Doncaster and Bassetlaw Hospitals NHS Foundation Trust Quality Report 2015/16

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Chief Executive's statement

In 2015/16 we have seen significant improvements in the quality of the care and services we provide, improvements which we aim to maintain and improve. *The Strategic Direction: Looking Forward to Our Future 2013-2017* set out our intentions to drive towards our patients receiving the best healthcare provided in our class.

Over the past year we have continued to embed our clinical governance processes, with the intent of optimising the line of sight from Board to Ward. The Care Group clinical governance arrangements have been steered through the development of structured agendas and workplans, which bring together key priority areas and align local priorities to the Trusts corporate objectives. The Care Group Management Structures implemented within the available budgets has provided a focused attention on quality of care; supplementing the Board agreed investments in staffing to continue to move towards the staffing levels identified by the evidence based tools used in the Trust, including e-panda, AUKUH, Best and Birth Rate Plus.

As a consequence of this, and other initiatives within clinical services, there has been an improvement in the clinical outcomes and quality indicators, in a year where the Trust has undergone a Care Quality Commission (CQC) Comprehensive Inspection, in April 2015. The outcome of the inspection was provided in October 2015, with an overall rating of "Requires Improvement". The hospital core service reporting lines, and the domains of Safe, Effective, Caring, Responsive and Well Led, showed 78% of the standards assessed were rated as "Good" with no "Inadequate" ratings. The CQC Action Plan, produced following the publication of the report has been taken forward, with many actions completed during the interval between inspection and feedback of the results.

Examples of some of the improved performance include the achievement of the 6 week diagnostic wait times standard, the 4 hour access standard through emergency departments in Quarters 1-3, and the elimination of 52 week waits for any referral to treatment pathways.

We have seen a very encouraging improvement in mortality indicators. In 2013/ 2014 the Trust was a national outlier for Hospital Standardised Mortality Ratio (HMSR) but has now moved to be within the expected range The latest data available shows an improvement in the 12 month rolling HSMR to be 96. The Standardised Hospital Mortality Indicator (SHMI), which also includes deaths following discharge from hospital, has also improved and is now within the expected range, following the trend improvement in HSMR. Analysis of the data shows that there is a gradual reduction in crude mortality, with an increased depth of coding based as a result of improved clinical documentation and the provision of 7 day services for end of life and palliative care.

Patient Safety remains at the forefront of the trusts objectives, with an impressive record of reduction in the rate of avoidable pressure ulcers greater than Category 2, with a 69% reduction in the past two years. We have achieved a lower than expected performance on

clostridium difficile prevalence with a 27% reduction in the number of hospital acquired cases, and a further significant reduction in the number of reports of lapses in care for these cases. There has been a reduction in repeated falls, and falls with harm caused, as well as serious harm from falls. The roll out of the Falls Champion role in the organisation is beginning to improve performance as we continue on our journey in support of the pledges set out in our Sign Up to Safety Plan, which encompasses all of the measures above. As part of the Sign up to Safety Plan the Trust was successful in securing some funding from the NHS Litigation Authority which is being utilised to support making improvements in imaging and diagnoses of fractures in the Emergency departments.

Being open and honest with patient safety is fully endorsed through the Duty of Candour Regulations which have built on our existing arrangements for openness with patients and their families following serious incidents, with a focus now being placed on those incidents that cause moderate harm. The Trusts incident reporting systems have been designed to capture this information and a patient information leaflet, designed to help structure the principles of openness and transparency being applied consistently for any occasion where they should be used.

We also recognise that there is more to be done, to eliminate never events, further reduce infection risks from MRSA bacteraemia, and improve our patient safety indicators further to achieve the Sign up to Safety target of a 50% reduction in avoidable harm over 3 years.

Our intent is to maintain and improve patient experience, and through the measures available, such as the inpatient survey, we can see a sustained quality of care being evidenced and assured. Our complaints management systems require improvements to ensure the timeliness of our responses. During the last year the Parliamentary Health Service Ombudsman (PHSO) identified that the Trust had achieved top 10 (best) performance in England in the three reported measures.

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Looking forward to our priorities for improvement in 2016/17

Delivering harm free care is again the Trust's focus for 2015/16 and the table below identifies those indicators which are our highest priorities:

Patient safety quality improvement targets	Target 2016/17	Actual 2015/16
1. Take a zero tolerance approach to "never events"	0	2
2. Reduce the number of healthcare associated infections - MRSA bacteraemia	0	2
3. Maintain or reduce the number of healthcare associated infections - C difficile	40	32

Clinical effectiveness quality improvement targets	Target 2016/17	Actual 2015/16
4. Reduce the number of deaths which may have been preventable - Hospital Standardised Mortality Ratio (HSMR)	<100	95.62 (Jan 15 – Dec15)
5. Reduce the number of deaths which may have been preventable - Summary Hospital-level Mortality Indicator (SHMI)	<100	105.7 (Oct 14 – Sep15)
6. Reduce avoidable Re-admissions	5.4%	5.73%

Patient experience quality improvement targets	Target 2016/17	Actual 2015/16
7. Reduce the number of complaints	535	563
8. Reduce the number of complaints issues about communication.	241	254
9. Improve response rates for Friends & Family Test – Accident & Emergency	6.9%	3.4%

*An additional quality improvement will be added following consultation with the Governors.

In identifying the priorities for improvement for 2016/17, the Trust has taken into account he views of:

Patients – via patient surveys & complaints monitoring
Staff – via staff surveys, 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.

Looking back at our priorities for improvement 2015/16

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 2015/16. A review of performance for each priority area can be found on pages 6-16

Key

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

Patient safety quality improvement targets	Target 2015/16	Actual 2015/16	Progress
1. Take a zero tolerance approach to "never events"	0	2	<
2. Reduce the number of healthcare associated infections - MRSA bacteraemia	0	2	→
3. Reduce the number of healthcare associated infections - C difficile	44	32	☆
4. Reduce the number of hospital acquired pressure ulcers above Category 2	82	52	☆
5. Reduce the number of repeat fallers	202	176	☆

Clinical effectiveness quality improvement targets

	Target 2015/16	Actual 2015/16	Progress
6. Reduce the number of deaths which may have been preventable - Hospital Standardised Mortality Ratio (HSMR)	102 after rebasing	95.62 (Jan 15 – Dec15)	☆
7. Reduce the number of deaths which may have been preventable - Summary Hospital-level Mortality Indicator (SHMI)	5% reduction on 111.80 (after rebasing) (Jan 14 - Dec14)	105.7 (Oct 14 – Sep15)	☆
8. Nursing Staffing Levels	97%	xx%	☆
9. Reduce avoidable Re-admissions	10% reduction from Q1 to Q4	5.73%	→

Patient experience quality improvement targets	Target 2015/16	Actual 2015/16	Progress
10. Ensure all agreed actions resulting from upheld complaints are completed within agreed timescales	100%	80%	→
11. Improve response rates for Friends & Family Test - Inpatients	28.3%	28.1%	→
12. Improve response rates for Friends & Family Test – Accident & Emergency	6.9%	3.4%	<
13. Demonstrate improvement in patient satisfaction scores - Inpatients	93%	97%	☆
14. Demonstrate improvement in patient satisfaction scores – Accident & Emergency	78%	86%	☆

Achievements against quality improvement priorities 2015/16

Quality improvement 1 – patient safety

Take a zero tolerance approach to "never events"

Why = these are largely preventable patient safety incidents that should not occur if preventative measures have been implemented within the Trust
Outcome = close to target. 2 never events reported

During 2015/16 the Trust reported 2 never events against a target of 0. 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."

