East Lancashire Hospitals NHS
NHS Trust

Quality Account

2014 | 15

Account of the Quality of Clinical Services
East Lancashire Hospitals NHS Trust
1st April 2014 to 31st March 2015

Safe | Personal | Effective

www.elht.nhs.uk

contents

Part 1

1.1 Introduction to the Trust

East Lancashire Hospitals NHS Trust was established in 2003 and is a large integrated healthcare organisation providing acute secondary healthcare for the people of East Lancashire and Blackburn with Darwen and community healthcare services for the population of East Lancashire.

Our population includes some of the most deprived areas of England and the area has an ageing population. Located in Lancashire in the heart of the north west of England, with Bolton and Manchester to the South; Preston to the West and the Pennines to the East, we serve around 530,000 patients.

The Trust has a total of 1079 beds, 25 theatres, 2 cardiac catheterisation labs, 7 endoscopy rooms and five hospital sites comprising Royal Blackburn Hospital, Burnley General Hospital, Pendle Community Hospital, Accrington Victoria Hospital and Clitheroe Community Hospital. We also provide services and clinics in a large number of community health centres across the area.

The Trust is a major local employer and as of April 2015, the Trust employed 7789 members of staff including over 3700 nurses and 528 doctors with 84% living in the East Lancashire area. The Trust is made up of four divisions:

- Integrated Care Group;
- Family Care;
- Surgery and Anaesthetic Services;
- Diagnostic and Clinical Support

We are a specialist centre for Hepatobiliary; Head and Neck and Urological Cancer Services, Vascular, Cardiology services and a network provider of Level 3 Neonatal Intensive Care.

1.2 Our Quality Account 2014-15

Quality Accounts are annual reports from providers of NHS healthcare and they serve to provide information about the quality of the services that they deliver. Quality Accounts have become an important tool for strengthening responsibility and accountability for quality within Trusts and for ensuring effective engagement of Trust leaders in the quality improvement agenda.

The requirement placed upon NHS Trusts to produce a Quality Account is set out in the Health Act 2009 and the associated NHS Regulations and as such places quality reporting on an equal footing with financial reporting.

By producing a Quality Account, Trusts are able to demonstrate their commitment to continuous evidence based quality improvement and to explain their progress to patients, the public and stakeholders.

The format and content of the Trust's Quality Account is in the main directed by Regulation and sets out:

- The Trust's priorities for Quality improvement for the forthcoming year
- Performance against quality priorities that the Trust set last year for this year
- Performance during the year against a range of nationally mandated quality indicators, initiatives and processes
- Performance during the year against a range of locally determined quality initiatives

1.3 Chief Inspector of Hospitals reviews

The CQC assessed all of the 14 Trusts who were in special measures in the early part of 2014. This approach builds on the methodology developed for the Keogh Review but goes further. A wide range of quantitative and qualitative information is gathered before the inspection. The inspection itself is undertaken by a team comprising clinicians, Experts by Experience and CQC inspectors. Eight core services are always inspected with each being assessed against five key questions: Is it safe? Is it effective? Are staff caring? Is the service responsive to patients' needs? Is the service well-led?

A rating is given to each service on each of these five questions on a four-point scale (outstanding, good, requires improvement or inadequate. East Lancashire Hospitals NHS Trust received its Chief Inspector of Hospitals review in April/May 2014 and the CQC recommended that the trust exit from Special Measures with continued support from the NHS Trust TDA on the basis that good progress had been seen on improving quality, the Trust had received no inadequate ratings and there was strengthened leadership at Board level. The Trust committed to continue making improvements to quality and safety through the publication of its Quality Improvement plan, the implementation of which is overseen by the Trust Board.

Some of the key achievements made since that time that have been part of the Quality Improvement Plan are:

- Reduction in Harms – particularly pressure ulcers, but also a focus on reducing falls, hospital acquired infection rates and medication errors
- Enhancing the numbers of clinical staff in the organisation, particularly nurses and doctors
- Improving the flow of patients in the hospital by improving the effectiveness of the emergency care pathway – further work is now underway to create greater capacity to treat patients who need a short length of stay in the hospital with in-reaching specialty clinicians
- Minimising inconvenience to patients by reducing short notice outpatient appointment cancellations by 50%
- Reducing mortality rates – now both HMSR and SHMI are within expected limits
- Improved bereavement services with the introduction of a new strategy and better facilities for bereaved relatives
- Improved care for patients with dementia through the launch of a new strategy and better ward facilities which are more dementia friendly
- Improved complaints processes that are more responsive and sympathetic to complainants needs and we have seen a significant reduction in both the number of complaints and the backlog for complaints resolution
- Learning lessons through recognition and the use of information gained from incidents and events as an opportunity to contribute to continuous improvement
- Improved communications and engagement with staff (our staff survey results this year show significant improvement) and with patients and the public through for example, our Tell Ellie programme
- Improvement in organisational leadership – the organisation now has a stable Board with new chair and chief executive and a number of other new appointments

1.4 Chief Executive's statement on Quality

The Trust has made considerable progress in the last couple of years, and this has been the result of an absolute focus on improving quality to achieve better outcomes and an enhanced experience for our patients. Whilst this focus has been maintained throughout the Trust, I can assure you that continuing to improve quality is my own personal priority, as well being the overriding priority of the Trust Board.

As a direct result of the Trust's first ever Quality Strategy (published in 2014) there has been a considerable emphasis on safety measures.

Efforts to increase the use of care bundles, prevent falls and eliminate pressure ulcers have had a significant impact.

It is rewarding to see a welcome and sustained reduction in mortality rates, putting us firmly back to within expected ranges.

Of course, there is more to do and you can be sure that we are not complacent. The Trust will be relentless in its pursuit of the best quality safe, personal and effective care for all of our patients, all of the time.

Kevin McGee
Chief Executive

Part 2

2.1 Our strategic approach to Quality

We have fundamentally changed our approach to quality and safety in the last year and, as a result, we have made a pledge to become recognised as an organisation which delivers **Safe**, **Personal** and **Effective** care. We have contributed to and signed up to the 'Sign up to Safety' Campaign and the 'Making Safety Visible' collaborative as an organisation and our Quality Strategy reflects the aims and pledges made in these programmes. These are detailed below.

Safe Care

Harms Reduction:

We have pledged to reduce moderate and above Harms by 15%. This is being actioned through our Harms Reduction Programme facilitated by the Sign up to Safety Programme, and through collaborative work with our 'buddy' organisation Salford Royal Foundation Trust.

Our Harms Reduction Programme is focusing on:

- Pressure ulcer reduction using a collaborative methodology
- Reducing falls with harm using a collaborative methodology
- Health care associated infections in conjunction with the TDA Infection Control Team
- Medication incidents monitored by the Medicines Safety and Optimisation Group
- Reducing Hospital Acquired Venous thromboembolism (VTE)

Mortality Reduction:

We have pledged to reduce our SHMI and HSMR to within the expected range; the equivalent of saving an additional 150 lives per year. We are working to achieve this by ensuring all deaths are reviewed to ensure any lessons for improvement can be acted upon and more specifically ensuring patients at risk of clinical deterioration are identified early and appropriate interventions are made. This will be achieved through the review of our clinical response and outreach teams and the use of clinical decision tools such as an

electronic 'early warning score' system as well as improving the reliability of care delivered using care bundles and adoption of Advancing Quality measures.

We will ensure we have adequate numbers of staff on duty who are appropriately trained and supervised to deliver the care required. This includes all staff; Medical (and Doctors in training), Nursing and Allied Health Professionals. Nurse staffing levels are monitored on a daily basis through safe staffing teleconferences coordinated by the Chief Nurse.

To ensure that we learn from safety incidents we will continue to encourage staff to report incidents and to remain in the top quartile of Trust's reporting to NRLS. In addition we will continue the development of the Serious Incident Requiring Investigation (SIRI) Panel to ensure serious incidents are properly investigated and reported and lessons learned with appropriate actions taken.

Personal Care

In response to the Keogh Review and stakeholder feedback we have focused upon making our services more responsive to patient's needs and our aim is to have 75% of Friends and Family respondents recommend our services.

We have focused on our complaints procedures to improve the speed and efficiency of our responses but more importantly to make our responses more compassionate and responsive to the actual issues raised. We will continue to improve our complaints process with particular emphasis on patient and relative feedback and contribution to how the process works.

We will continue to improve our end of life care and the support offered to bereaved families. We have appointed a Bereavement Facilitator and have a comprehensive bereavement action plan in place. The Bereavement Steering Group reports to our End of Life Steering Group which is monitored through the Trust's Patient Experience Committee.

From a patient experience point of view we have a Family, Patient and Carer Experience Strategy which will ensure that as a Trust we put patients first and respect individuals during the provision of their care. A supporting comprehensive action plan has been developed with implementation overseen by the Patient Experience Committee which includes representation from our local partners e.g. Health Watch.

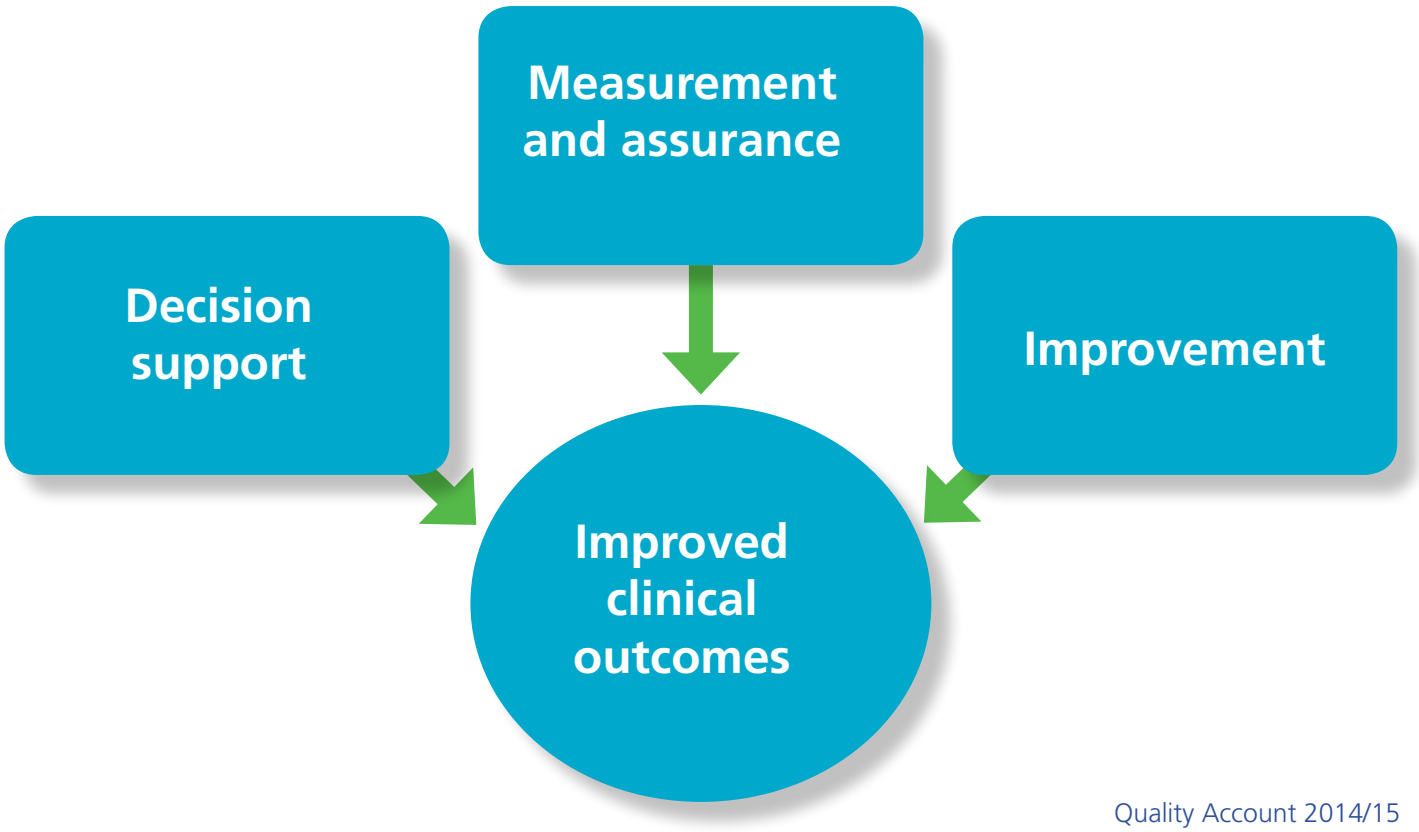
Clinically Effective Care
The Trust has reviewed the function and delivery of its Quality and Safety Unit to establish a team and resource to support clinical teams in the delivery of improved Clinical Effectiveness and Quality Improvement. Improved outcomes will be delivered through reliable delivery of best practice. This is illustrated in figure 1 below and will be achieved by strengthening:

