvement.

Priority Areas

In reviewing the Trust’s priorities and progress against 2018/19 plans, it has considered where future improvement is required and engaged with patient groups, families and staff to identify areas for particular focus. These include learning from mortality reviews, looking at the reason for inpatient falls, and reporting the number of pressure ulcers.

Our comments on the six quality improvement priorities for 2019-20 are:

Priority 1: Learning from incidents, complaints and mortality reviews
We support any action by the Trust to ensure that, when things go wrong, a proper investigation takes place to find out the cause of what went wrong. Also, that learning takes place as a result. And we welcome regular meetings with the Patient Experience and Engagement Steering group to look at how complaints are being used to shape services going forward.

Priority 2: Reduction in avoidable harm
Patient safety has to be a key priority in any hospital and we fully support action to reduce avoidable harm across Yeovil Hospital. This includes a sustained improvement in sepsis management, a reduction in the incidence of hospital acquired infection, a reduction in the number of falls, and a reduction in the incidence hospital acquired pressure ulcers which we know has been one of the key safety priorities at the Trust for a number of years.

Priority 3: Increase staff capability to recognise and respond to those with mental health needs
We know that the benefits of integrated care across boundaries (health, social care, employment and housing) are understood. However, integrated care for people with mental health conditions does not always happen. This can lead to poor patient experience and reduced quality of care. We note that a priority for the Trust is to increase the capability of staff to recognise and respond to those patients with mental health needs (children, adults in crisis and older people). The Trust’s developing partnership with Somerset Partnership NHS Foundation Trust should mean closer working between physical and mental health care services and a greater opportunity for better mental health training for hospital staff.
**Priority 4: Improve patient experience**
We note that the Trust is committed to providing the best possible patient experience and is always looking for ways to improve that experience for both inpatients and outpatients. This area has been a long-standing priority and it is essential that patients, carers and members of the public are treated as equal partners and have confidence that their feedback is listened to and has led to improved services. We commend action by the Trust to form partnership working initiatives to bring staff and users together and to monitor the effectiveness of these initiatives.

**Priority 5: Strengthen collaborative working across health and social care**
We know that the benefits of collaborative working across health and social care, in particular those regarding discharge, STP involvement and Academy activity are understood. We commend action to strengthen collaborative working to deliver sustainable improvements in care. In particular we note that the Trust has worked collaboratively to improve discharge by way of the development of a discharge checklist, a patient information leaflet to prepare patients for discharge, and the introduction of ward-based dispensing. Key to these improvements is to equip staff with the necessary skills and experience to cope with the heavy demands and pressures placed upon them and reduce staff turnover year on year.

**Priority 6: Staff retention and wellbeing**
We note that the results of the 2018 Staff Survey show that the Trust continues to improve and is above average in virtually every area. The response rate was 71% compared to the national rate of 44%. We commend proposed action by the Trust to support, encourage and develop staff – whether new or existing staff. With workforce supply an ongoing challenge, it is important that the health, safety and wellbeing of staff is given a high priority and that all is done to encourage their retention.

Summary

Overall, we feel that this is a balanced report covering both past performance and proposals for future priorities. We are pleased to see that patient engagement and experience is considered throughout the report. We look forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and carers are heard and taken seriously.
Annex 2 - Statement of Directors' responsibilities in respect of the quality report

In preparing this annual quality account the Trust's Board of Directors has satisfied itself that the content meets the requirements set out in the NHS Foundation Trust annual reporting manual and supporting guidance.

The content of the report is consistent with internal and external sources of information, including:

- Board minutes and papers between April 2018 and March 2019
- Papers relating to quality reported to the Board between April 2018 and March 2019
- Feedback from the Commissioners
- Feedback from the Governors
- Feedback from local Healthwatch organisations
- The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009
- The latest national patient surveys
- The latest national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment
- CQC quality and risk profiles

The quality report presents a balanced picture of the Foundation Trust's performance over 2018/19. The performance information is reliable and accurate, and there are proper internal controls over the collection and reporting of the performance measure included in the Quality Report. These controls are subject to review to confirm that they are working effectively in practice. The data underpinning the measure of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to scrutiny and review; and the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

[Signatures]

Date 24/5/19 Chairman

Date 24/5/19 Chief Executive