Year	Number of NE's reported*	Per 1000 occupied bed days
2012/13	2	0.0062
2013/14	3	0.0092
2014/15	1	0.0030
2015/16	2	0.0063

Details of the Trust's reported never events during 2015/16 is as follows:

- June 2015: wrong site surgery as a result of displaced abdominal organs due to pregnancy. Outcome: This incident was investigated and the findings identified learning points which have provided an opportunity to review and refine theatre pathway checklists.
- February 2016: Retained surgical swab. Outcome: this was an orthopaedic case where the issue was known at the end of procedure during the wound closure checks. Despite some exploration of the wound the swab was not identified and imaging did not identify it in the operating theatre. The subsequent identification with further imaging required the patient to undergo a minor procedure to remove the swab.

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

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.

* It should be noted that year on year figures are not directly comparable as the original 'Never Events' definition as set out by NPSA in April 2009 was expanded for 2011/12 and then expanded further in 2012/13, and revised again in 2014/15
Data Source: Doncaster and Bassetlaw 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 = close to target. 2 cases

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

The MRSA blood stream infection rate per occupied bed day remains below the Monitor de minimis limit. The Trust identified 2 cases of MRSA bacteraemia, one in the first quarter was deemed to have some lapses in care due to delayed sampling and use of intravenous Paracetamol which masked the patients temperature and potential sepsis, and as such may have been avoidable. The other occurred 10 months later within the Q4, and was deemed unavoidable. The blood culture contamination rates overall continues to remain below 3% and help to support the Trust's strategy to prevent MRSA bacteraemia cases.

Quality improvement 3 – patient safety

To reduce levels of hospital acquired C-diff

Why = the Trust wishes to ensure the safest possible care for patients by reducing the number of healthcare acquired infections.
Outcome = target achieved. 32 cases, a 27% reduction on last year.

Year	Number of reported cases	Per 1000 occupied bed days
2012/13	67	0.1988
2013/14	41	0.1269
2014/15	44	0.1353

2015/16	32	0.1023

For 2015/16 the Trust was set a trajectory of no more than 40 cases of C difficile by the Foundation Trust regulator, Monitor. Despite the challenges faced by a further reduction of C-diff trajectory the Trust remained one of the very few hospitals within Yorkshire and Humber to achieve their year-end trajectory with 32 cases; a 27% reduction on the 2014/ 2015 result. The main themes from Post Infection Reviews were associated with compliance issues with antimicrobials, delay in sampling and isolation. Considerable work has been done to update exiting antimicrobial policies and develop new guidelines as well, as the current emphasis is to prevent Antimicrobial Resistance (AMR) which is now a global threat.

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

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

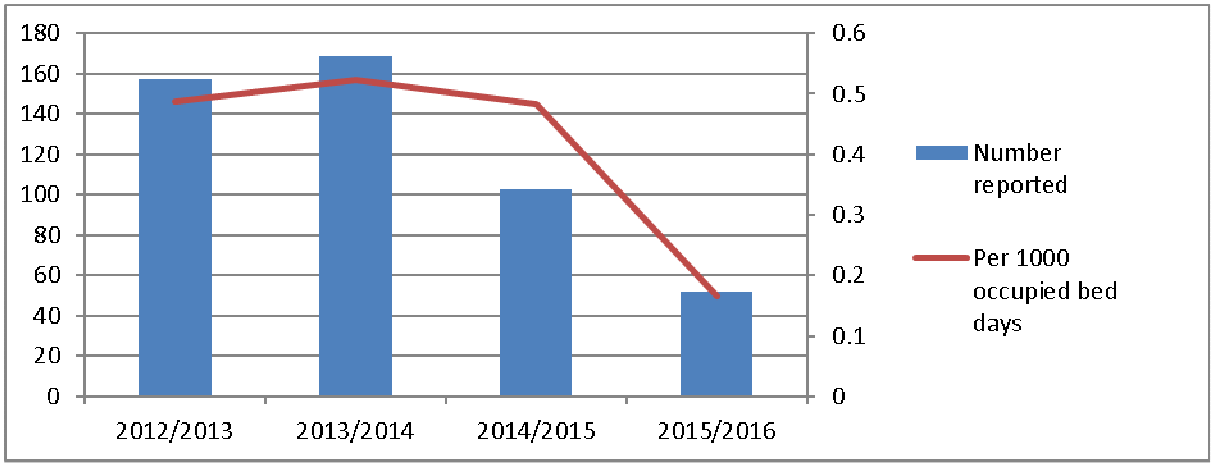
Quality improvement 4 – patient safety

Reduce the number of hospital acquired pressure ulcers above Category 2 (category 3 & category 4)

Why = To prevent injury to our patients relating to hospital acquired pressure ulcers, our Trust has adopted a zero tolerance approach
Outcome = Target achieved. 69% reduction in the last two years.

The Trust has continued to see a further reduction in the incidence of hospital acquired pressure ulcers (category 3, 4 and ungradable). Over the last two years a reduction of 67% has been achieved.

Year	Number of reported cases	Per 1000 occupied bed days
2012/13	157	0.4878
2013/14	169	0.5231
2014/15	103	0.4828
2015/16	52	0.1662



This is a result of the continuation of the Trust's Pressure Ulcer Prevention strategy which comprises of:

Risk Assessment and nursing documentation

- Trust wide risk assessment tool which simplifies the risk assessment process
- Risk assessment within two hours of admission
- Review and update nursing documentation related to pressure ulcer prevention and management

Equipment

- Provision of pressure relieving equipment within 4 hours of admission in accordance with patient's pressure ulcer risk status

Education

- The continuation of competency based education programme for trained staff
- Development of a new competency based training programme for untrained staff as part of a project for NHS England

Audit

- Development of an electronic audit tool which allows the monitoring of the standards set within the Trust's pressure ulcer prevention and management policy
- Roll out of the electronic audit tool across the Trust enabling Ward Managers to undertake surveillance monitoring

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

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

Quality improvement 5 – patient safety

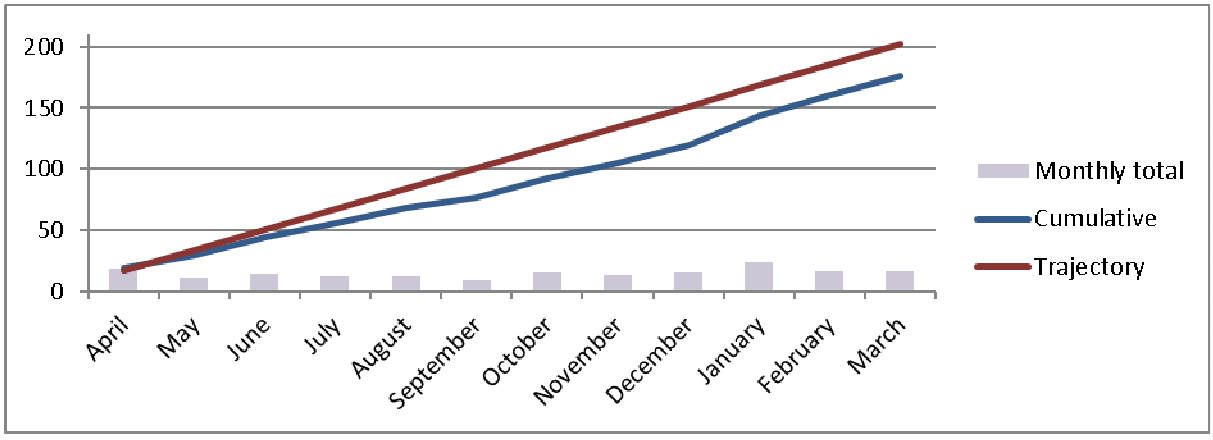
Reduce the number of repeat fallers

Why = Patients who have multiple falls run a greater risk of sustaining a significant injury from each fall that they have. While risk assessment for all patients is expected, the interventions to prevent falls do not prevent all patients from falling. Those who are at risk have an increased risk and so the post-fall review of preventative measures should further reduce risk for the patient concerned.
Outcome = Target achieved. 28% reduction.