Decision support - through
- Supporting development of agreed health economy clinical pathways
- Strengthening governance for guidelines, pathways and care bundles
- Improving access to best practice guidance, with a single point of access using information technology

Measurement and assurance - through
- Moving the emphasis of measurement from past harm, to real time monitoring and predictive technology and prevention
- Automation in measurement
- Smaller audit samples measuring small tests of change over time
- Multi-professional audit
- National audit and benchmarking
- Measuring reliability of best practice by Advancing Quality compliance, and a similar approach to other care bundles

Improvement - through
- A dedicated Quality Improvement Team and Resource
- Supporting clinical teams with the development of skills and knowledge in improvement methodology based on our "7 Steps to Safe Personal Effective Care'
- Developing a central register of improvement programmes and projects
- The development of a quality improvement projects framework with Doctors and other professionals in training
- Delivery of quality improvement initiatives through ward and department Share to Care meetings
- Improved data and information analysis and presentation

Figure 1 - Key Elements of Clinical and Effectiveness and Quality Improvement



Through these developments we will continue to increase the number of patients who receive evidence-based care. We will oversee this via the Clinical Effectiveness Committee which monitors compliance with national and local guidance; this includes National Institute Clinical Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), College/ Specialty guidance, AQ (Advancing Quality) guidelines and the compliance with local care bundles. The Clinical Audit Committee will be subsumed into the Clinical Effectiveness Committee to reflect the move to measurement in real time to drive improvement. We will continue to monitor timeliness of care with specific improvement plans for delivery of Emergency Department, Referral to Treatment and Cancer

We have a good record of patient recruitment for clinical trials; we are one of the leading recruits for portfolio studies in the region. Our Research and Development Strategy continues to ensure that as many patients as possible are able to participate in clinical research studies. We will learn from this research new approaches to care that can be rapidly implemented locally

An area for development is to improve our adoption of innovative techniques and technologies. A Deputy Medical Director for performance has recently been appointed with clear objectives for improving adoption of innovative technologies.

To facilitate improvement of the delivery of Safe, Personal and Effective Care we will continue to invest in and develop Quality Improvement Capacity and Capability within the Organisation. This will involve the development of a dedicated Quality Improvement Team whose role will be to oversee all quality improvements within the organisation, spread the standardized quality improvement methodology, monitor achievement of improvement targets and intervene where appropriate and to educate and facilitate all staff to become involved in quality improvement projects.

2.2 Commissioning for Quality

The lead Commissioner for the Trust is East Lancashire Clinical Commissioning Group (CCG) accounting for approximately two thirds of activity undertaken by the Trust with Blackburn with Darwen CCG accounting for the major proportion of the remaining activity

Relationships and communication with lead CCG's has been strengthened during 2014-15. Monthly Quality Review Meetings are held, chaired by East Lancashire CCG with attendance from Quality Leads from all organisations. The focus of these meetings is around Clinical Effectiveness, Safety and Risk, Quality Improvement and the Patient and Family Experience. In addition, communication has further been strengthened by the introduction of a weekly teleconference between the lead CCG, the Commissioning Support Unit (CSU) and the Trust.

The escalation process for incidents, risks and events of concern has been revised and improved during 2014-15 to ensure timely and appropriate communication to all relevant parties.

Evidence to verify improvements is collated from Divisions and presented to one of the monthly subcommittees of the Trust Board which are:

- Patient Safety and Risk Assurance Committee
- Clinical Effectiveness Committee
- Patient Experience Committee

Following the above meetings, validated reports and data are shared with the CCG and the CSU to provide assurance and to support Health Economy decision making. Reports include:

- Complaints and PALS report
- Health Care Associated Infection report
- Exception reports against key performance standards

During 2014-15 a quality scorecard has been developed to facilitate monitoring against a range of quality indicators. It is planned to further enhance this scorecard during 2015-16

2.3 Quality monitoring and assurance

During 2014-15 the East Lancashire Hospitals NHS Trust provided and/ or sub-contracted 8 NHS services. These services have been identified using the Care Quality Commission's definition of regulated activities. The services provided during the year were:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Management of supply of blood and blood-derived product

The Trust has reviewed all the data available on the quality of care in all of these NHS services. The Trust uses its integrated quality, safety and performance scorecard to facilitate this.

Reports to the Trust Board, the Patient Safety and Governance Committee, Patient Experience Committee, Clinical Effectiveness Committee, Patient Safety and Risk Assurance Committee and Executive Management Board all include data and information relating to quality of services. Progress against last year's priorities for quality improvement as set out in our Quality Account 2013-14 has been managed by way of these reporting functions.

The income generated by the NHS services reviewed in 2014-15 represents 94.1% of the total income generated from the provision of NHS services by the East Lancashire Hospitals NHS Trust for 2014-15.

2.4 Priorities for quality improvement 2015-16

Our Quality Account provides a range of quality improvements that we have pursued during 2014-15. To enable our patients, staff and stakeholders to help us prioritise our quality improvements for inclusion in our 2015-16 Quality account we conducted a short survey which asked those who completed it to rank a number of quality improvement initiatives in order of priority.

The results indicated that the top three quality improvement priorities for 2015-16 are:

No	Quality priority aim	How the quality priority achievement will be measured	How the quality priority achievement will be monitored
1	Reduce the risk of malnutrition and dehydration through improvements in the assessment of patient's needs, access to and choice of food and increased support for patients at mealtimes	Achievement will be measured by way of a risk and performance assessment framework which will include a ward level scorecard system	Regular report to the Trust's Nutrition and hydration Steering Group
2	Increase compliance with the sepsis care bundle to improve the recognition and timely management of severe sepsis and sepsis shock	Achievement will be measured by way of assessment of compliance against the Advancing Quality sepsis target and National sepsis CQUIN	Bi Monthly report performance report to the Clinical Effectiveness Committee
3	Reduce medication incidents that cause moderate or more harm by 20%	Achievement will be measured by way of a trajectory based upon the starting baseline position and the end point target	Bi monthly performance report to the Patient Safety and Risk Assurance Committee

2.5 Mandated statements on quality of NHS services provided

The Trust is required to include outcome information with its Quality Account on a range of quality focussed functions and these are set out below

2.5.1 Clinical Audit and Confidential Enquiries

Clinical Audit involves improving the quality of patient care by reviewing current practice and modifying it where necessary. The Trust takes part in Regional and National Clinical Audits, and also carries out local audits. Sometimes there are also National Confidential Enquiries which investigate an area of health care and recommend ways of improving it.

The Trust also takes part in these Confidential Enquiries. During 2014-15, 39 National Clinical Audits / Programmes and 5 National Confidential Enquiries covered NHS services that East Lancashire Hospitals NHS Trust provides. During that period East Lancashire Hospitals NHS Trust participated in 95% of National Clinical Audits and 100% of National Confidential Enquiries of the National Clinical Audits and National Confidential Enquires which it was eligible to participate in. The National Clinical Audits and National Confidential Enquiries that East Lancashire Hospitals NHS Trust was eligible for, and subsequently participated in are set out in the table below.

The National Clinical Audits and National Confidential Enquiries that East Lancashire Hospitals NHS Trust participated in, and for which data collection was completed during 2014-15 also appears in the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number or registered cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	NICOR	Continuous	Yes	100%
Adult Community Acquired Pneumonia	BTS	Intermittent	Yes	100%
Bowel cancer (NBOCAP)	RCS	Continuous	Yes	100%
Care of dying in hospital (NCDAH)	RCP	Intermittent	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Coronary Angioplasty/National Audit of PCI	NICOR	Continuous	Yes	100%
Diabetes (Adult)	HSCIC	Continuous	Yes	100%
Diabetes (Paediatric) (NPDA)	RCPCH	Continuous	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	BOA	Continuous	Yes	100%
Fitting child (care in emergency departments)	CEM	intermittent	Yes	100%
Fractured neck of femur (care in emergency departments)	CEM	intermittent	Yes	100%
Inflammatory Bowel Disease (IBD) programme	RCP	Intermittent	Yes	100%
Lung cancer (NLCA)	RCP	Continuous	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	TARN	intermittent	Yes	>65%
Mental health (care in emergency departments)	CEM	intermittent	Yes	100%
National Audit of Intermediate Care	NHS Benchmarking Network	Intermittent	No	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National COPD Audit Programme	RCP	Intermittent	Yes	100%
National Comparative Audit of Blood Transfusion programme	NHSBT	Intermittent	Yes	100%
National Complicated Diverticulitis Audit (CAD)	Yorkshire Surgical Research Collaborative	Intermittent	No	100%
National Emergency Laparotomy Audit (NELA)	RCA	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Joint Registry (NJR)	HQIP	Continuous	Yes	100%
National Prostate Cancer Audit	BAUS	Continuous	Yes	100%
National Vascular Registry	Vascular Society	Continuous	Yes	100%
Neonatal Intensive and Special Care (NNAP)	RCPCH	Continuous	Yes	100%
Oesophago-gastric cancer (NAOGC)	RCS	Continuous	Yes	100%

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Older people (care in emergency departments)	CEM	Intermittent	Yes	100%
Pleural Procedure	BTS	Intermittent	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	BSR	Continuous	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP): Post-Acute Organisational Audit	RCP	intermittent	yes	100%
Sentinel Stroke National Audit Programme (SSNAP): Clinical Audit	RCP	Continuous	yes	>75%
BSUG Audit Database	BSUG	Continuous	Yes	100%
BAUS cancer registry: Surgery relating to the urinary tracts	BAUS	Continuous	Yes	100%
BAETS national audit: Surgery on the endocrine glands to achieve a hormonal or anti-hormonal effect in the body	BAETS	Continuous	Yes	100%
Head and Neck Oncology (DAHNO)	HSCIC	Continuous	Yes	100%
Epilepsy 12 audit (Childhood Epilepsy)	RCPCH	Intermittent	Yes	100%
Heavy Menstrual Bleeding (HMB)	RCOG	Intermittent	Yes	100%
Learning disabilities - feasibility study (1 year)	RCPsych	Intermittent	Yes	100%

