Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Quality Accounts 2020/21

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4)(a) of the National Health Service Act 2006

Chief Executive's statement

As reflected within our Annual Report, 2020/2021 has been one of the most challenging years within the Trust's existence. As such, all of our quality indicators have been impacted in some way and it is important that the context of 2020/ 2021 is kept in mind when reading this year's Quality Account.

This is also the final version of this report we will produce in this format, as we move to a new arrangement as specified by our regulators. As such, this Quality Account is shorter and concludes last year's standards and targets, rather than having the normal narrative, which includes the setting of new targets and quality objectives.

As you will see in the pages that follows, we have achieved some of the targets that we set ourselves in 2019/20, missed others and maintained within the rest. Last year we reflected upon good progress and I believe that the fact that our indicators are still close to target in many respects, outlines the journey we have made as a Trust within recent years, as well as our ability to keep a consistent level of service despite the pressures of the pandemic.

Much of our planned work was disrupted this year, whilst increased activity as a result of COVID-19 meant that mortality rates were also higher than expected (a picture also seen nationally). It also means that much of the time we would have spent innovating, or driving through changes, has been allocated elsewhere, as all we mustered an 'all-hands-on-deck' approach to the pandemic, particularly during the peaks of activity.

There are however, regardless of COVID-19, still areas where we can improve, as outlined in the incidences of 'Never Events' and work is now underway to improve where we can do more to minimise incidents such as this, and we will endeavour throughout the next year to make any necessary improvements.

Each year we look forward to implementing changes and enhancements, however, unlike any previous period the next 12 months will be critical for our Trust. We must understand what has gone well in 2020/21, what could have gone better, and where we need to focus our efforts. All of this must also take place whilst we look to recover our activity levels, reduce our waiting lists and improve the safety, quality and responsiveness of our services particularly in the areas where challenges have been exacerbated by the difficulties presented by the pandemic. We have our work cut out, but it is a challenge that we relish and we are already underway with much of it.

As a final note as we look towards the future, in many ways 2021/2022 will be a very unique year, and while we will push towards further improvements and enhancements, COVID-19 will, and has, impact upon what we are able to achieve. However, it is our pledge as a Trust that we will do all we can to further build upon our successes and, ultimately, improve as an organised whether it is the best of times, or the worst of them.

To the best of my knowledge, the information in this Quality Account is accurate.

Richard Parker OBE
Chief Executive
1 June 2021

Looking forward to our priorities for improvement in 2021/22

Our priorities for the next financial year will align with our Business Plan for 2021/22. At the time of writing this report, final business plans are not yet available, therefore we are unable to share our objectives. We will however share the report as soon as we can here:

https://www.dbth.nhs.uk/about-us/our-publications/

Furthermore, we will align our improvements in quality standards to our Chief Nurse's and Executive Medical Directors annual objectives. Specifically:

- Demonstrate Improvements in governance, management information, systems and processes to improve performance against the CQC Acute Insight Standards.
- Demonstrate delivery of the standards required to achieve Outstanding in the CQC domain.
- Demonstrate delivery of the standards required to achieve Good in the CQC domain – are services safe? Specifically:

    1. Develop and implement a Quality Framework which shapes the delivery of improvements in patient safety and experience.
    2. A 20% reduction in falls causing medium – severe harm.
    3. Achieve compliance with the National Perinatal Framework and Ockenden recommendations.
    4. Deliver national access standards for cancer diagnosis and treatment.
    5. Deliver national access standards for elective and diagnostic care.
    6. Deliver urgent and emergency care access standards.
    7. Ensure that the patient and carer voice is listened to by delivering co-produced outcomes.
    8. Celebrate, share and promote good practice.

In identifying and drafting these preliminary priorities for improvement for 2021/22 the Trust has taken into account the views of:

- **Patients and their care outcomes**: Via patient surveys and complaints monitoring
- **Staff**: Reports on clinical outcomes and incident reporting
- **Commissioners:** Via quality meetings and contractual arrangements
- **Service users:** Via the work of the Patient Experience and Engagement Committee and priorities identified in analysis of key themes.

Looking back on our priorities for improvement in 2020/21

Over the last year we have made substantial improvements in delivering harm free care. The following tables provide an overview of our achievements against the quality improvement targets we set for 2019/20.