The Trust invested in the Sign Up to Safety Campaign and as part of this work, the Trust has received funding to invest in a Falls Prevention Practitioner through the Fred and Ann Green Legacy. The Falls Prevention Practitioner supports the improvement of falls prevention, through Falls Champions, training and delivering the strategic steps to support reliable care processes.

During 2015/16 the Trust has seen not only a reduction in repeated falls, but the number of falls causing harm, falls causing serious harm and falls measured through the Safety Thermometer point prevalence audits have also reduced.

Year	Number of repeated falls	Per 1000 occupied bed days
2014/15	224	0.6888
2015/16	176	0.5632



To further support the Trust's aim for falls reduction, we will:

- Continue to set improvement targets for each ward based on their performance in 2015/16 to make further improvement on their performance.
- Continue with the training of falls champions on all wards within the Trust
- Revise and update the falls prevention care pathway to reflect the latest best practice evidence
- Develop and trial an enhance care team, who will provide additional support to patients who are at the highest risk of harm due to their clinical condition and falls risk.

- Conduct daily safety risk reviews in order to prioritise appropriate levels of observation.
- Further roll out of "Safety Huddles" – These are Falls safety briefings, Led by senior clinicians, to support the team in identifying those patients whom are at risk of falling and implement plans to prevent such incidents.

Progress, Monitoring & Reporting: Using DatixWeb monitor and review the rates of falls and repeated falls. Use the monitor and review process to identify trends. Monthly reporting at ward and care group level ensure Trust-wide learning. Monthly reporting to Patient Safety Review Group and Bone Health Group.

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

Quality improvement 6 & 7 – clinical effectiveness

Reduce the number of deaths which may have been preventable

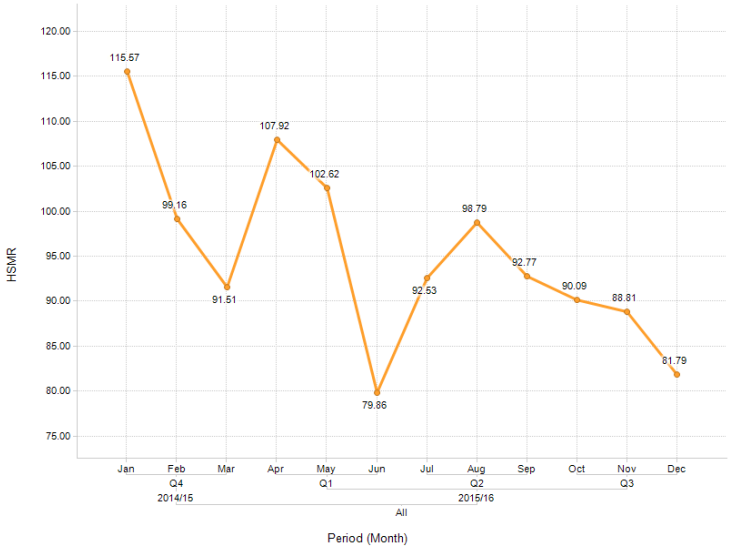
Why = Implementing a system for continuous review of HSMR and SHMI will support achievement of no avoidable deaths and no avoidable harm to patients
Outcome = Target achieved. HSMR 95.62. SHMI 105.7

The Trust has progressed a comprehensive action plan to improve care quality and decrease mortality. Over the last 12 months, crude mortality has decreased and this decrease has been manifest in a significant improvement in both HSMR, and latterly in our SHMI. From a position where both indicators were above the expected range, both are now within the expected range and our rolling 12 month HSMR at the end of January is below 100.

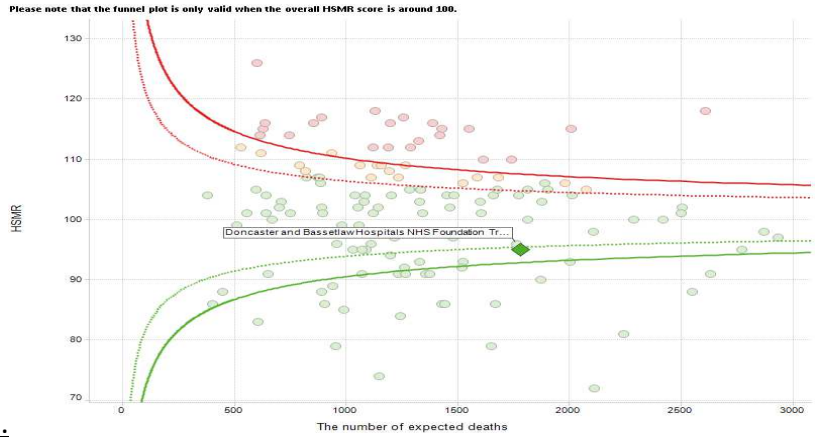
Whilst our risk adjusted mortality has improved, we continue to concentrate on identifying potentially avoidable deaths to ensure that learning from these is disseminated. To facilitate this, we are actively contributing to the pilot of the Yorkshire and Humber Academic Health Science Network into structured mortality reviews.

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)

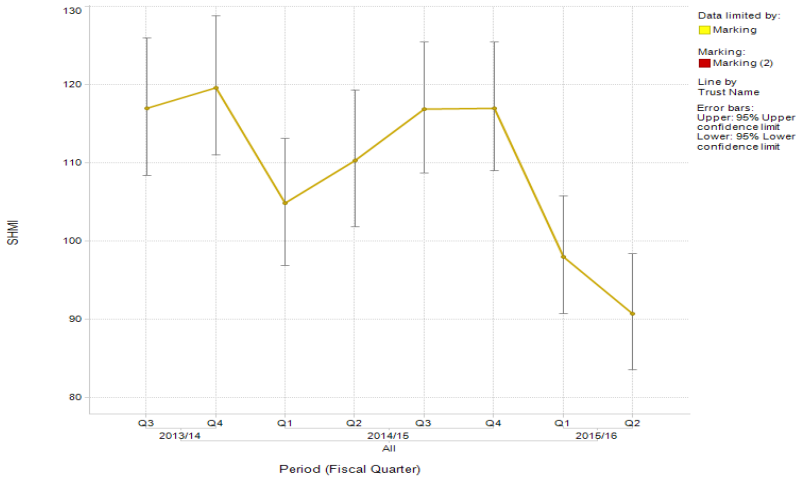
Reduction in HSMR



HMSR comparison with other acute trusts.



Reduction in SHMI



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 8 – clinical effectiveness

To increase the proportion of rotas which achieve the planned levels of nurse staffing.

Why = To support safe staffing across the inpatient ward areas, to ensure the right people, with the right skills, are in the right place at the right time – a guide to nursing midwifery and care staffing capacity and capability (2013)