Key to Audit Coordinator abbreviations

BAETS	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BOA	British Orthopaedic Association
BSR	British Society for Rheumatology
BSUG	British Society for Uro-Gynaecologists
BTS	British Thoracic Society
CEM	College of Emergency Medicine
COPD	Chronic Obstructive Pulmonary Disorder
DAHNO	Data for Head and Neck Oncology
DAHNO	Data for Head and Neck Oncology
FFFAP	Falls and Fragility Fractures Audit Programme
HQIP	Health Quality Improvement Partnership
HSCIC	Health & Social Care Information Centre
ICNARC	Intensive Care Audit & Research Centre
MINAP	Myocardial Infarction National Audit Project
NAOGC	National Audit of Oesophago-Gastric Cancer

NBOCAP	National Bowel Cancer Audit Project
NCDAH	National Care of the Dying in Acute Hospitals
NHSBT	NHS Blood & Transplant
NICOR	National Institute for Cardiovascular Outcomes Research
NPDA	National Paediatric Diabetes Audit
PCI	Percutaneous Coronary Intervention
RCA	Royal College of Anaesthetists
RCOG	Royal College of Obstetrics & Gynaecology
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatry
RCS	Royal College of Surgeons

National Confidential Enquiries

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2014-15	Sample Submission
Gastrointestinal Haemorrhage	NCEPOD	Once	Yes	Yes	100%
Sepsis	NCEPOD	Once	Yes	Yes	100%
Acute Pancreatitis	NCEPOD	Once	Yes	Study in progress	100%
Elective surgery (National PROMs Programme)	Quality Health	Continuous	Yes	Yes	100%
Maternal, infant and new born programme	MBRRACE-UK	Continuous	Yes	Yes	100%

Key to Audit Enquiry Coordinator abbreviations	
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
PROMS	Patient Recorded Outcome Measures
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits – United Kingdom

The final or interim reports of 32 National Clinical Audits were received and reviewed by the East Lancashire Hospitals NHS Trust in 2014-15. Of the 16 intermittent audits participated in, 12 National Clinical Audit reports have been reviewed by the Trust, 1 is awaiting review and data collection is on-going for 2 audits. Of the 22 continuous audits, annual and quarterly reports are reviewed at Audit or Multi-Disciplinary Team meetings / relevant forums and committees for discussion and action where identified.

Following the review of National Clinical Audit reports, East Lancashire Hospitals NHS Trust intends to continue to implement the following actions to improve the quality of healthcare provided:

- All audit activity is to be presented at specialty/multi-specialty audit or other appropriate forums. It is at these meetings that recommendations and action plans will be decided so that practice and quality of care can be improved. These action plans will form part of the Clinical Audit annual report which will be presented to the Clinical Effectiveness Committee for on-going assurance and monitoring.
- We are also working collaboratively with East Lancashire Clinical Commissioning Group (CCG) and associated commissioners to use audits to ensure that key patient safety and quality aims that are aligned to the CQUIN are reviewed and reported in order to set revised aims for 2015-16.

363 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2014-15. The results of which were presented / scheduled to be presented at specialty/ multi-specialty audit or other appropriate forums and the Trust intends to take the following actions to improve the quality of healthcare provided:

- All audits will be presented and discussed at specialty/multi-specialty audit meetings and/or appropriate forums where action plans will be agreed
- Lessons learned will be included in audit meeting discussions alongside any actions required and captured for sharing
- Monitoring of action matrices will occur at subsequent audit or designated meetings to ensure that actions are implemented to agreed timescales
- All specialty audit meeting minutes and action matrices will be reviewed at Divisional / Directorate Quality / Effectiveness meetings with assurance on completion of Trust Forward Audit plans monitored at the Trust's Clinical Effectiveness Committee
- Compliance with the Trust Policy on undertaking Clinical Audit Activity will be audited and reported at the Trust's Clinical Effectiveness Committee
- We will collate all Clinical Audit activity into an annual report as a record of all activity and actions undertaken and lessons learned as a result of audit to improve quality and patient care. This report will be received by the Trust Clinical Effectiveness Committee

2.5.2 Research and development

The number of patients receiving NHS services provided or sub-contracted by the Trust in the period 01 Apr 14 to 31 Mar 15 that were recruited during that period to participate in research approved by a research ethics committee was 1278

2.5.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of East Lancashire Hospital Trust's income in 2014-15 was conditional on achieving quality improvement and innovation goals agreed between East Lancashire Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The goals were a combination of national and local Commissioner agreed CQUIN schemes.

Further details of the national goals for 2014-15 and for the following 12 month period are available electronically on the NHS England website.The table on the next page sets out brief details of the Trust's CQUIN scheme for 2014-15

Goal Number	Scheme	National/ Local	Description
1	Friends and Family Test	National	Further implementation of patient FFT in outpatient and day case departments and implementation of FFT for staff. Increasing FFT response rates for A & E and inpatients.
2	NHS Safety Thermometer (pressure ulcers)	National	Reduction in pressure ulcer prevalence.
3	Dementia and delirium care	National	Achieve 90% against the 3 national dementia assessment standards. Regular audit of carers of people with dementia. Delivery on agreed training programme.
4	AQ acute myocardial infarction	Local CCG	Achievement of AQuA threshold for care bundle
5	AQ Heart Failure	Local CCG	Achievement of AQuA threshold for care bundle
6	AQ Hip and Knee	Local CCG	Achievement of AQuA threshold for care bundle
7	AQ Pneumonia	Local CCG	Achievement of AQuA threshold for care bundle
8	AQ Stroke	Local CCG	Achievement of AQuA threshold for care bundle
9	AQ COPD	Local CCG	Achievement of AQuA threshold for care bundle
10	AQ Hip Fracture	Local CCG	Achievement of AQuA threshold for care bundle
11	AQ Sepsis	Local CCG	Achievement of AQuA threshold for care bundle
12	AQ AKI	Local CCG	Achievement of AQuA threshold for care bundle
13	AQ Diabetes	Local CCG	Achievement of AQuA threshold for care bundle
14	AQ Alcoholic Liver Disease	Local CCG	Achievement of AQuA threshold for care bundle
15	Local Care Bundles	Local CCG	Implementation of local care bundles and achievement of agreed trajectories for acute kidney injury, alcoholic liver disease and skin.
16	Advice and Guidance	Local CCG	Implementation of Advice and Guidance service in three specialties on Choose & Book
17	End of Life	Local CCG	Development and implementation of the Care of the Dying Policy, undertaking quarterly care of the dying audits and training of staff in palliative and end of life care.
18	Professional Standards	Local CCG	Establish monitoring systems and improvements in an agreed set of internal professional standards.
19	Mental Health Liaison Referral	Local CCG	Ensuring patients with suspected or known mental health problems have timely access to liaison with Mental Health Liaison team by improving referral times to 2 hours.
20	Screening inequalities stocktake, action plan and implementation	Local Area Team	Diabetic Eye Screening and Breast Screening services to undertake stocktake and deliver action plan to improve access and coverage for vulnerable and deprived groups.
21	Dental coding	Local Area Team	Implement consistent coding in line with NHS England plans.
22	Dental FFT	Local Area Team	Implementation of FFT in all services providing dental activity from October 2014.
23	Neonatal Intensive Care Quality Dashboard	Specialised Commissioning	Submit neonatal quality dashboard identifying and actioning areas for improvement.
24	Neonatal Intensive Care – Access to Breast Milk	Specialised Commissioning	Increase the number of preterm babies receiving some of their own mother's breast milk at final discharge home from the neonatal unit.

Goal Number	Scheme	National/ Local	Description
25	Cancer and Blood Hand Held Record	Specialised Commissioning	Introduce patient held self-care plans including contacts to access care in emergencies.
26	HPB Named Carer and Multidisciplinary Team	Specialised Commissioning	Ensure patients receiving antiviral therapy for Hepatitis C have a named carer and that 85% of patients initiating therapy for Hepatitis C are discussed at a multidisciplinary meeting.
27	Case Management		
	Local CCG	Implementation of a Case Management model across Community Services	

2.5.4 Care Quality Commission (CQC) compliance

East Lancashire Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional

The Care Quality Commission has not taken enforcement action against East Lancashire Hospitals NHS Trust during 2014-15.

East Lancashire Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.5.5 Data Quality Assurance

The Trust submitted records during April to December 2014 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:

– 99.8% for admitted patient care;
– 99.9% for outpatient care; and
– 99.3% for accident and emergency care.

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

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

2.5.6 Information quality and records management

The Trust score for 2014 - 15 for Information Quality and Records Management assessed using the Information Governance (IG) Toolkit was 80% against a target of 98%

The Trusts overall performance against all elements of the IG Toolkit was 74% against a target of 94%

To improve these scores, the Trust is developing an IG improvement action plan which will include objectives associated with:

- Improving IG training by increasing coverage to 95% of staff who will have completed the IG annual training for 2015-16.
- Reviewing and updating all training material.
- Targeting training for Information asset managers and Information asset owners.
- Targeting bespoke training based on IG incidents, risks and lessons learnt from reported incidents.
- Updating Information asset registers across the Trust and signing off risk assessments against these.
- Reviewing and updating or re-writing all information related policies.
- Conducting an IG audit in a minimum of 4 corporate records areas. (excluding Medical Records and Coding which are reviewed and audited annually).
- Updating and issuing patient information leaflets (for ward and clinic areas) so patients understand why we collect their data, what we use it for and how we safeguard it.
- Embedding IG within the Trust by looking at communication processes, reporting requirements etc.
- Ensuring lessons are learnt from all IG incidents.

2.5.7 Clinical coding audit

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- HRG / Payment 96.6% accuracy - 3.4% error rate.
- Primary Diagnosis (original error rate) - 4% and Primary Diagnosis (all errors) - 4%.
- Secondary Diagnosis (original error rate) - 2.3% and Secondary Diagnosis (all errors) – 2.9%
- Primary Procedure (original error rate) - 1.9% and Primary procedure (all errors) – 1.9%
- Secondary procedure (original error rate) - 8.4%) and Secondary procedure (all errors) - 13.2%

2.6 Complaints management

As an organisation, feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, both for individuals and for the wider NHS, as well as contributing to a culture of learning from experience. Patients, relatives and carers are encouraged to communicate any concerns to staff in a supported environment with the aim of addressing those concerns in a clear and concise manner.

All staff are expected to try to resolve a patient or relative concern at the time of this being raised with them. We have adopted the principles of good complaints handling as set out by the Parliamentary and Health Service Ombudsman which are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Trust Board acknowledges the importance of listening to patients' stories directly. As a result, patient stories are now regularly featured at Board meetings. The Board recognises that not every perception held by a patient, or every complaint made, will be necessarily upheld. Nevertheless, it remains important to understand how patients, relatives or carers have seen matters.

In addition the Board receives weekly reports relating to new issues raised and a complaint is chosen randomly for presentation to the Executive Team on a bi-monthly basis. The complaint investigation, response and compliance with Trust Policy is assessed, in order that the process can be continually improved.

The Customer Relations Team is an integrated team of PALS/Complaints Officers, who deal with concerns raised formally and informally. The combined role ensures that individual concerns are addressed effectively and lessons are learnt from the issues raised. During 2014-15, 1920 PALS enquiries were dealt with by the team. These were received from a variety of sources. The team reports key performance indicators to Executive and Divisional leads to closely performance manage concerns raised and to ensure a timely response is provided. The Trust received 562 formal complaints during this period. Complainants are contacted as soon as possible following raising their concerns. Discussions take place regarding how the complaint will be dealt with, timescales for a response to be provided and a meeting offered, where appropriate. The aim is to ensure that personal contact is maintained.