Key ☆ = target achieved → = close to target < = behind plan

Patient safety quality improvement targets	**Target 2020/21**	**Actual 2020/21**	**Progress**
Take a zero-tolerance approach to Never Events	0	4	<
Reduce the number of healthcare associated infections (MRSA bacteraemia)	0	2	<
Reduction in patients suffering moderate and severe harm from an inpatient fall	<40	33	☆
Reductions in category three hospital acquired pressure ulcers	<50	56	<

Clinical effectiveness quality improvement targets	**Target 2020/21**	**Actual 2020/21**	**Progress**
Reduce the number of deaths which may have been preventable - Hospital Standardised Mortality Ratio (HSMR)	<95	109.14	<
Reduce the number of deaths which may have been preventable - Summary Hospital-level Mortality Indicator (SHMI)	<100	112	<
80% of deaths screened as part of structured judgement review (SJR) **(Governor selection)**	80%	95 (by end of Q4)	<
Reduce the number of missed hospital appointments	<7%	10.4%	<

Patient experience quality improvement targets	**Target 2020/21**	**Actual 2020/21**	**Progress**
Reduce the number of complaints relating to staff attitude and behaviour	5% reduction based on 2019/20 outturn	181	<
Reduction of noise at night for patients (to minimise disturbed sleep)	70%	No data Survey's not completed	N/A
Ensure patients feel involved with decisions about their care	95%	No data Survey's not completed	N/A

Achievements against quality improvement priorities 2020/21

Quality improvement 1 – patient safety

Take a zero tolerance approach to "never events"

These are largely preventable patient safety incidents that should not occur if preventative measures have been implemented within the Trust
Outcome = Four cases, exceeded target.

Never Events are defined by the National Patient Safety Agency (NPSA) as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.'

Period	Number of incidents reported*	Per 1000 occupied bed days
2015/16	2	0.0063
2016/17	1	0.0034
2017/18	0	0.0000
2018/19	1	0.0060
2019/20	4	0.0153
2020/21	4	0.0179

During 2020/21 there were four 'Never Events'.

The Trust has an incident reporting system that specifically enables any member of staff to highlight never events or serious incidents, so that any potential case can be reviewed rapidly. This provides a culture of openness and the duty of candour to our patients.

1. **Administration of Potassium in error**
Patient administered potassium chloride from pre filed syringe instead of Actrapid Insulin.

2. **Procedure performed on wrong patient**
Two patients with same surname in the same clinical area leading to a Bone marrow biopsy being performed on the wrong patient.

3. **Retained tampon post procedure**
Eight days post episiotomy repair a retained tampon was identified during investigations of an infected perineum

4. **Wrong Site procedure**
Wrong side Erector spinae pain block administered, right side instead of left

Progress, Monitoring & Reporting: The learning from root cause analysis which follows any such events is shared Trust-wide to ensure a Never Event does not happen again in the future. Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems. This data is governed by: National definitions

Quality improvement 2 – patient safety

To reduce levels of hospital acquired MRSA bacteraemia

Why = the Trust wishes to ensure the safest possible care for patients by reducing the number of healthcare acquired infections.

Outcome = Two Cases, exceeded target

Year	Number of reported cases	Per 1000 occupied bed days
2012/13	2	0.0062
2013/14	2	0.0061
2014/15	2	0.0061
2015/16	2	0.0063
2016/17	3	0.0102
2017/18	2	0.0072
2018/19	0	0.0000
2019/20	2	0.0076
2020/21	2	N/A

We initiated a zero tolerance to MRSA bloodstream infection (BSI) by being proactive with the search and destroy approach post following an MRSA bacteraemia on the 28 October 2017. We went through 2018/19 with zero Trust attributed MRSA bloodstream infection, achieving more than 700 days. However, in 2020/21 in the midst of the COVID pandemic we reported two cases within the month of February 2021. The Post Infection Review concluded that both patients had acquired their MRSA while in hospital. There was a history of peripheral venous cannulation (PVC) in the first case and central venous catheters (CVC) in the second case, both cases reported as no lapses in care and deemed unavoidable.