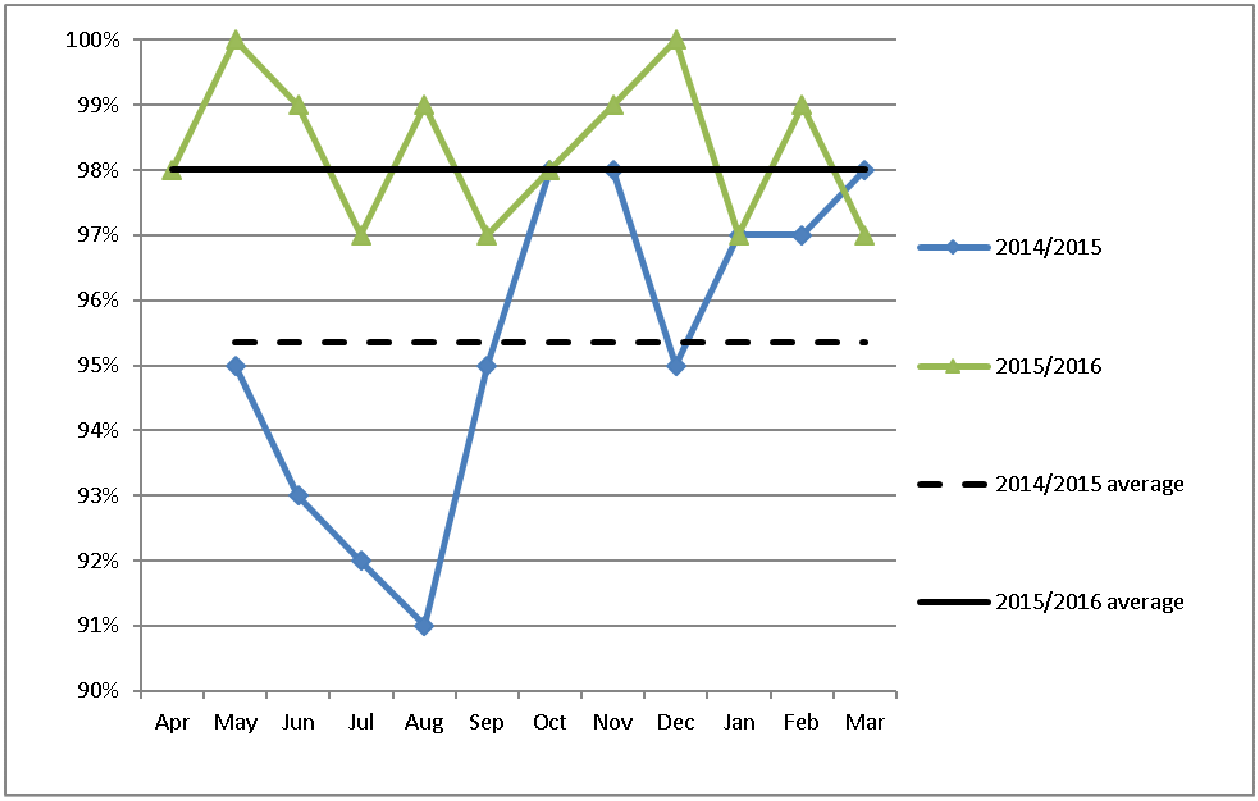
Outcome = Target achieved. 98.3%

Great progress has been made on nursing workforce information and staffing numbers and for the year the overall nursing workforce is within 2% of our identified target of 100%

The major issue facing most acute hospitals nationally, and locally, continues to be the challenge of filling qualified vacancies. We continue to take actions to mitigate the risks including:

- Put measures in place to reduce use of non-framework agencies and to minimise the breaching of the price cap
- Continue to monitor and use the escalation processes to tightly control use of registered and non-registered agency usage
- Implement recommendations from Lord Carters report specifically in relation to optimising clinical resources as further guidance becomes available
- Continue to progress the Non-Medical workforce utilisation programme utilising enabling tools e.g. Calderdale Framework, including;
    - Challenging and reviewing skill mix to make better use of Non-registered staff exploring the development of extended roles
    - Reviewing the non-ward staff roles and responsibilities
- Continue to monitor e-Roster efficiency with quarterly follow up meetings

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/ 2015		95.00%	93.00%	92.00%	91.00%	95.00%	98%	98.00%	95.00%	97.00%	97.00%	98%
2015/ 2016	98%	100%	99%	97%	99%	97%	98%	99%	100%	97%	99%	97%



A cap on agency expenditure for registered general and specialist nursing staff, midwives and health visitors has been in place since October 2015. The annual ceiling for the Trust has been set at the lowest level of 3% which is a reflection of the relatively low level of bank and agency usage when compared to the national picture. The cumulative percentage for October – March is 2.97%, which is within the 3% cap.

Progress, Monitoring & Reporting: Monthly reporting of establishment against actual nursing working. Reporting to the Board of Directors takes place monthly.

Quality improvement 9 – clinical effectiveness

Reduce the number of avoidable re-admissions

Why = Avoidable emergency re-admissions are a symptom of poor planning and support for patients when going home. The can also identify pathways of care that are prematurely discharging patients before they are well enough to cope at home.
Outcome = close to target

During 2015/16 the Trust has been working with partner provider organisations who manage the community services as part of the Commissioning for Quality and Innovation (CQUIN) scheme. The two schemes that contribute to this process of reducing the number of avoidable readmissions are the End of Life and Discharge schemes. Both schemes have set out to collaborate with partner organisations with working groups focused on improving the pathways of patients moving between services.

For End of Life care the joint working has helped to map the services that contribute to supporting patients, families and other professionals and help them navigate the health and social care system. Undertaking multi-disciplinary case reviews has helped refine and join up services, with clinicians focused on patients and the support that they need.

In the Discharge scheme staff across services have been surveyed and focus groups have provided valuable insights to develop improvements in the mapping of services in both Doncaster and Bassetlaw. Joint working groups have reviewed cases where there are opportunities to improve communication at discharge and prevent readmissions where avoidable.

Emergency readmissions occur for a wide range of reasons, often due discharges where there is a risk that a patient will not manage at home, but following optimised support, the team feel that an attempt to help patients return home is justified. Avoidable readmissions have been identified in both of joint working groups and some improvement is evident from the data analysis.

	Readmission Rate Q1 (Jan – Mar)	Readmission Rate Q4 (Oct – Dec)	Difference	Difference %
2014	6.39%	6.01%	0.38	**5.9**
2015	6.18%	5.73%	0.45	**7.3**

Progress, Monitoring & Reporting: Establish a process to review re-admissions. Monitoring through the CQUIN working groups and reporting to the board on the Readmission rate in the Business Intelligence report.

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

Quality improvement 10 – patient experience

Ensure all agreed actions resulting from upheld complaints are completed within agreed timescales

Why = learning from complaints is taken forward through actions to improve services in line with the needs of the patients.
Outcome = Close to target. 80% achieved.

In 2014 the Trust introduced a new policy; C*omplaints, Concerns, Comments and Compliments; Resolution and Learning*, which has provided a framework to improve the timeliness and quality of replying to complaints through improved consistency in the quality of investigations of complaints. The development of tools to identify learning points specific to the complaints have improved the identification of what issues are to be addressed and how this has been done which is included in the reply letters to complainants. For this quality account measurement, the Trust has audited the complaint action plans which are high risk and those learning points raised by the Parliamentary and Health Service Ombudsman (PHSO).

This audit has identified that 80% of the action plans have been completed in full with evidence of this. The 20% that are incomplete have been found to have partial completion but not sufficient to be classed as complete by the timescale set. These actions are being followed up with the services involved and will be reported through the Patient Experience Committee.

In the context of learning and improving the quality of services the Trust has reduced the number of complaints from 2014/15 by 11.8% and with each Care Group making an improvement, contributing to the overall reduction. Most notable improvement has been seen in the Emergency Care Group which had a 17.6% reduction in complaints. There is further work required to optimise learning from complaints in the Trust, building on the improvements already seen and the Top 10 performance nationally with the PHSO rate of contacts, investigation and those up held, reported in the 2014/15 PHSO annual statistics.

Progress, Monitoring & Reporting: Internal Audit review of actions. Audit of high risk and Parliamentary Health Service Ombudsman investigations. Reporting to the Patient Experience and Engagement Committee.

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

Quality improvement 11 & 12 – patient experience

Improve response rates for the Friends and Family Test

Why = The Trust believes that every patient should feel that they matter and are at the heart of everything we do.
Outcome = Behind plan. A&E completion rate 1.9%. Inpatient completion rate 19.2%

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. Since it was initially launched across inpatient areas in April 2013, the FFT has been rolled out in phases across the Trust to give all patients the opportunity to leave feedback on their care and treatment.

In 2015/16, as FFT had been established for two years, it became part of the NHS Standard Contract, rather than a CQUIN, recognising that both collecting and using FFT should be undertaken as part of everyday NHS business.