Further developments have taken place to ensure that complainants are kept informed of the progress of the complaint investigation, ensuring greater compassion within responses to complaints through education and formal training and evidencing actions taken to improve services.

Further training is planned for the coming year to raise awareness of staff responsibilities, Trust policy and NHS Complaints regulations, in addition to training on operational complaints handling. This will ensure that complaints are dealt with in a timely and appropriate manner.

The main issue for the Board is to receive assurance that lessons are learned from complaints, not only from an individual complaint, but across the Trust, where themes have been identified. During 2014-15, the Trust has developed quarterly reports to include more detailed analysis on trends and themes, as well as lessons learned.

The Trust has also continued to develop the Share 2 Care Bulletin to ensure that lessons learned from complaints and incidents are disseminated to all staff and learning is shared at a local level within wards and teams. This will be further developed in 2015-16 and mechanisms for sharing lessons learned will also be strengthened.

Complainants have the right to take their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the Trust's response. During the financial year, 14 complaints were referred to the Ombudsman, of which 2 were not upheld, 1 required further Trust action involving reimbursement and 11 are currently being reviewed.

Part 3

3.1 Achievement against quality priorities set in 2013-14 for 2014-15

The table below sets out the quality priorities that the Trust identified for implementation during 2014-15 and the progress made

No	Subject	Quality Priority Aim	Progress and achievement during 2014-15
1	Mortality Reduction	Reduce HSMR and SHMI ratios to the national average or below	The Trust's SHMI figure is 1.10 which is as expected The Trusts HSMR figure is 106.07 which is within expected range The Trusts indicative HSMR is within expected range and below national average
2	MRSA	Achieve zero MRSA bacteraemias	The Trust has recorded one attributable MRSA bacteraemia in year therefore narrowly missing this target The Trust continues to further improve compliance with hand hygiene, antimicrobial prescribing and aseptic non touch technique
3	Falls reduction	Reduce harm from falls by 15%	Further information on the above is set out in section 3.3 of this report
4	Complaints	Investigate 90% of formal complaints within Trust approved timescales Ensure 80% of complainants are satisfied with the overall complaints process	The aim to investigate 90% was not achieved due to the outstanding backlog at April 2014. 75% were responded to within 25 working days, in accordance with Trust Policy. The 90% target will be the aim for the current year, as the backlog is reduced. Feedback questionnaires received relating to concerns raised in 2014-15 show that 60% of those who responded were either happy or very happy with the complaints process. This will be monitored throughout the current year.
5	Early warning scores (EWS)	Implement an electronic system for EWS Further improve early warning scores on identifying deteriorating patients and the escalating response to the deteriorating patient	The Trust has embarked on a comprehensive review of EWS management and this has included: – A scoping exercise to identify a range of electronic system solutions – Appointment of a clinical lead for the deteriorating patient work programme – Appointment of a dedicated band 8a post to facilitate the implementation phase of the programme – Improved the use of the paper forms prior to the implementation of the electronic solution – Introduced a more robust audit process which has identified 'hot spots'. This has enable targeted and specific training to improve these areas
6	Pressure ulcers	Reduce avoidable grade 2 pressure ulcers by 15% Achieve zero tolerance for avoidable grade 3 and grade 4 pressure ulcers	The Trust has achieved a 98% reduction in avoidable grade 2 pressure ulcers The Trust has not recorded any grade 3 or 4 avoidable pressure ulcers in February and March 2015 Further information on the above is set out in section 3.3 of this report

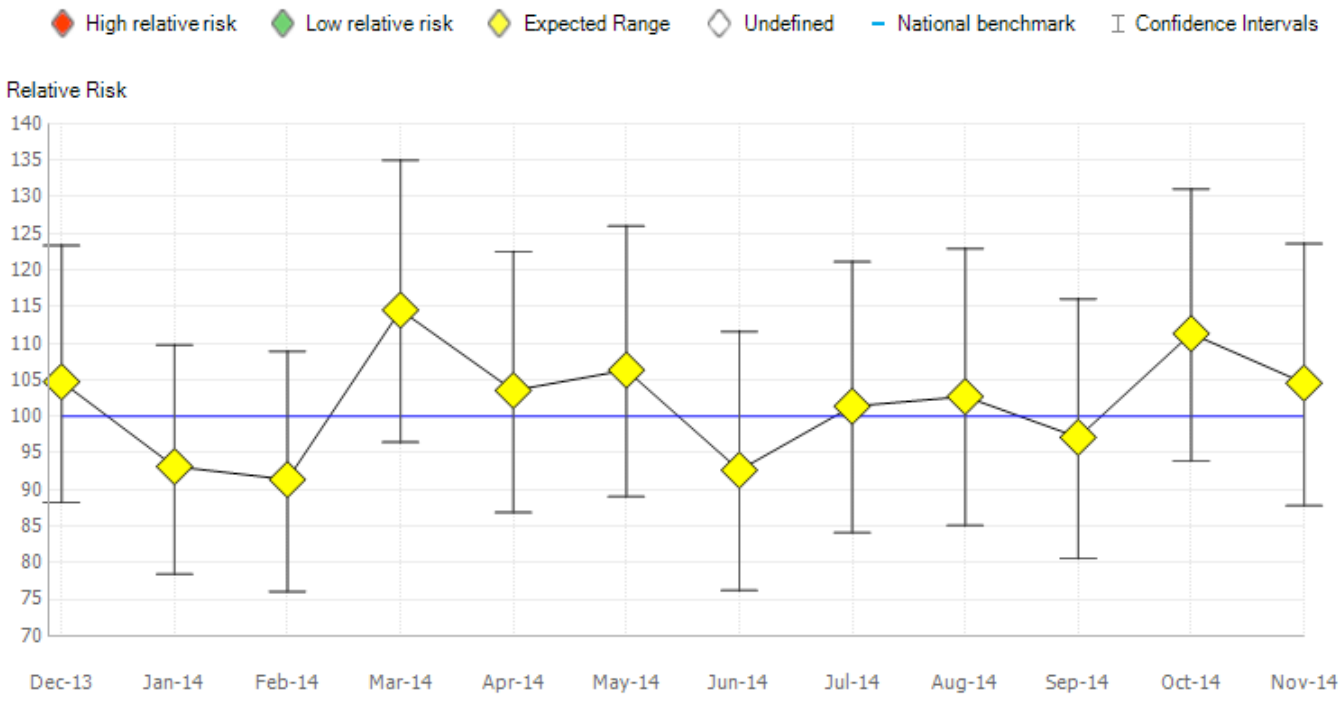
3.2 Achievement against nationally determined quality indicators 2014-15

The Trust is required to provide data and information within its Quality Account on a range of nationally determined quality indicators. These are set out below:

3.2.1 Hospital Mortality Reduction

Hospital Standardised Mortality Ratio (HSMR)
The HSMR measures deaths in 56 diagnosis groups which account for the majority of in hospital deaths. This is a risk adjusted measure which looks solely at deaths that occur in hospitals and takes palliative care and deprivation into account in the risk adjustment. Annual rates are published in the Dr Foster Guide each year.

The graph below sets out the Trust's HSMR performance from December 2013 to November 2014.



Summary Hospital-Level Mortality Indicator (SHMI)
The SHMI was introduced by the Department of Health in 2011-12 and reports on risk adjusted ratios of deaths that occur in hospital and up to thirty days after discharge, divided by the number of deaths that were expected given the size of the Trust and other factors such as the patient's age, method of admission and underlying medical conditions. The published SHMI trend data up to September 2014 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Rolling 12 months to Dec-13	Rolling 12 months to Mar-14	Rolling 12 months to Jun-14	Rolling 12 months to Sep-14
East Lancashire NHS Trust SHMI Value	1.129	1.123	1.100	1.09
East Lancashire NHS Trust % of deaths with palliative care coding	17.4	19.2	20.9	TBC
East Lancashire NHS Trust SHMI banding	1 (higher than expected)	1 (higher than expected)	2 (as expected)	2 (as expected)
National SHMI	100	100	100	100
Best performing Trust SHMI	0.624	0.539	0.541	TBC
Worst performing Trust SHMI	1.176	1.197	1.198	TBC
Trust with highest % of deaths with palliative care coding	46.9	48.5	49	TBC
Trust with lowest % of deaths with palliative care coding	1.3	0	0	TBC

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:
- The SHMI and HSMR are now as expected following a focussed effort on key areas identified in the Keogh review relating to improvements in care delivered.
- A more reflective expected mortality rate due to improvements in the capture of co-morbidities and palliative care coding.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services:
- Increasing awareness of mortality ratios across the Trust
- Improving reliability of care by introducing further care bundles and improving compliance rates.
- Improving the current mortality review process, to ensure risks identified are investigated and key themes are identified and acted on.
- Reducing health care acquired infections
- Improving the response to the deteriorating patient.

In 2015-16 these actions will be consolidated and fully embedded within the Trust. This will be supported by the introduction of systematic audit and performance management.

3.2.2 Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) indicate quality improvement from the patient perspective. Since April 2009 there have been four clinical procedures covered, these are hip replacements, knee replacements, groin hernia & varicose veins. PROMs calculate the health gain after surgical treatment using pre and post-operative surveys. PROMs are typically short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time. The health status information collected from patients by way of PROMs questionnaires before and after an intervention provides an indication of the outcomes or quality of care delivered to NHS patients. The following tables sets out East Lancashire Hospitals NHS Trust's PROMs % improvement performance compared with the national average.

	2011-12	2012-13	2013-14			2011-12	2012-13	2013-14
Groin Hernia					**Varicose Vein**			
ELHT	54.20%	47.80%	48.80%		ELHT	48.90%	39.10%	59.10%
National average	50.20%	51.00%	50.60%		National average	52.70%	53.60%	51.80%
Knee Replacement					**Hip**			
ELHT	80.80%	79.40%	78.90%		ELHT	88.20%	89.50%	88.20%
National average	80.70%	78.80%	81.40%		National average	89.70%	87.50%	89.20%

A plan to support improvement is under development and will be performance managed by the Patient Safety and Governance Committee during 2015-16

3.2.3 Readmissions

The following tables sets out the Trust's performance during 2014-15 for emergency readmissions within twenty eight days of discharge

All Ages	2012/2013	2013/2014	2014/2015
Readmission Rate	12.58%	11.97%	12.22%

Age Band	2012/2013	2013/2014	2014/2015
0-15	15.50%	13.87%	13.89%
16+	11.72%	11.42%	11.72%

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reason:

- Adult readmissions remain within expected range with little variance
- Paediatric readmissions are consistently higher and this may partly be as a result of the Trust's open access policy which ensures quality of care for families but impacts on readmission rates. The open access policy has recently been reviewed and revised and as such it is anticipated that this will have a positive impact on future paediatric readmission rates

East Lancashire Hospitals NHS Trust has taken the following action within its Divisions to reduce its readmission rates and so improve the quality of its services:

Family Care

Readmission rate audits undertaken by the division's Utilisation Management Team have been completed with all actions implemented. This work has been led by the divisions nominated readmissions lead consultant

A health economy wide patient information leaflet which helps support parents in managing their children's key illnesses has been developed and launched

Coding of all relevant admissions continues to be reviewed to ensure accuracy of readmission data collected

Integrated Care Group
The Ambulatory Care Service has become embedded over the winter period with extended hours opening during peak periods. This will be further progressed as part of the Acute Medical Model development which will include a larger Acute Medical Unit with an integral frailty pathway. This model is currently being piloted.