With the COVID-19 pandemic gradually resolving, we are actively pursuing the practices we initiated in late 2017 through 2018/19 and which led to the achievement of zero MRSA BSI for greater than 700 days, and then 340 days:

I. Identifying on admission all previously colonised patients with MRSA, and ensuring if on antibiotic to treat an infection/sepsis they also have anti-MRSA antibiotic, we also advise the use of oral antibiotics if possible to reduce risk of intravenous devises with the increases risk.
II. VIP scores are monitored closely and documented in clinical notes to initiate prompt action on their removal if early sign of phlebitis or infection at the cannula sites.
III. Early initiation and completion of decolonisation treatments and ensuring repeat screening results negative.
IV. Continue to promote the non-touch technique (NTT) when taking blood cultures to reduce risk of picking up skin flora organism during blood culture procedures in septic patients

Progress, Monitoring & Reporting: Dashboards are completed for the monitoring and reporting of HCAIs. Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems
This data is governed by: National definitions

Quality improvement 3 – patient safety

Reduction in patients suffering moderate and severe harm from an inpatient fall

Outcome = There were 33 falls which resulted in moderate or severe harm reported during 2020/21 – Target Achieved

Year	Moderate/Severe Harm	Per 1000 occupied bed days
2019/20	46	0.1707
2020/21	33	0.1477

This year, 1,386 patients have fallen, of which 33 falls resulted in moderate and severe harm. Of these incidents 7 of those fall being escalated as serious incidents.

In comparison to 2019/20 there were 1,162, of which 46 falls resulted in moderate and severe harm. Of these, four were escalated as Serious Incidents.

This means we have seen a 19.3% increase in identified falls but a 28.2% reduction in falls with moderate and severe harm.

The now established 'Learning from Falls' panel is extracting the learning from these cases, which is sent out to all ward managers, matrons and divisional directors of nursing as live as possible. A year end collation of themes will be also shared across the Trust so the falls accreditation can be based around local learning.

The new Holistic Care Team has now launched, with the support if the Qi team. This will include the falls prevention practitioner, lead dementia nurse along with a MDT. The initial focus will be on the 10 wards with the highest rates.

Progress, Monitoring & Reporting: Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions.

Quality improvement 4 – patient safety

Reduction in category 3 hospital acquired pressure ulcers

Outcome = There were 56 hospital acquired category 3 pressure ulcers reported during 2020/21 – Target NOT achieved (below 50).

Year	Number of category 3 pressure ulcers	Per 1000 occupied bed days
2019/20	57	0.2115
2020/21	56	0.2508

There were 56 Category 3 HAPU reported during 2020/21, a slight decrease from last year but not in line with our target.

We have an established 'Learning from HAPU' panel which extracts learning from reported cases. The learning is circulated to all ward managers, matrons and divisional directors of nursing.

An annual collation of themes is also shared across the Trust so the Skin Integrity accreditation is based around local learning.

Progress, Monitoring & Reporting: Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions.

Quality improvement 5 and 6 – clinical effectiveness

Reduce the number of deaths which may have been preventable

Implementing a system for continuous review of HSMR and SHMI will support achievement of no avoidable deaths and no avoidable harm to patients.

Outcome = HSMR: 109.14 (Jan 20 – Dec 20) SHMI 112 (Jan 20 – Dec 20). Target NOT achieved.

Year	HSMR	SHMI
2013	111.12 (Jan 13 – Dec 13)	108.47 (Oct 12 – Sep 13)
2014	108.68 (Jan 14 – Dec 14)	112.88 (Oct 13 – Sep 14)
2015	95.62 (Jan 15 – Dec 15)	105.7 (Oct 14 – Sep 15)
2016	91.08 (Jan 16 – Dec 16)	102 (Dec 15 – Nov 16)
2017	87.42 (Jan 17 – Dec 17)	101 (Dec 16 – Nov 17)
2018	92.43 (Jan 18 – Dec 18)	101 (Jan 18 – Dec 18)
2019	99.25 (Jan 19 – Dec 19)	111 (Jan 19 – Dec 19)
2020	109.14 (Jan 20 – Dec 20)	112 (Jan 20 – Dec 20)

Over the last 12 months the overall HSMR has remained within the expected range however an increase is seen by the twin peak surge as a result of COVID-19 in the spring and autumn. Case mix continues to be challenging with an ageing population and high level of co-morbidity as evidenced in the depth of coding. The crude mortality follows a similar trajectory and is currently on a downward trend which is already beginning to show in the early HSMR monthly figures for 2021.

The SHMI including deaths outside hospital within 30 days of discharge also remains in the expected range. The SHMI is always higher than the HSMR as it makes no adjustments for palliative care.

Progress, Monitoring & Reporting: Monitoring of the Trust HSMR and SHMI continues through the Mortality Monitoring Group. Reporting to the Board of Directors takes place monthly.

Data Source: HED.

This data is governed by: National definitions.