	A&E Completion Rates	Inpatient Completion Rates
2013/2014	25.1%	27.5%
2014/2015	6.9%	28.3%
2015/2016	3.4%	28.1%

Inpatient The ward discharge facilitators along with ward nursing staff have remained proactive in giving patients the opportunity to provide feedback on their experience. Throughout 2015/16 the Trust has a response rate of 28.1%.

Emergency Department (ED) The response rates nationally are lower than the rates for inpatient areas. However, our response rate has been disappointing despite exploring a number of initiatives including a text messaging service. Our response rates have consistently been below other Trusts across NHSE Yorkshire & the Humber (13.6%) and nationally across England, with our best performance for response rate being at 6.7% and our worst at 1.9% (Apr 15 – Jan 16). The overall rate is 3.4% for 2015/2016.

The Emergency department have recently reviewed their systems and processes for increasing the response rate for FFT in 2016/ 2017

Progress, Monitoring & Reporting: Monthly monitoring of A&E and inpatient FFT completion rates. Monthly reporting to the Board of Directors. Monthly benchmarking against national reporting.

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

Quality improvement 13 & 14 – patient experience

Improve patient satisfaction scores for the Friends and Family Test

Why = The Trust believes that every patient should feel that they matter and are at the heart of everything we do.
Outcome = Target achieved. A&E satisfaction score 86%. Inpatient satisfaction score 97%

In addition to recording response rates that FFT tool allows an understanding of whether people would recommend the services they have used . When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. Since it was initially launched across inpatient areas in April 2013, the FFT has been rolled out in phases across the Trust to give all patients the opportunity to leave feedback on their care and treatment.

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	A&E patient satisfaction scores	Inpatient patient satisfaction scores
2014/2015	78%	93%
2015/2016	86%	97%

Inpatient The average for the percentage of patients who would recommend our services is 96%. When compared with other Trusts across NHSE Yorkshire & the Humber and nationally across England, both our response rate and percentage of patients who would recommend our services has been better for 8 out of the 10 months where comparative data is available (Apr 15 – Jan 16).

Emergency Department (ED) Significant improvements have been made, surpassing the trajectory we set ourselves for 2015/16. However like the response rates, our patient satisfaction scores have

been disappointing with an 83% average of patients recommending our ED services compared with an average for NHSE Yorkshire & the Humber of 88%. The Emergency Department routinely analyse feedback provided for ways in which to improve the patient experience and the service.

Progress, Monitoring & Reporting: Monthly monitoring of A&E and inpatient FFT completion rates. Monthly reporting to the Board of Directors. Monthly benchmarking against national reporting.

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

This data is governed by: National definitions

Statements of assurance

Review of services

During 2015/16, Doncaster and Bassetlaw Hospitals NHS Foundation Trust provided and or sub-contracted 49 relevant health services.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by Doncaster and Bassetlaw Hospitals NHS Foundation Trust for 2015/16.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Doncaster & Bassetlaw Hospitals NHS Foundation Trust in 2015/16 that were recruited to research was 3941. Of these, over 1000 participants were recruited onto studies adopted onto the National Institute for Health Research Portfolio

During 2015/16, 49 additional studies were approved to commence within the Trust, which include Clinical Trials of Investigational Medicinal Products (CTIMPs) and Medical Device trials. The Trust supports research in differing roles, either as a sponsoring organisation, a participating organisation or as a participant identification centre. The department of Research and Development is continuing to expand to reflect both the increasing level of research activity and also to support the continuing advancement of research within the Trust, with the Research team providing comprehensive support to researchers during the planning, set-up and delivery phases of research.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to patients and to making our contribution to wider health improvements. Our clinical staff members stay abreast of the latest possible treatment options and active participation in research leads to successful patient outcomes. Our engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques.

In July 2015, we reviewed all the key targets we had ourselves for the first year of our Research and Development Strategy 2013-2018 and had met nearly all of them, including a number set for Year 3. Particular successes include recruiting the first patient outside of the US for a rheumatology clinical trial and the first global patient for a surgical study, as well as our team being shortlisted for two prestigious national awards; the HSJ 'Research Impact' award and the Nursing Times 'Clinical Research Nursing' award.

Participation in clinical audits

During 2015/16, 33 national clinical audits and 2 national confidential enquiries covered relevant health services that Doncaster and Bassetlaw Hospitals NHS Foundation Trust provides.

During that period, Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in 84% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Hospitals NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in during 2015/16 are as follows:

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Clinical Audits that the Trust was eligible to participate in during 2014/15			
Audits that the Trust was eligible to participate in during 2014/15	**Trust participation in audits**	**Data collection completed during 2015/16**	**% of cases submitted**
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Participated	Completed	100%
Adult Asthma	N/A	N/A	N/A
Bowel cancer (NBOCAP)	Participated	Completed	100%
Cardiac Rhythm Management (CRM)	Participated	Completed	100%
Case Mix Programme (CMP)	Participated	Completed	100%
Child Health Clinical Outcome Review Programme	Participated	Completed	100%

Chronic kidney disease in primary care	N/A	N/A	N/A
Congenital heart disease (Paediatric cardiac surgery) (CHD)	N/A	N/A	N/A
Coronary angioplasty (PCI)	N/A	N/A	N/A
Diabetes (Adult)	Did not participate	N/A	N/A
Diabetes (Paediatric) (NPDA)	Participated	Completed	100%
Elective surgery (National PROMs Programme)	Participated	Completed	100%
Emergency Use of Oxygen	Participated	Completed	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Participated	Completed	100%
Inflammatory bowel disease (IBD) programme	Participated	Completed	100%
Lung cancer (NLCA)	Participated	Completed	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Participated	Completed	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	N/A	N/A	N/A
National Adult Cardiac Surgery Audit	N/A	N/A	N/A
National Audit of Intermediate Care	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Participated	Completed	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Participated	Completed	100%
National Comparative Audit of Blood Transfusion programme	Participated	Completed	100%
National Complicated Diverticulitis Audit (CAD)	Participated	Completed	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participated	Completed	100%
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Did not participate	N/A	N/A
National emergency laparotomy audit (NELA)	Participated	Completed	52%
National Dementia Audit	Participated	Completed	100%

National Heart Failure Audit	Participated	Completed	62%
National Joint Registry (NJR)	Participated	Completed	100%
National Ophthalmology Audit	Did not participate	N/A	N/A
National Prostate Cancer Audit	Participated	Completed	100%
National Vascular Registry	Participated	Completed	100%
Neonatal intensive and special care (NNAP)	Participated	Completed	100%
Non-invasive ventilation – adults	N/A	N/A	N/A
Oesophago-gastric cancer (NAOGC)	Participated	Completed	100%
Paediatric Asthma	Participated	Completed	100%
Paediatric intensive care (PICANet)	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	N/A	N/A	N/A
Procedural Sedation in Adults (Care in Emergency Departments)	Did not participate	N/A	N/A
Pulmonary hypertension (Pulmonary Hypertension Audit)	N/A	N/A	N/A
Renal replacement therapy (Renal Registry)	Participated	Completed	100%
Rheumatoid and early inflammatory arthritis	Participated	Completed	100%
Sentinel Stroke National Audit Programme (SSNAP)	Participated	Completed	100%
UK Cystic Fibrosis Registry	N/A	N/A	N/A
UK Parkinson's Audit (previously known as National Parkinson Audit)	Participate	Completed	100%
Vital Signs in Children (Care in Emergency Department)	Did not participate	N/A	N/A
VTE risk in lower limb immobilisation (Care in Emergency Departments)	Did not participate	N/A	N/A

The reports of 33 national clinical audits were reviewed by the Trust in 2015/16 and Doncaster and Bassetlaw Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust will undertake any actions which were found necessary to improve the quality of healthcare.

The reports of 123 local clinical audits were reviewed in 2015/16 and we intend to take the following actions to improve the quality of healthcare:

- The Trust will ensure all actions are taken forward through the clinical governance arrangements at specialist and Care Group level.