The admissions avoidance team has now transferred into the developing Intensive Home Support Service and provides an in-reach service to the Trust's Emergency Department, Medical Assessment Unit and medical wards and patients are actively followed up on discharge from hospital. The Integrated Neighbourhood Teams are also now in place across the Pennine Lancashire patch.

The trust is working with social care and Clinical Commissioning Group colleagues to implement an Integrated Discharge Service, the first phase of which will be in place by October 2015.

The above key developments are part of a wider service transformation programme which is being developed with our partners to ensure that we provide Care Closer to Home wrap around care in an out of hospital environment to avoid all unnecessary admissions.

Surgery and Anaesthetics
The main area requiring attention to the number of readmissions within the division has been in urology. As such, work is being carried out by the Urology Assessment Unit (UAU) to improve the emergency admission pathway for Urology patients. It is anticipated that this will result in reduced admissions and improved patient outcomes for this group of patients

3.2.4 Inpatient survey

The Picker Institute was commissioned by 78 trusts to undertake the Inpatient Survey 2014. A total of 850 patients from East Lancashire NHS Trust were sent a questionnaire. 838 were eligible for the survey, of which 388 returned a completed questionnaire, giving a response rate of 46%. The response rate for the Trust's Inpatient survey in 2013 was 50%.

The table below sets out the Trust's performance in 2014 for inpatients:

The Trust has improved significantly on the following questions (lower scores are better):		
	2013	**2014**
Hospital: toilets not very or not at all clean	6 %	3 %
Hospital: hand-wash gels not available or empty	6 %	3 %
Nurses: sometimes, rarely or never enough on duty	47 %	40 %
Surgery: not told how to expect to feel after operation or procedure	50 %	41 %
Overall: not treated with respect or dignity	27 %	19 %
Overall: rated experience as less than 7/10	25 %	18 %
Overall: Did not receive any information explaining how to complain	64 %	57 %
The Trust has worsened significantly on the following questions (lower scores are better):		
	2013	**2014**
None		
ELHT results were significantly better than the 'Picker average' for the following questions (lower scores are better):		
	Trust	**Average**
Hospital: patients using bath or shower area who shared it with opposite sex	6 %	12 %
Hospital: bothered by noise at night from staff	16 %	20 %
Hospital: toilets not very or not at all clean	3 %	6 %
Nurses: talked in front of patients as if they weren't there	14 %	19 %
ELHT results were significantly worse than the 'Picker average' for the following questions (lower scores are better):		
	Trust	**Average**
Hospital: not offered a choice of food	26 %	21 %
Care: staff did not do everything to help control pain	36 %	30 %
Discharge: delayed by 1 hour or more	92 %	86 %

East Lancashire Hospitals NHS Trust considers that the data reflects the enormous effort and work that has gone into inpatient experience and care as a result of:

- Special measures improvement work
- Development of vision and values for highlighting with our staff the importance of these being at the heart of all the care that they deliver to our patients
- Engagement and hard work of staff to improve the care experience of patients, their carer's and families.

East Lancashire Hospitals NHS Trust intends to take the following actions to improve the related areas:

- Support directed action plans within the catering, pain management and discharge facilitation areas.
- Continue to engage and work with our patients, their carer's and families around our provision of services to maintain the quality delivered.

Children's Survey

The Picker Institute was commissioned by 69 NHS trusts and one private provider to undertake the Children's Inpatient & Day Case 2014 Survey. A total of 433 young inpatients and day-case patients discharged from the East Lancashire NHS Trust were sent a questionnaire. 430 patients were eligible for the survey, of which 101 returned a completed questionnaire, giving a Trust response rate of 23%. The average response rate for the 70 'Picker' Trusts was 27%.

The table below sets out the Trust's results for Children and Young People:The Trust **has improved significantly on the following questions:**

(lower scores are better):

	2012	2014
Parent did not feel that child was always safe on the hospital ward	24 %	3 %
Child did not always feel safe on the hospital ward	26 %	11 %
Child not always given enough privacy when receiving care and treatment	36 %	15 %
Child not always given enough privacy when receiving care and treatment	36 %	11 %
Staff did not do everything they could to help ease their child's pain	49 %	25 %
Child did not feel that staff did everything they could to help their pain	46 %	14 %
Parent not given enough information about how child should use the medicines	10 %	2 %
The Trust has worsened significantly on the following questions (lower scores are better):		
	2012	**2014**
None		
ELHT results were significantly better than the 'Picker average' for the following questions (lower scores are better):		
	Trust	**Average**
Planned admissions: hospital changed admission date at least once	[5] %	19 %
Parent did not feel that child was always safe on the hospital ward	3 %	10 %
Staff did not agree a plan with parent for their child's care	5 %	10 %
Parents did not always have confidence and trust in staff members treating child	12 %	21 %
Young Person not fully involved in decisions about their care and treatment	[20] %	41 %
Staff did not fully explain to child how their operation had gone	[5] %	28 %
Parent not given enough information about how child should use the medicines	[2] %	8 %
Young person not fully told what would happen after they left hospital	[13] %	37 %
ELHT results were significantly worse than the 'Picker average' for the following questions:		
	Trust	**Average**
None		

East Lancashire Hospitals NHS Trust considers that the data reflects the enormous effort and work that has gone into Children's Inpatient experience and care as a result of:

- Special measures improvement work
- Development of vision and values for highlighting with our paediatric staff the importance of these being at the heart of all the care that they deliver to our patients
- Engagement and hard work of paediatric staff to improve the care experience of young patients, their carer's and families.

East Lancashire Hospitals NHS Trust intends to take the following actions to continue its improvement:

- Support continuous improvement within the paediatric wards to promote and share good practice
- Continue to engage and work with young people, their carer's and families around our provision of services to maintain the quality delivered.

3.2.5 Friends and family test (staff element)

April 2014 saw the commencement of the first publication of data from the NHS Staff Friends and Family Test (FFT) to give staff a greater say in improving healthcare.

The Staff FFT is a powerful feedback tool which asks staff across NHS trusts the following two questions:

- How likely they would be to recommend their organisation to friends and family as a place to work
- How likely they would be to recommend it as a place to receive care/treatment.

Members of staff also have the opportunity to give free-text feedback after each question. East Lancashire Hospitals NHS Trust commenced the survey in Quarter 1 of 2014 with a small sample size for pilot purposes. Following this a full census of all staff was taken for Quarter 2 and Quarter 4. The results of which are:

How likely are you to recommend this organisation to friends and family if they needed care or treatment?

Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know
531	976	336	106	39	26
% of people who would be likely to recommend it Q4		*2014 National Staff Survey Q3		Staff Friends & Family test Q2	
75%		60%		71%	

How likely are you to recommend this organisation to friends and family as a place to work?

Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know
444	925	354	176	98	15
% of people who would be likely to recommend it Q4		*2014 National Staff Survey Q3		Staff Friends & Family test Q2	
68%		59%		66%	

*Quarter 1 data cannot be benchmarked as this was a pilot survey and Quarter 3 is replaced by the National Staff Survey.

It is anticipated that the Staff FFT will help to promote a big cultural shift at the Trust, where staff have further opportunity and confidence to speak up and where the views of staff are increasingly heard and acted upon.

The overall aims for the Staff FFT are to:

- Identify trends in staff opinion on a more frequent basis than the staff survey, thereby allowing action at an early stage.
- Supplement existing information such as the staff survey.
- Provide a further way in which staff can put forward ideas for improvements in services.

\ELHT has seen improvements in both Staff FFT scores each Quarter.

The East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:
- Data is as received from NHS England and had been quality checked locally by the Occupational Health Department.

The East Lancashire Hospitals NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services by,
- Further embedding the Employee Engagement Strategy to provide a greater response to the test.
- Further developing the ten key enablers which have been previously identified to enhance levels of employee engagement together with the additional three behavioural indicators used to demonstrate high employee engagement levels.
- Converting suggestions from employees into specific actions to bring the strategy to life.
- The employee engagement strategy will integrate with our core values; link with national objectives set out in the NHS Constitution 2010 and the Macleod Report Engaging for Success 2009. The Trust will be an exemplar of best practice for employee engagement in the UK. The strategy will support our Trust vision and help us to become one of the top performing NHS Trusts in the country.

3.2.6 Friends and family test (patient element)

In April 2013, the Department of Health introduced the Friends and Family Test (patient element) as a means to establish whether patients that have recently received care within acute hospital Trusts would be happy for their friends or relatives to receive similar care within the same environment.

The question that is asked is:
- How likely are you to recommend our service to your friends and family if they needed similar care or treatment?

Patients are invited to respond to the question by choosing one of six options ranging from extremely likely to extremely unlikely.

This question must be asked of every inpatient, accident and emergency attender and maternity services user within 48 hours of their attendance or discharge.

Since January 2015 the Friends and Family Test was extended to capture the feedback from NHS funded community services. There is no target response rate for community services set as yet.

Trusts are expected to achieve a minimum response rate from patients of 40% by the end of quarter 4 for inpatients, 20% by the end of quarter 4 for accident and emergency and an overall response rate of 15% for maternity services.

The following table sets out the East Lancashire Hospitals NHS Trust's response rates for inpatients, accident and emergency attenders and maternity services and also how these results compare with other Trust's nationally for the period April 2014 to March 2015.

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Inpatient % patient response rate												
ELHT	61%	61%	63%	61%	61%	57%	58%	52%	48%	47%	54%	55%
National Average	35%	36%	38%	38%	37%	37%	38%	37%	34%	36%	40%	Not avail
A&E % patient response rate												
ELHT	20%	18%	13%	8%	13%	21%	25%	23%	25%	23%	23%	23%
National Average	19%	19%	21%	20%	20%	20%	20%	19%	18%	20%	21%	Not avail
Combined inpatient and A&E % patient response rate												
ELHT	36%	35%	31%	27%	30%	35%	37%	33%	33%	32%	34%	35%
National Average	Not Available											
Antenatal % patient response rate												
ELHT	14%	11%	21%	30%	10%	6%	10%	16%	11%	12%	14%	16%
National Average	*Not Available											
Delivery % patient response rate												
ELHT	26%	22%	27%	27%	12%	10%	24%	28%	30%	29%	21%	38%
National Average	23%	23%	23%	23%	22%	21%	21%	22%	20%	23%	24%	Not avail
Post Natal % patient response rate												
ELHT	7%	11%	66%	57%	48%	28%	67%	62%	45%	57%	34%	39%
National Average	*Not Available											
Community Post Natal % patient response rate												
ELHT	11%	9%	9%	14%	10%	4%	7%	16%	17%	24%	21%	17%
National Average	*Not Available											

* Feedback from maternity providers suggested that identifying an accurate eligible population for questions 1, 3 and 4 was complex and time-consuming. As a result, NHS England permitted providers to submit estimates for the eligible population data at questions 1, 3 and 4. As the eligible population figures submitted for these questions are estimates, NHS England does not publish a response rate for questions 1, 3 and 4. Response rates have only been published for question 2 as NHS England was confident that the eligible population figures submitted for question 2 were accurate (based on hospital birth records)."

Net Promoter Scores were utilised by the NHS to identify overall patient satisfaction or in the case of the Friends and Family Test, to identify how likely patients are to recommend the Trust's services to friends and family. A review of the Friends and Family Test was published in July 2014 and this suggested that the presentation of the data should move away from using the Net Promoter Score (NPS) to an alternative measure. In line with this, the NHS England statistical publication moved to using the percentage of respondents that would recommend / wouldn't recommend the service in place of the NPS.