Quality improvement 7 – clinical effectiveness

80% of deaths screened as part of the structured judgement review (SJR) process.

Outcome = 95% target not achieved.

Year	
Q1 2020/21	68%
Q2 2020/21	90%
Q3 2020/21	88%
Q4 2020/21	95%

During 2020/21 all deaths of patients over the age of 18, in-patients and those who die in the Emergency Department, are subjected to by the Medical examiner team.

This scrutiny could be carried out by the Medical Examiner Officer or more in depth scrutiny by the Medical examiner where needed.

Over the last 18 months the Medical examiner team has grown and developed into an effective team, providing independent scrutiny of a large percentage of deaths.

It is the aspiration of the team that they will have input into 100% of all hospital deaths before this service becomes statutory, very likely in April 2022.

In addition, the team will also begin to have input into community deaths in the future.

Progress, Monitoring & Reporting: Monthly reporting to Mortality Governance Group and Clinical Governance Committee.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions.

Quality improvement 8 – clinical effectiveness

Reduce the number of missed hospital appointments

Outcome = 10.4%, exceeded target

In 2017, it was highlighted that the Trust was in the bottom 20% of Hospital Trust for performance in patient did not attend - DNA. With over 500,000 hospital appointments each year, over 50,000 appointments are missed. The impact of missed appointments results in significant waste in precious clinical services, reduced patient experience, impact on patient waiting times and financial risk due to waste of appointment time.

The Trust has therefore undertaken a missed appointments improvement project in partnership with Healthwatch Doncaster to engage with people in Doncaster and Bassetlaw to understand why people miss their hospital appointment and to learn how, together, we can improve our services and overall patient experience. An evaluation report was produced with a number of recommendations. These recommendations were supported by the Trust Board and partnering organisational boards. An action plan was developed and a monthly steering group was formed to drive forward the recommendations.

Much of this work continued in 2020/21, however as a result of COVID-19 some of our appointment arrangements were changed and the digital reminder system was turned off as we reconfigured services to new arrangements. The fact that despite this time our performance only dipped by 0.01% may indicate that we have made improvements.

As of May 2021, we have launched our digital letters system, as well as brought our reminder service back online and expect the DNA rate to improve going forward.

Year	Actual Performance
2017/18	10.7%
2018/19	10.3%
2019/20	10.3%
2020/21	10.4%

Progress, Monitoring & Reporting: Monthly reporting to Clinical Governance Committee.

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions.

Quality improvement 9 – patient experience

Reduce the number of complaints relating to staff attitude and behaviour

Good attitude and behaviour is paramount to providing a good quality service and patient experience. This also relates to the families and visitors of patients, and reinforces out Trust values.

Outcome= 181, this demonstrates an increase in the number reported during 2019/20. Target not achieved.

In the Quality account for 2020/21 there was an objective to have a 5% reduction on 2019/20 figure of 138.

With the 5% decrease the 2020/21 figure was expected to be 131 or less, however the final figure for 2020/21 was 181. This is a 23.7% increase (based on the 138 reported for 2019/20), rather than the planned aim of a 5%.

Progress, Monitoring & Reporting: Reporting monthly to the Patient Experience & Engagement Committee and quarterly to the Clinical Governance Committee

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions

Quality improvement 10 – patient experience

Reduction of noise at night for patients (to minimise disturbed sleep)

Outcome = Not observed due to COVID-19 pandemic.

The Trust continues to work to reduce unnecessary noise at night, with the Sleep Helps Healing (SHH) campaign, raising awareness with all Trust staff of the importance of rest for patients while in hospital. Work will be picked back up following COVID-19 pandemic.

Progress, Monitoring & Reporting: Reporting monthly to the Patient Experience & Engagement Committee and quarterly to the Clinical Governance Committee

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions

Quality improvement 11 – patient experience

Ensure patients feel involved with decision about their care

Outcome = Not observed due to COVID-19 pandemic

The bedside information has been in place for two years and is available for every inpatient to be able to read and feel informed about decisions in care. The new EIDO system (which enables this kind of work) has been piloted to provide comprehensive medico-legal compliant content and digital consent solutions to support informed shared decision-making throughout the patient journey to successfully manage and deliver patient consent to treatment. This is currently going through a business case to extend the library.

Progress, Monitoring & Reporting: Reporting monthly to the Patient Experience & Engagement Committee and quarterly to the Clinical Governance Committee

Data Source: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust internal systems.

This data is governed by: National definitions