We have listed below three examples of improvements which have been made as a result of audits undertaken throughout 2015/16:

Vitamin D Deficiency in Medical Inpatients at Bassetlaw Hospital

Vitamin D deficiency and insufficiency may further increase fracture risk in patients with decreased bone mineral density. We audited serum 25-hydroxyvitamin D (25OHD) concentrations in medical inpatients in BDGH between April 2014 to January 2015 (10 months) and their relationship to calcium and vitamin D. The total number of patients analysed was 200 (age range 18-99 years), with mean age of 76. The following cut-off points for serum 25OHD were used: levels < or = 30 nmol/L for severe deficiency, > 30-50 nmol/L for moderate, and > 50 nmol/L for mild.

Of the 209 attendances audited:
78/209 (37.3%) had mild vitamin D deficiency,
54/209 (25.8%) had moderate vitamin D deficiency,
68/209 (32.5%) had severe vitamin D deficiency,
9/209 (4.3%) died during their admission,
70/122 (57.4%) moderate/severe patients had their vitamin D deficiency treated according to local Trust guidelines
42/122 (34.4%) had documented evidence that their GP was notified in the discharge letter.
It was also established that there was no relationship between serum calcium levels and vitamin D deficiency whereas it was found that patient's alkaline phosphatase level was exponentially high with the severity index of vitamin D deficiency

Standards (Results in brackets)
1. 100% of moderate vitamin D deficiency patients should be treated according to local Trust guidelines. (59.3%)
2. 100% of severe vitamin D deficiency patients should be treated according to local Trust guidelines. (55.9%)
3. 100% of the patients should have documented evidence that their GP was notified in their discharge letter. (34.4%)

Action Plans

1. To incorporate discharge summaries and what is required of the junior doctors in the Induction and display an A4 poster in ATC.
2. Junior doctors to add/paste any abnormal results identified to the discharge summaries as a daily routine when such results are obtained. To be discussed in the induction.
3. To prescribe Vitamin D 100000 units, not as a stat dose but on the regular side as a single dose as we have seen that it gets charted as out of stock and then missed on various occasions.

Prostate Cancer Audit – Referral to Diagnosis

Prostate cancer is the commonest form of cancer in men. It affects mainly older men and is worse in men of Black/African-Caribbean origin.

Standards (Results in brackets)

1. All patients to be seen within 14 days of referral (85.29%)
2. All patients to have PSA result documented (100%)
3. All patients to have DRE result documented (100%)
4. 86% of patients to have 'Decision to treat' made within 41 days of referral (29.41%)

Conclusions

- We are falling short on some of our targets
- We are pretty good at seeing referrals within 14 days – but could be better
- Particularly 'rate-limiting' steps:
    - Time from Clinic to MRI scan
    - Time from MRI MDT to Biopsy
    - Time taken to report Biopsy
- Scope for improvement.

Action Plan

1. Aim to see referrals within 7 days
2. MRI scans to happen quicker – within 7 days (Radiology agreed to dedicate 10 MRI slots per week)
3. Aim for Biopsies to happen within 7 days
4. Aim for Biopsy report within 7 days
5. When patient is discussed in MDT – re-iterate number of days on pathway till that time.

Audit of the Fractured Neck of Femur Best Practice Tariff

Standards (results in brackets)

1. 100% to theatre within 36 hours. (54.5%)
2. 100% admitted using assessment tool. (82.7%)
3. 100% assessed by geriatrics within 72 hours. (80.9%)
4. 100% had pre-op and post-op AMT. (100%)
5. 100% joint orthopaedic and geriatric care. (100%)
6. 100% discussed in geriatric directed MDT. (100%)

Methodology
100 patients reviewed over a 3 month period.

Conclusions
Overall, only 33.6% met all Best Practice Tariff criteria.
This resulted in a loss of £42,340 to the Trust over a 3 month period.

Action Plan
1. Design jointly agreed assessment tool
2. Implement pilot assessment tool for use in NOF patients
3. Re-audit tool implemented

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of Doncaster and Bassetlaw Hospitals NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed by the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at:
http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf

The monetary total in 2015/16 conditional upon achieving quality improvement and innovation goals was £6.80 million. The total associated payment in 2015/16 was £XXX million.

We have worked with our local commissioners to ensure that the CQUIN scheme was aligned with local commissioning strategies and our own strategic direction and core values.

Working together the CQUIN income has been used to incentivise and accelerate quality and innovation improvements above the baseline requirements set out in the standard contract.
Although challenging, the Trust successfully achieved the majority of improvements and innovations which had been agreed.

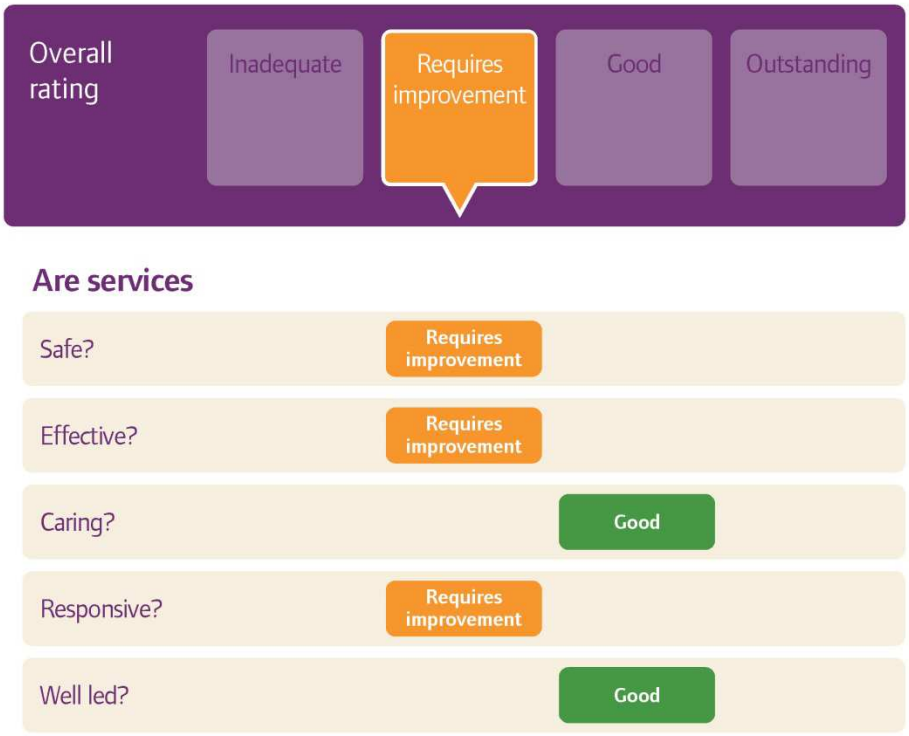
Statements from the CQC

Doncaster and Bassetlaw Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is Full Registration compliance with no conditions on registration.