The following table sets out the Trust's net promoter scores / percentage who would recommend the service and also how these compare with other Trust's nationally for the period April 2014 to March 2015.

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Inpatient Net Promoter Score / % recommend												
ELHT	78	80	79	78	79	98%	98%	99%	98%	97%	98%	98%
National Average	74	74	74	74	74	94%	94%	95%	95%	94%	95%	Not avail
A&E Net Promoter Score / % recommend												
ELHT	28	30	24	18	28	80%	79%	77%	74%	80%	81%	81%
National Average	55	54	53	53	57	86%	87%	87%	86%	88%	88%	Not avail
Combined inpatient and A&E Net Promoter Score / % recommend												
ELHT	61	64	65	66	65	91%	90%	89%	86%	89%	90%	91%
National Average	Not Available											
Antenatal Net Promoter Score / % recommend												
ELHT	73	78	81	83	66	92%	92%	98%	100%	100%	93%	98%
National Average	65	67	67	62	66	95%	95%	96%	96%	95%	95%	Not avail
Delivery Net Promoter Score / % recommend												
ELHT	94	93	89	90	89	98%	91%	91%	97%	96%	94%	97%
National Average	76	77	77	77	77	95%	95%	97%	97%	97%	97%	Not avail
Post Natal Net Promoter Score and % recommend												
ELHT	92	91	87	78	77	82%	91%	93%	96%	96%	97%	93%
National Average	64	65	67	65	65	91%	91%	93%	93%	93%	93%	Not avail
Community Post Natal Net Promoter Score and % recommend												
ELHT	83	78	81	72	75	90%	95%	93%	92%	95%	94%	94%
National Average	77	77	77	75	76	96%	96%	97%	98%	97%	98%	Not avail

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Our inpatient response rates regularly exceed the national average as we consider the collection of feedback from our patients to be a high priority; therefore staff are encouraged to collect information from patients.
- A system for SMS text messaging was recently introduced and the response rates for A&E attenders have increased and are now regularly above the national average.
- The Trust also gets a consistently high score on the willingness to recommend the service.

East Lancashire Hospitals NHS Trust intends to take the following action to improve this percentage, and so the quality of its services:

- Continue to regularly monitor the response rates and provide advice and support to specific areas so that information is collected and inputted in a timely manner.
- Going forward, the Friends and Family test is being introduced to other departments and services to promote a Trust wide view of patient services.

3.2.7 Venous thromboembolism (VTE) risk assessment

The table below sets out the Trust's VTE risk assessment performance compared with the national average and the best and worst performing Trusts:

VTE assessments (2014-15)		Quarter 1	Quarter 2	Quarter 3
East Lancashire NHS Trust	Number of VTE assessed admissions	28548	28437	28537
	Total admissions	29254	29127	29140
	% of admitted patients risk assessed for VTE(rounded to nearest decimal)	98%	98%	98%
	ELHT position nationally among the Total number of Acute Trusts in the country on VTE Risk assessment (example: starting with the highest scorer titled 1/164)	40/164	42/162	30/160
National	Number of VTE assessed admissions	3379137	3439307	3430143
	Total admissions	3517180	3575719	3574620
	% of admitted patients risk assessed for VTE (rounded to nearest decimal)	96%	96%	96%
Best performing Trust	(The Trusts reporting 100% all have small numbers of admissions)	3 Trusts with 100%	3Trusts with 100%	9Trusts with 100%
Worst performing Trust		87%	86%	81%

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Systems and processes are in place to risk assess all appropriate patients utilizing the National VTE assessment tool on admission. This now involves both adult inpatient admissions and day cases.
- The Trust monitors quarterly VTE performance figures routinely using an electronic system with real time capture of data on admission from the Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS).
- Each of the Trusts Divisions participates in a rolling programme of clinical audit to ensure effective compliance with VTE assessment.
- Trust VTE performance has consistently been in excess of 97.5% since July 2014, in excess of 97% since July 2013 and prior to that in excess of 95%.

East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

- Monitoring of VTE risk assessment through formal Bi-monthly reporting by all Divisions through the Trust VTE committee which functions as a sub-committee of the Trust Patient Safety and Risk Assurance Committee (PSRA)
- VTE Clinical leads have been identified to represent the divisions on the Trust VTE committee to provide clinical leadership and support to further improve performance on VTE risk assessment
- Supporting Divisional Governance leads and matrons to carry out spot checks on VTE assessment compliance at ward level
- Undertaking a retrospective audit of a random sample of patients who are known not to have been subject to VTE risk assessment as per above data
- Continuing with a rolling programme of VTE assessment clinical audit across Divisions

3.2.8 Clostridium Difficile Infection (CDI)

The table below sets out the data made available to the Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period. The table also provides comparative data with other NHS Trusts nationally

	CDI rate (for year to Nov 13)	CDI rate (for year to Nov 14)
National rate (Ordinary Acute Trusts)	14.9 CDI cases per 100,000 bed days	13.1 CDI cases per 100,000 bed days
ELHT rate	8.0 CDI cases per 100,000 bed days	9.6 CDI cases per 100,000 bed days
Best performing nationally	2.4 CDI cases per 100,000 bed days	3.6 CDI cases per 100,000 bed days
worst performing nationally	37.5 CDI cases per 100,000 bed days	43.8 CDI cases per 100,000 bed days

East Lancs NHS Trust considers that this data is as described for the following reasons:

- Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level.

East Lancs NHS Trust intends to take actions to improve this rate and so the quality of its services by:

- Further improving compliance to hand hygiene, improving antimicrobial prescribing and expanding the post infection review process. The Trust will also continue with its current approach of zero tolerance to hospital acquired infections and will aim to further reduce this rate year on year

In 2014/15 there were 87 cases of Clostridium Difficile toxin identified in the laboratory. The trajectory for East Lancashire Trust for 2014/15 was 23 post 3 day of admission cases. The outturn was 32 cases. All the 87 cases had a post infection review by a multi-disciplinary team including members of medicines management, CCG Quality Leads, Public Health Infection Prevention Nurses and 9 cases were assigned to East Lancashire Trust.

3.2.9 Patient safety incidents

NHS Trusts are required to submit the details of incidents that involve patients to the National Reporting and Learning System (NRLS) on a regular basis. The Trust continues to upload data via the NRLS on a monthly basis. The NRLS publishes Organisation Patient Safety Incident Reports bi annually showing comparative data with other large acute organisations. The Trust is able to use this information to understand its reporting culture. High reporting Trusts usually have a strong safety culture and as such the Trust continues to actively encourage the reporting of incidents and near misses.

The information in the table below has been extracted from NRLS reports and sets out the Trust's performance for the last four reporting periods. The table also compares the Trust's performance against other similar large acute organisations (cluster).

Patient safety incidents per 100 admissions	Oct 2012 to March 2013	April 2013 to Sept 2013	Oct 2013 to March
2014			
ELHT number reported	**6562**	**7116**	**8015**
ELHT reporting rate	**10.4**	**11.1**	**12.5**
Cluster average number	**4428**	**4399**	**4493**
Cluster average reporting rate	**7.2**	**7.1**	**7.3**
Minimum value for cluster	**1761**	**1967**	**787**
Maximum value for cluster	**7835**	**7757**	**8015**

Patient safety incidents resulting in severe harm	Oct 2012 to March 2013	April 2013 to Sept 2013	Oct 2013 to
Mar 2014			
ELHT number reported	**0**	**1**	**35**
ELHT % of incidents	**0**	**0**	**0.4**
Cluster average number	**24.9**	**22.8**	**20**
Cluster average reporting rate	**0.6**	**0.6**	**0.5**
Minimum value for cluster	**0**	**1**	**0**
Maximum value for cluster	**101**	**86**	**102**
Total incidents across cluster	**973**	**889**	**762**
Cluster % of incidents	**0.6**	**0.5**	**0.4**

Patient safety incidents resulting in death	Oct 2012 to March 2013	April 2013 to Sept 2013	Oct 2013 to
Mar 2014			
ELHT number reported	**0**	**3**	**5**
ELHT % of incidents	**0**	**0**	**0.1**
Cluster average number	**6.8**	**4.9**	**5.7**
Cluster average reporting rate	**0.2**	**0.1**	**0.1**
Minimum value for cluster	**0**	**0**	**0**
Maximum value for cluster	**20**	**15**	**14**
Total incidents across cluster	**267**	**191**	**216**
Cluster % of incidents	**0.2**	**0.1**	**0.1**

East Lancashire Hospitals NHS Trust considers that this data is as described for the following reasons:

For the data period April to September 2014, the NRLS has made significant changes to the way in which incident data is analysed and presented. This includes a change to the categorisation of Trusts in that East Lancashire Trust is now benchmarked against 139 other non-specialist acute Trusts as opposed to 37. As such, accurate comparison between this data period and the historic data periods that are set out above is not entirely possible.

- Incident reporting within the Trust is seen as a positive learning opportunity to prevent re occurrence and as such the number of incidents that are reported is steadily increasing
- Enhanced investigation and improved accuracy of the grading of severe harms and deaths resulting from patient safety incidents has resulted in an increase in the numbers recorded

East Lancashire Hospitals NHS Trust has under taken the following actions to improve these rates and so the quality of its services:

- Investment in root cause analysis training for incident investigators to ensure accurate and effective investigation outcomes
- Review of fields on the Trust's electronic incident management system
- Introduction of a suite of incident management documentation to ensure effective reporting and investigation
- Overhaul of the functionality of the Trust's serious incident scrutiny panel

3.2.10 Never Events

The NHS defined Never Events as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented and included incidents such as:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

East Lancashire Hospitals NHS Trust reported a nil return for Never Events during 2014 –15.

3.3 Quality achievements and outcomes in 2014-15

This section of the Quality Account provides an overview of a range of key quality improvement outcomes that have been achieved by the Trust during 2014-15

- **Hospital Children's Diabetes Service 'Best in North West'**

East Lancashire Hospitals NHS Trust Children's Diabetes Service has been rated equal best in the North West

Changing the face of diabetes care for children and young people with type 1 diabetes in East Lancashire, the Trust was one of just 13 children's diabetes services in England to score 100% for their hospital service, in the inspection carried out by the National Diabetes Peer Review Programme. The children's multidisciplinary team was also highly commended, receiving the highest score in the North West

Rated 4th in the country for the performance of its Multi-Disciplinary team, the review highlighted innovation by the hospital Children's Diabetes Service in reducing clinic waiting times and introducing evening educational sessions to make it easier for patients and families to attend together

The Children's Diabetes service was also commended for the quality of psychological support they provide to children and families who battle diabetes on a daily basis

The Children's Diabetes Service, including two consultants, five paediatric specialist nurses, two dieticians and a psychology practitioner, was specially commended for its work with schools which includes school clinics which facilitate peer support and educational sessions for children with diabetes when they start secondary education

- **Quality Mark attainment**

Staff on Ward C5 at the Royal Blackburn Hospital have been recognised for their hard work and commitment to patient care by being awarded a prestigious Quality Mark.

The Quality Mark is run by the Royal College of Psychiatrists and has been established to encourage hospital wards to become involved in improving the quality of essential care of older people and to recognise good care provision, as identified by patient feedback.

Ward C5 was awarded the Quality Mark for the care given based on reviews submitted by patients. The reviews examined patient's level of comfort, support from staff and receiving of appropriate help amongst other criteria.