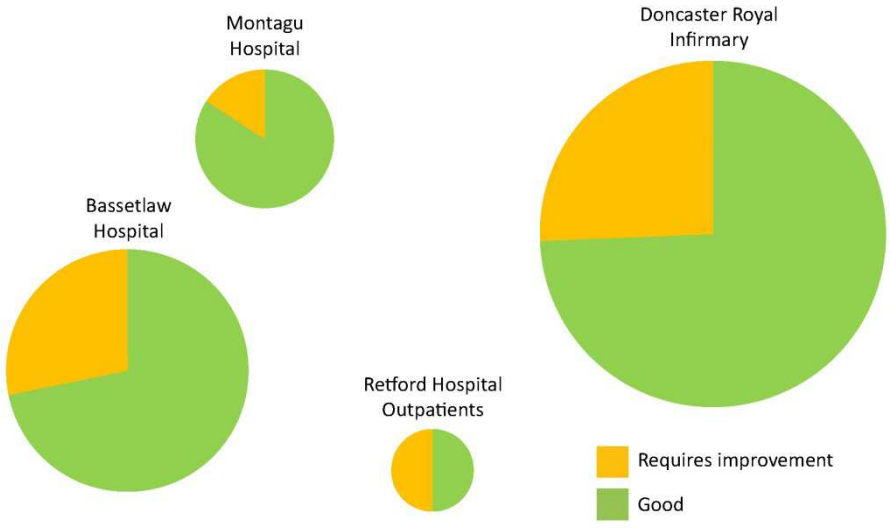
The Care Quality Commission has not taken enforcement action against Doncaster and Bassetlaw Hospitals NHS Foundation Trust during 2015/16.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has undergone a Comprehensive Inspection by the Care Quality Commission in April 2015. The subsequent findings were that the Trust overall outcome was "Requires Improvement". Doncaster Royal Infirmary, Bassetlaw Hospital and Retford Hospital were given outcome of "Requires Improvement", with Montagu Hospital being as assessed as "Good".



Positively noted in the assessment was that there were no services or components of core pathways identified as "Inadequate", with a total of 74% of services and their component parts being assessed as "Good".



Data quality

Doncaster and Bassetlaw Hospitals NHS Foundation Trust submitted records during 2015/16 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 the patient's valid NHS number was:

- 99.7% for admitted patient care – national position 99.2 %
- 99.8 % for outpatient care – national position 99.4%
- 98 % for accident and emergency care – national position 95.3 %

-which included the patients valid General Medical Practice Code was:

- 99.9 % for admitted patient care – national position 99.9 %
- 99.9 % for outpatient care – national position 99.9 %
- 99.8 % for accident and emergency care – national position 99.1 %

Information governance toolkit attainment 2015/16

Doncaster and Bassetlaw Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 of 75% and was graded as 'satisfactory'.

The Action and Improvement areas for 2016/17

The IG Objectives and Improvement Plans were formally agreed by the Information Governance Group (IGG) at its meeting on the 3rd March 2016; these Objectives and Improvement Plans are an integral element of the Trust's Information Governance Assurance Framework (IGAF), which is reported to and approved by the Trust Audit & Non Clinical Risk sub Committee annually. The IGG will also continue to concentrate their efforts on the ever changing standards in the coming financial year. These mainly relate to:

- Regularising the responsibilities and reporting arrangements for Information Governance and RA Smartcard Management involving the Trusts Caldicott Guardian/SIRO and the Trusts Care Groups and the Corporate Departments
- Improving the way in which Smartcards are managed and used by the Trusts Care Groups and the Corporate Departments, with particular emphasis on using them for:
    - Auditable access to Trust Information Systems through Position Based Access Controls (PBAC)
    - And for their extended use for access to National eLearning Management Systems, and the Trust's Statutory & Essential Training (SET) regime.
- Extending the use of The Summary Care Record Access Role to Oral & Maxillofacial Surgery (OMFS) staff
- Working smarter with FOI Requests internally, and improving access to published Information available to the Public through the Trust Internet website www.dbh.nhs.uk

Clinical coding error rate

Doncaster and Bassetlaw Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. In line

with Information Governance Requirements the Trust had external inpatient clinical coding audits, (diagnoses and procedure coding) undertaken during 2015/2016 which resulted in the Trust maintaining IG Level 3. The combined results of the audits were:

- Primary diagnoses incorrect - 4.5%
- Secondary diagnoses incorrect – 4.75%
- Primary procedures incorrect – 4.49%
- Secondary procedures incorrect – 4.53%

The results should not be extrapolated further than the actual sample audit as some of the issues raised may only relate to the speciality selected and will not apply to other specialities. Extrapolating the overall results would not provide an accurate position in relation to performance. The audited consisted of 404 finished consultant episodes split over 2 audits. The 1st audit in August 2016 included UTI diagnoses, sign and symptom coding and coding undertaken by Clinical Coders who were still under training. The 2nd audit was undertaken following the new PAS and Encoder implementation and was cross specialty.

During 2015/2016 the Trust implemented both a new Patient Administration System (PAS) and a Clinical Coding Encoder. These systems are still being embedded within the Trust and have had a significant impact on the Trust including the Clinical Coding department.

The Trust recognises the importance of high quality information as a fundamental requirement for the prompt, safe and effective treatment of patients. High quality information is critical to the delivery of high quality care to patients and in meeting the needs of clinical governance, management information, accountability, financial control, health planning and service agreements.

High quality business information supports decision making as well as ensuring that the Trust reports it performance accurately both internally and externally including Commissioners, Monitor, the Department of Health and the Care Quality Commission.

Achievement of CQUIN, accurate charging for PbR and non PbR income, through robust data collection and reporting, is also reliant on high quality data. It also provides Commissioner confidence and assurance.

Maintaining and driving improvements in data quality continued to be an area of high priority and focus for the Trust, during 2015/2016 and this will continue in 2016/2017 and beyond. The Trust continues to invest in data quality resources.

Key highlights include:

- In October 2016, the Trust implemented a modern Patient Administration System (PAS), which alongside other benefits, has provided opportunities for long term improved data quality. As with all major new system implementations, there have been some initial data quality challenges, and focused work continues to address these challenges.

- Nationally, data quality is measured by the Secondary Uses Service (SUS) Data Quality Dashboards. For 2015/2016 to month 10 (latest published data) the Trust had a composite score of 99.2% across a range of indicators which cover inpatients, outpatient and A&E, against a national comparative score of 96.2%. The Trust is consistently above the national average and is 4th within South Yorkshire and Bassetlaw. This is a significant achievement given the implementation of a new PAS system partway through the year.
- 18 Weeks data quality continues to be of high priority for the Trust with routine validation firmly embedded within the Trust. This ensures we have high quality data to maintain the accuracy of waiting times to support treating patients in chronological order for the same clinical priority, support demand and capacity modelling and ensure accurate performance reporting.
- Key priority packages of work were agreed and delivered in line with the requirements laid down within the Data Quality Improvement Plan for 2015/2016 within the NHS Standard Contract with Commissioners. The PAS Replacement and the ability to continue to report high priority areas, with data that could be relied upon, was of the highest priority and will continue to be a key of focus for 16/17.
- We continue to provide focus on key data quality performance areas through the Trust Data Quality Group. The group identifies key work streams to address areas of concern and then monitors and review progress against improvement targets. A key focus for 15/16 has been the PAS replacement system and this will continue in to 16/17. The Data Quality Group reports to the Trust Information Governance Group.
- We continue to undertake key regular data quality audits, both to fulfil Information Governance and local requirements. We promote the principle of “Right First Time” in respect of recording patient information. This also links into the Trust’s financial Turnaround projects and will gain additional focus in 16/17.
- For all Trust system implementations, data quality is a key element within the project, including potential risks along with mitigating strategies and actions.

The Trust is required to report on a core set of indicators. Presented, in the table below is the required data for the last two reporting periods. The data was made available by the Health & Social Care Information Centre.						NHS Trusts & NHS Foundation trusts performance	
				National Average	**Doncaster & Bassetlaw NHS Foundation Trust intends to take the following actions to improve this number, and so the quality of its services by:**	**Highest**	**Lowest**
The value and banding of the SHMI* for the Trust	1.0556 Banding 2 (2012/13)	1.128 Banding 1 (2013/14)	1.057 Banding 2 (2014/15)	1 Banding 2 (2014/15)	Implementing all the measures which have been outlined in page 57 of the Quality Account 2015/16		
Patient Reported Outcome Measures (PROMs) **(EQ 5D Adjusted average health gain)** **Groin hernia surgery** **Varicose vein surgery** **Hip replacement surgery** **Knee replacement**	 0.099 0.176 0.401 0.322 (**2012/13)**	 0.076 0.138 0.423 0.322 **(2013/14)**	 0.067 0.119 0.455 0.331 **(2014/15)**	 0.084 0.095 0.437 0.315 **(2014/15)**	Ensuring that the Clinical Director within the Care Group actively monitors the PROMs scores and takes action as appropriate in order to improve health gain scores for patients.	**Awaiting Data**	**Awaiting Data**
Readmissions to hospital within **28 days of being discharged, percentage aged:** **0 – 15** **16 and over**	10.82% 11.45% (**2010/11)**	10.24% 11.86% (**2011/12)**	**Awaiting Data**	**Awaiting Data**	**NARRATIVE NEEDED**	**Awaiting Data**	**Awaiting Data**
Responsiveness to inpatients personal needs	68.9% **(2012/13)**	67.4% **(2013/14)**	69.9% **(2014/15)**	68.9% **(2014/15)**	The Trust's achievement is above the national average. We will continue to monitor the views of our service user and implement changes where necessary in order to improve the experience of our patients.	86.1% **(2014/15)**	59.1% **(2014/15)**
Percentage of staff employed who would recommend the Trust as a provider of care to their family or friends	59% **(2013)**	**57%** **(2014)**	64% (2015)	70% **(2015)**	**NARRATIVE NEEDED**	85% **(2015)**	46% **(2015)**
Percentage of patients who were admitted to hospital and who were assessed for venous thromboembolism	95.0% **(Apr 15- Jun 15)**	95% **(Jul 15 – Sep15)**	95% **(Oct 15- Dec15)**	95.5% **(Oct 15- Dec15)**	Trust performance remains on target.	100% **(Oct 15- Dec15)**	84.9% **(Oct 15- Dec15)**
Rate of C.difficile per 100,000 bed days	21.5 **(2012/13)**	14.2 **(2013/14)**	15.0 (2014/15	14.5 **(2014/15)**	Implementing all the measures which have been outlined in page 55 of the Quality Account 2014/15	62.2 **(2014/15)**	2.6 **(2014/15)**
Number and rate of patient safety incidents reported within the Trust	Number: 3905 Rate: 26.6 (Oct 13-Mar14)	Number: 35 Rate: 0.24 (Apr14 -Sep14)	Number: 5548 Rate: 36.08 (Oct 14-Mar15)	Number: Rate: (Oct 14-Mar15)	Incident reporting rates are within the expected range when compared to our class.	Number: 12,784 Rate: 62.54 (Oct 14–Mar 15)	Number: 443 Rate: 3.57 (Oct 14–Mar 15)
Percentage of patient safety incidents which resulted in severe harm or death.	**Awaiting Data**	**Awaiting Data**	**Awaiting Data**	**Awaiting Data**	**NARRATIVE NEEDED**	**Awaiting Data**	**Awaiting Data**
The Doncaster & Bassetlaw NHS Foundation Trust considers that all the data contain in the above table is as described for the following reasons: *It has been extracted from HSCIC systems without further amendments, and the Trust has considered underlying reasons for its performance against these indicators, putting action plans in place as required*							

Review of Quality Performance 2015/16

The indicators below are included to demonstrate the Trust's performance against some additional quality initiatives which were selected by the Board of Directors and which were monitored internally throughout 2015/16. Some of the indicators were mandatory for 2015/16, however, the remaining indicators were chosen as we were able to benchmark against national targets.

The achievements made throughout 2015/16 against national targets and regulatory requirements are set out in the table below;

National targets and regulatory requirements	2013/14	2014/15	2015/16	National target or trajectory 2015/16
Screening all elective in-patients for MRSA *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**100%**	**100%**	**100%**	**100%**
MRSA – maintaining the annual number of MRSA bloodstream, infections at less than half the 2003/04 level *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**2**	**2**		**0**
Clostridium difficile year on year reduction *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**41**	**44**	**32**	**40**
Maximum waiting time of four hours in A&E from arrival to admission, transfer or Discharge *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**95.5%**	**92.9%**	**94.51%**	**95%**
A two week wait from referral to date first seen comprising: • **all cancer** • **Symptomatic breast patients** *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	 **93.7%** **93.9%**	 **94.9%** **94.1%**	 **93.9%** **94.7%** **(data upto month 11)**	 **93%** **93%**
A maximum wait of 31 days from diagnosis to treatment of all cancers *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**99.2%**	**98.7%**	**98.8** **(data upto month 11)**	**96%**
A maximum wait of 62 days from urgent GP referral to treatment of all cancers	**89.2%**	**87.8%**	**84.3%** **(data upto month 11)**	**85%**
A maximum waiting time of 31 days for subsequent treatments for all cancers: • **Surgery** • **Drugs** • **Radiotherapy and Other** • **62 day - screening** ***(this figure includes the Rare Tumours which are managed on a 31 day Referral to treatment pathway)***	 **98.3%** **100%** **100%** **94.2%**	 **99.1%** **100%** **100%** **94.4%**	 **97.6%** **98.4%** **100%** **91.4%** **(data upto month 11)**	 **94%** **98%** **94%** **90%**

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems				
18 week maximum wait from referral to treatment (admitted patients) *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**84.8%**	**88.2%**		**90%**
18 week maximum wait from referral to treatment (patients on an incomplete pathway) *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**92.8%**	**93%**		**92%**
100% of people with diabetes to be offered screening for early detection (and treatment if needed) of diabetic retinopathy *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**99.9%**	**94.5%**		**100%**
Breastfeeding Initiation *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**66%**	**64.3%**	**64.3%**	**68%**
Breastfeeding at transfer to Health Visitor *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**32.9%**	**29.6%**	**33.8%**	**40%**
All patients who have operations cancelled for non-clinical reasons to be offered another date within 28 days *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**1.14%**	**1.2%**		**0.75%**
Number of Patient Safety Incidents *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**10485**	**10260**		**N/A**
Percentage of Patient Safety Incidents resulting in severe harm/death *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**3.8%**	**1.03%**		**N/A**
Staff sickness rates *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**3.98%**	**3.97%**	**4.6%**	**<3.5%**
Number of staff who have had a Personal Development Review (PDR) with the last 12 months. *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**66%**	**42.33%**	**68.40%**	**N/A**

** *Data collection changed mid year from breast feeding at 10 days post delivery to at the time of transfer to Health Visitor and from just those women who initiated breast feeding to all women who gave birth to a live baby.*

*** *This indicator was not measured in 2008/09*

**** *This indicator was not measured in 2008/09 & 2009/10*

***** *This indicator was not measured in 2008/09, 2009/10, 2010/11, 2011/12*

Comments on the 2015/16 Quality Account were received by:

Nottinghamshire Healthwatch

Doncaster Healthwatch

Bassetlaw Clinical Commissioning Group (CCG)

Doncaster Clinical Commissioning Group (CCG)

Governors

Overview and Scrutiny Committee Doncaster

Health Scrutiny Committee Nottinghamshire

Statement of directors' responsibilities in respect of the quality account/report

The directors are requires under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Account for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation for the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to March 2016
  - Papers relating to Quality reported to the Board over the period April 2015 to March 2016;
  - Feedback from commissioners dated **XX/XX/20XX**;
  - Feedback from Governors dated **XX/XX/20XX**;
  - Feedback from Local Healthwatch organisations dated **XX/XX/20XX**
  - Feedback from Overview and Scrutiny Committee dated **XX/XX/20XX**
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated **XX/XX/20XX**
  - The latest national patient survey dated February 2016;
  - The latest national staff survey dated February 2016;
  - Care Quality Commission Intelligent Monitoring Reports dated May 2015
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated **XX/XX/20XX**
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measure of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporated the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual) .

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

By order of the Board

xx May Add in signature Chairman
xx May Add in signature Chief Executive

Independent Auditor's Report to the Board of Governors of Doncaster and Bassetlaw Hospitals NHS Foundation Trust on the Annual Quality Report

[To be added by auditors]

Assurance work performed

[To be added by auditors]