Assessment feedback marked out staff on C5 as giving excellent care to their patients. This ranged from senior managers having a strategic view of the patient's requirements to ward staff delivering high quality care on a daily basis – culminating in patients having a positive experience when admitted to the ward.

- **Community Equipment Service**

Achieves BSI 9001 Quality Standard East Lancashire Community Equipment Service which is the area's largest provider of equipment and aids for daily living is proud to announce it has become the first service of its kind in the region to achieve BSI 9001 certification, the international benchmark for quality management.

British Standards Institute (BSI) 9001:2008, the world's most popular standard for Quality Management, recognises that the policies, practices and procedures of the East Lancashire Community Equipment Service delivers consistent quality in the equipment and services provided for the people of East Lancashire.

The service offers a wide range of loan equipment to support the care and independence needs of East Lancashire residents, from mobility, bathing and toileting equipment to pressure relieving mattresses, hoists and specialist seating.

Improvements to Bereavement Care

Reflecting its commitment to ensure better end of life care, the Trust's bereavement care services and facilities have been expanded and improving as follows:

- Dedicated Bereavement Care Suite at The Royal Blackburn Hospital and Burnley General Hospital
- Blackburn with Darwen Registrar to provide on-site registration of death service (Royal Blackburn Hospital)
- Improvements to the Mortuary Viewing room (Royal Blackburn Hospital)
- Coroner's Officer on site service (Royal Blackburn Hospital)
- Improved security equipment to protect the personal belongings of deceased patients
- Comfort Bags of toiletries for relatives who stay in hospital overnight to be with a loved one approaching their end of life
- Bereavement care education for frontline staff.

The Trust has spent almost a year working with hospital staff, bereavement experts, local hospices and other NHS hospitals to improve its bereavement care, including the appointment of a full-time Bereavement Care Senior Nurse.

"We understand that we have one chance to get things right at this very difficult time," says the Trust's Chief Nurse Christine Pearson. "and we want to get things right every time."

"Bereavement care is now very much a priority and the improvements made in recent months have a single purpose: to offer better facilities and support for family members and loved ones after the death of someone close."

In January, ELHT introduced new End of Life guidelines for staff caring for dying people. Based on 5 Priorities for Care, the guidance emphasises the needs and wishes of the dying person and those close to them.

Homely hospital ward

Patients and carers of people with dementia and cognitive impairments will now find a 'Home in Hospital' environment on Ward C5 at Royal Blackburn Hospital.

Acute Medical Ward C5 has been awarded £1.4m from the Kings Fund under the 'enhancing the healing environment' project to provide an enhanced dementia friendly environment for a cohort of elderly medical patients.

The pioneering ward is an exemplar physical environment for people with dementia and their carers in a general hospital. The creative enhancements seen within the ward and the calming and comfortable environment will help people with dementia, improve the working environment for staff and provide an improved setting for all patients.

John Dean, Associate Medical Director at the Trust, said: "There is increasing evidence that the physical environment where we deliver care has a major impact on outcomes for people with dementia. It also improves the experience of care for them and their carers as well as being more rewarding for staff.

"We have developed a programme of simple changes to ward and communal areas across all Trust sites, whilst introducing the dementia friendly principles from the very beginning of the refurbishment on Ward C5.

"These enhancements will help people with dementia, improve the environment for staff and generally provide a more comfortable, calm and relaxing setting for all patients."

The ward has had a complete overhaul and includes a number of innovative details that set it apart from a normal hospital ward to ensure a relaxing environment for all patients, but especially those with dementia.

Introduction of intelligent LED lighting systems to set the mood for individual patients have been installed, along with specialist signage systems using words, icons and symbols. The wards also use bright colours as well as appropriate flooring and handrails.

Sandra Nuttall, Clinical Dementia Nurse Lead at East Lancashire Hospitals NHS Trust, said: "The number of people who develop Dementia is set to double over the next 15 – 20 years. Knowledge of dementia is the responsibility of all health and social care staff and I am pleased to be part of this project to continue to improve environments across all hospital sites to make them more accessible and friendly for people with dementia and their carers, families and friends."

Dr Nick Roberts, Consultant Physician and Geriatrician at the Trust, said: "The ward has been refurbished to a high standard to provide supervised reception and a large open social area that enables a calm, caring, homely environment, maximising safety and dignity."

"The new ward provides a mix of single and small communal bed areas (14 beds in total) with identifiable wet rooms, bathrooms and toilets all providing suitable provision on the basis that all patients matter and each patient receives safe, personal and effective care."

- **Falls reduction**

Patient falls are one of the most common patient safety incidents reported across the NHS.

Within the Trust's Quality strategy and Quality Account 2014-15, reducing patient falls resulting in harm has been identified as a specific harm reduction area with a goal of achieving a 15% reduction. As part of achieving this goal, tests of change have been developed and 4 wards across the Trust have been identified to trial these tests in view of them having the highest numbers of falls with harm

The outputs of the tests of change trial are set out below:

- A high number of patients were falling in the toilet or by the bedside on getting up from the commode when unattended. As such a change to existing clinical practice has been implemented to support safe toilet / commode supervision for those patients who were assessed as being at high risk of falls. The Trust recognises that effective communication and maintaining privacy and dignity are important elements of this particular change.

- A review of falls incidents indicated that patients were slipping because they were mobilising bare footed, in unsuitable footwear or in bed socks. Research undertaken in other NHS Trusts indicated that issuing slipper socks with grips had reduced falls incidence.

- The Trust commenced a focussed trial of red multi grip slipper socks which enabled staff to easily identify those patients at high risk of falls as well as increasing the safety of patients during mobilisation.

- It was identified that a significant number of patient falls were occurring overnight. As part of the trial the Acute Falls Lead has engaged with ward managers to review the layout of the ward environment and has advised on how staff might reposition themselves on the ward when they are writing notes or updating care plans to enable better vision and observation of patients during the night.

The impact of the implementation of these interventions is under review and to date, the results have been very positive with an overall reduction in falls and also a reduction in harm cause to patients who have suffered a fall.

Work is now underway to spread this work across a wider footprint within the Trust.

Pressure ulcer reduction

During 2014-15, the Trust embarked on a comprehensive review of pressure ulcer incidence, prevention and management. The review was led by the Deputy Chief Nurse and was supported by a dedicated steering group. The steering group developed and implemented a Trust wide action plan which was populated by the outputs of investigations into pressure ulcers that patients acquired whilst under the care of ELHT.

Further work was undertaken to improve the reporting, grading and verifying as well as the investigations of pressure ulcers. A more focused approach to education and training was also implemented.

Through the advance of the pressure ulcer collaborative a number of "test of changes" were trialled on several wards, further supporting th reduction in acquired pressure ulcers.

Work was also undertaken to increase the compliance with the SKIN care bundle which aims to ensure that patients receive a pre-determined series of interventions to prevent pressure ulcers from developing. The results of the Trust's 2014-15 care bundle audit is set out below:

Standard	Q1	Q2	Q3	Q4
All Sections of the SKIN care bundle completed	56%	63%	87%	81%

In summary, the interventions that the Trust has put into place has reduced the incidence of acquired pressure ulcers for our patients. The table below sets out the data associated with this reduction throughout the year:

Acquired Pressure Ulcers at ELHT													
	2014									2015			Grand total
	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Grade 2 – Inpatient and community beds	19	5	21	17	20	30	17	18	6	3	2	1	165
Grade 3 - Inpatient and community beds	0	1	1	5	2	2	1	2	1	1	0	0	16
Grade 4 - Inpatient and community beds	0	1	0	0	1	0	0	0	0	0	0	0	2
Totals	19	7	22	22	23	32	18	20	7	4	2	1	183
Grade 2 – Community	49	39	33	49	40	52	42	23	9	12	1	0	347
Grade 3 – Community	3	6	2	8	4	2	1	0	0	0	0	0	26
Grade 4 – Community	2	0	0	0	1	0	0	0	0	0	0	0	3
Totals	**54**	**45**	**35**	**57**	**45**	**54**	**43**	**23**	**9**	**12**	**1**	**0**	**376**

3.4 Statements from stakeholders

The Trust has consulted with its stakeholders on the accuracy and content of the Quality Account 2014-15 and all commentary that has been received has been included verbatim as follows:

East Lancashire Clinical Commissioning Group

East Lancashire Clinical Commissioning Group (EL CCG) welcomes the opportunity to comment on the 2014/15 Quality Account for East Lancashire Hospitals Trust (ELHT).

ELHT has demonstrated its continued commitment throughout 2014/15 to making improvements to quality and safety and the CCG were pleased to see the Trust moved out of Special Measures and progress key areas of their Quality Improvement Plan.

The Quality Account provides a detailed report of the Trusts achievements and challenges and sets clear priorities for 2015/16.

EL CCG support the priorities put forward for 2015/16 and have worked with the Trust to agree Quality and Commissioning for Quality and Innovation (CQUIN) measures for the coming year which will complement these priorities, including local measures for Advancing Quality Sepsis, roll out of an electronic tool to assist with management of nourishment and hydration and medicines management related measures.

The CCG will continue to work closely with the Trust throughout 2015/16 on the Quality agenda. In 2014/15 weekly teleconferences between the CCG Quality Team and Trust Governance were established and will continue. Monthly quality meetings will also continue along with the Trust and CCG engaging in a series of announced and unannounced safe, personal and effective care walk-rounds.

ELHT has achieved 22 of the 27 national quality indicators included in their contract, with unprecedented levels of attendance at the emergency department impacting on A&E 4 hour performance and ambulance handover rates.

Referral to treatment time targets have underperformed at specialty level, however the CCG are pleased with the work completed by the Trust to reduce waiting list backlogs in order to make the position in 2015/16 more sustainable.

The Trust has achieved 20 of 22 local quality indicators included in their contract and all bar 2 CQUIN indicators (Advancing Quality Pneumonia and Heart Failure). There is a data lag of approximately 3 months, so final position for Advancing Quality is not yet available. Exception reports and recovery plans have been received for all areas of underperformance providing the CCG assurance of actions being taken by the Trust to improve quality in these areas along with timescales.

Good progress has been made against the priorities set out in last year's account. The CCG set a local target for zero tolerance grade 3 and 4 pressure ulcers by Quarter 4 of 2014/15. ELHT has not reported a grade 4 pressure ulcer since August 2014, up to the end of the financial year. Excellent progress towards reducing avoidable grade 2 pressure sores with a commendable 98% reduction.

The CCG looks forward to working with the Trust in 2015/16 on reducing harm from falls, building on the review undertaken by the Trust in 2014/15 and learning from work undertaken on pressure ulcers.

The Trust has shown commitment to improving complaints processes in 2014/15. The number of 'live' complaints has reduced throughout the year as has the number of complaints progressing to the formal complaint stage, with much more proactive involvement from front line staff to discuss and resolve issues directly for and with patients.

ELHT had an extremely challenging target for reduction in Clostridium Difficile infections in 2014/15 which was based on the excellent performance in 2013/14 and recorded 32 cases against a target of 23. The Trust continues to perform well against the National Rate and remains one of the better performing ordinary acute trusts. The Trust has been set a target of 28 cases for 2015/16 and the CCG will continue to work with ELHT on post infection reviews in order to learn lessons that can be shared across the Health Economy.

MRSA had a zero tolerance target for 2014/15. ELHT has narrowly missed this target with a single case attributed to the Trust in 2014/15.

Inpatient survey results are encouraging and demonstrate good improvement in patient experience across a number of measures.

The CCG are pleased with progress made by the Trust for Friends and Family (FFT), with successful rollout to staff, outpatient and community services. The response rate has improved for A&E services and the CCG would like to see further improvement in the percentage of patients who would recommend the service in 2015/16. ELHT has demonstrated learning from patient feedback throughout the year, through 'Share to Care' and 'You Said, We Did' with details available to view on wards.

ELHT has participated in 95% of National Clinical Audits and 100% of National Confidential Enquiries and this is a clear indication of an organisation with a commitment to

delivery of evidence based safe care.

Data quality assurance remains high with compliance being maintained in recording of a valid NHS number and General Medical Practice Code. At the time of writing clinical coding audit results for 2014/15 were unavailable. Clinical coding supports clinical care, treatment and outcomes and is directly linked to payment and costs. The CCG hopes to see further improvements in primary diagnosis recording when results are published.

There is some concern around Information Governance Toolkit compliance, with the Trust graded as 'not satisfactory' due to training rates dropping below the required level of 95%. The Trust has an action plan in place to ensure compliance in 2015/16 - a copy has been requested and is awaited by the CCG to be assured on actions being taken.

EL CCG look forward to working with ELHT over the next year to ensure that services commissioned are of a high quality standard and provide safe, personal and effective care.

Healthwatch Blackburn with Darwen

The Trust has welcomed independent patient experience gathered by Healthwatch BwD. They have helped facilitate our weekly signposting and engagement access point at the Blackburn site, and meet monthly with the Healthwatch Chief Executive to ensure patient feedback gathered is listened to and acted upon.

We have had trust representatives attend our public board meetings to discuss relevant negative publicity, and explain to local residents their action plan. This has been well received from the Board and our membership.

Healthwatch BwD has noted the positive improvements the Trust has made following being placed into special measures. We have also noted the improvements in patient experience in many areas. This includes the cleanliness and hand-gel availability, which we hope will help achieve zero MRSA bacteraemias in the coming year. We would like to congratulate the Trust on their regional and national praise for both the Children's Diabetes service and ward C5.

Although there has been a reduction from the previous year, we also note the high percentage of patients not being informed how to make a complaint and not being informed how to feel after an operation or procedure. Along with addressing these issues, we would expect to see the Trust review the 24% of staff would not recommend the Trust to their family and friends.

Healthwatch Lancashire

Thank you for sharing your Quality Account for 2014-15 with Healthwatch Lancashire. This report articulates the Trust's focus on improving quality as evidenced by the development and embedding of a quality strategy and the Trust's exit from special measures in April / May 2014.

The Trust's strategic approach to quality is to be commended and it is good to note that quality is focused on provision of safe, personal and effective care. It is also pleasing to note that the Trust has implemented a family, patient and carer experience strategy as is the Trust's commitment to clinical research and clinical audit.

Whilst there is evidence of the Trust's progression and progress in respect of improving quality some of the information provided is overly complex and lacks clarity eg CQUIN, SHMI and Friends & Family Test data. Patient Safety Incident data is of concern also indicates the Trust requires further improvements and focus on this extremely important facet of patient care but it is commendable that the Trust has reported nil never events in 2014/15. The Quality achievements and outcomes detailed eg for children's diabetes care are also evidence of the Trust's commitment to improving patient care.

Blackburn with Darwen Health and Wellbeing Board

On behalf of Blackburn with Darwen Health and Wellbeing Board I would like to thank you for the opportunity to comment on the East Lancashire Hospitals Trust Quality Account 2014-15.

The Board is pleased to see that the ELHT is moving in the right direction following the Keogh review and that it continues to build the trust and satisfaction of service users about quality and safety of ELHT services.

The Board welcomes active engagement and working together to improve the patient experience of admissions / discharges to the hospital through the Better Care Fund. The Board also notes that the hospitals are increasingly open to wider partnership working for both locality based prevention and improved treatment models. These will deliver better and more comprehensive health care support to the community as a whole. The hospitals new contribution to the Local Public Service Board is a key route for this work to link to the Blackburn with Darwen Health and Wellbeing Board.

The Board notes that the Trust has welcomed independent patient experience gathered by Healthwatch BwD. The Trust has helped facilitate their weekly signposting and engagement access point at the Blackburn site and have met monthly with the Healthwatch Chief Executive to ensure patient feedback gathered is listened to and acted upon.

Healthwatch BwD have had Trust representatives attend their public Board meetings to discuss relevant negative publicity, and explain to local residents their action plan. This has been well received from the Board and their membership.

Healthwatch BwD has noted the positive improvements the Trust has made following its placement into special measures. They have also noted the improvements in patient experience in many areas. This includes the cleanliness and hand-gel availability, which they hope will help achieve zero MRSA bacteraemias in the coming year. We would like to congratulate the Trust on their regional and national praise for both the Children's Diabetes service and ward C5.

Although there has been a reduction from the previous year, we also note the high percentage of patients not being informed how to make a complaint and not being informed how they might feel after an operation or procedure - we would like to see this improve over the coming year.

Along with addressing these issues, we would also expect to see the Trust review and seek further insight on the 24% of staff who would not recommend the Trust to their family and friends.

I would be grateful if you could let me know how the final quality account, including consultation responses, will be reported to key stakeholders and members of the community and I look forward to continued discussions in respect of quality improvement across the East Lancashire health economy.

Lancashire Health Scrutiny Committee

The role of the Lancashire Health Scrutiny Committee is to review and scrutinise any matter relating to the planning, provision and operation of the health service in the area and make reports and recommendations to NHS bodies as appropriate.

The Committee undertake this responsibility through engagement and discussions with the Trust, addressing any areas of concern as they arise. It is the intention of the Committee that this methodology of ensuring that the Trust improve patient safety and deliver the highest quality care to the residents of Lancashire will continue by having an oversight of how the Trust evidence the provision of quality and safe services.

In addition the Health Scrutiny Committee will seek reassurance that every effort is being made to ensure; financial stability, reasonable waiting times and the safeguarding of the most vulnerable.

3.5 Statement of Directors Responsibilities

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

29.6.15 ..... Date ..... Chairman

29.6.15 ..... Date ..... Chief Executive

3.6 Auditors limited assurance report

Grant Thornton

Independent Auditor's Limited Assurance Report to the Directors of East Lancashire Hospitals NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of East Lancashire Hospitals NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Percentage of patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of directors and auditors

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated May 2015;
- feedback from Local Healthwatch dated May 2015;
- feedback from the Lancashire Health Scrutiny Committee involved in the sign off of the Quality Account;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 15 June 2015;
- the latest national patient survey dated February 2015;
- the latest national staff survey dated February 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated March 2015;
- the annual governance statement dated 3 June 2015; and
- the Care Quality Commission's Intelligent Monitoring Report dated December 2014.

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

This report, including the conclusion, is made solely to the Board of Directors of East Lancashire Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and East Lancashire Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower 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 impact 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 thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by East Lancashire Hospitals NHS Trust.

Basis for qualified conclusion

The indicator reporting the percentage of patients risk-assessed for VTE did not meet the six dimensions of the data quality in the following respects:

- **Reliability –** In the sample of cases we reviewed for 5 of the 25 cases the Trust's Patient Administration System (PAS) or Electronic Patient Tracking System (EPTS) indicated that a VTE risk assessment had taken place, but review of the patient records identified that the patient was in a low risk cohort where no VTE risk assessment was required and there was no evidence that this risk assessment had been completed. Whilst the low risk cohorts are included in the indicator, due to the misclassification of the patients we have not been able to obtain sufficient assurance that the data is reliable.

Qualified conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

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3.7 Glossary

Term	Explanation
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Antimicrobial	An agent that kills microorganisms or inhibits their growth
Audit Commission	A statutory corporation that sets standards for auditors and oversees their work
Care bundle	A group of interventions which are proven to treat a particular conditions
Care Quality Commission (CQC)	The independent regulator for health and social care in England
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary
Clinical research	A process that determines the safety and effectiveness of medications, devices, diagnostic products and treatment
Clostridium Difficile Infection (CDI)	A type of infection
Commissioning for Quality and Innovation (CQUIN)	A payment framework linking a proportion of a Trusts income to the achievement of quality improvement goals
Datix	An electronic system that supports the management of risk and patient safety incidents
Dr Foster guide	A national report that provides data on patient outcomes in hospitals in the UK
Francis report	A report that set out the causes of the failings in care at Mid Staffordshire NHS Trust
Hospital Episode statistics	A data warehouse containing records of all patients admitted to NHS hospitals in England
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths occurring within hospitals
Indicator	A measure that determines whether a goal or an element of a goal has been achieved
Information governance toolkit	An online tool that enables NHS organisations to measure their performance against information governance requirements
Integrated Care group	An amalgamation of the medical and community services functions within East Lancashire NHS Trust
Monitor	A health service regulator within the NHS in England
Morbidity	The disease state of an individual, or the incidence of illness in a population
Mortality	The state of being mortal, or the incidence of death (number of deaths) in a population
MRSA bacteraemia	A type of infection
National Confidential Enquiries	A process to detect areas of deficiency in clinical practice and devise recommendations to resolve them
National Reporting and Learning System (NRLS)	A national electronic system to record incidents that occur in NHS Trusts in England

Term	Explanation
National Early Warning Scores (NEWS)	A tool to standardise the assessment of acute-illness severity in the NHS
NHS England	A body that oversees the budget, planning, delivery and day-to-day operation of the NHS in England set out in the Health and Social Care Act 2012
NHS number	A twelve digit number that is unique to an individual and can be used to track NHS patients between NHS organisations
NICE Quality Standards	A concise set of prioritised statements designed to drive measurable quality improvements within a particular area
Palliative care	When there is no cure for an illness, palliative care tries to make the end of a person's life as comfortable as possible.
Parliamentary and Health Service Ombudsman	A body that investigates complaints where individuals perceive they have been treated unfairly or have received poor service from government departments, other public organisations and the NHS in England
Patient Administration System (PAS)	A system used by acute trusts to electronically record patient information eg contact details, appointments, admissions
Patient Advice and Liaison Service (PALs)	A service that offers confidential advice, support and information on health-related matters
Payment by results	A form of financing that makes payments contingent on the independent verification of results
PDSA	Plan, Do, Study Act methodology for quality improvement
Pressure ulcer	Sores that develop from sustained pressure on a particular part of the body
Research ethics committee	A committee that approves medical research involving people in the UK, whether in the NHS or the private sector
Risk summit	A meeting of relevant agencies to address an issue of serious concern
Safety express	A national improvement programme to facilitate the delivery of harm free care to patients
Safety Thermometer	A local improvement tool for measuring, monitoring and analysing patient harms and harm free care
Secondary uses service	A national NHS database of activity in Trusts, used for performance monitoring, reconciliation and payments
Share 2 Care	A process to facilitate sharing of best practice and lessons learned
Summary Hospital level Mortality Indicator (SHMI)	The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die
Strategic Executive Information System (STEIS)	An information management system utilised to performance manage serious untoward incident investigations
Trust Development Authority (TDA)	A body which is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers
Venous thromboembolism (VTE)	A blood clot forming within a vein

East Lancashire Hospitals NHS
NHS Trust

This document is available in a variety of formats and languages.

Please contact Trust Headquarters for more details:
East Lancashire Hospitals NHS Trust
Royal Blackburn Hospital
Haslingden Road
Blackburn
BB2 3HH

Tel 01254 732801

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