QUALITY ACCOUNT

2016 – 2017

CONTENTS

EAST LANCASHIRE HOSPITALS NHS TRUST – QUALITY ACCOUNT REPORT 2016-2017

1.0 PART ONE – INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

East Lancashire Hospitals NHS Trust (ELHT) 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 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 forming a natural boundary with Yorkshire.

We provide high quality healthcare services primarily to the residents of East Lancashire and Blackburn with Darwen, which have a combined population in the region of 530,000.

- We employ just over 7,000 staff, some of whom are internationally renowned and have won awards for their work and achievements.
- We treat over 600,000 patients a year from the most serious of emergencies to planned operations and procedures.
- We offer care across five hospital sites, and various community sites, using state-of-the-art facilities.

We have a total of 996 beds:

- 631 beds at the Royal Blackburn Teaching Hospital
- 241 beds at the Burnley General Teaching Hospital
- 33 community inpatient beds at Clitheroe Community Hospital
- 19 community inpatient beds at Accrington Victoria Hospital
- 72 community inpatient beds at Pendle Community Hospital

We provide a full range of acute hospital and adult community services. We are a specialist centre for hepatobiliary, head and neck and urological cancer services, in addition to providing specialist cardiology services and a network provider of Level 3 Neonatal Intensive Care.

Our key commitment is to the delivery of the best possible healthcare services to the local population while ensuring the future viability of our services by continually improving the productivity and efficiency of services. This core focus has enabled demonstrable improvement in our key access, quality and performance indicators.

There are two private finance initiative (PFI) schemes for parts of the buildings at Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital sites, valued at over £70m and £20m respectively. We continue to make major investments in our healthcare facilities, predominantly focusing on our on-going commitment to the Burnley General Teaching Hospital site.

1.2 Our Vision and Values

Our key commitment is to the delivery of the best possible healthcare services to the local population while ensuring the future viability of our services by continually improving the productivity and efficiency of services. This core focus has enabled demonstrable improvement in our key access, quality and performance indicators. The strategic framework which guides all our activities is shown in the diagram below:

1.3 **Our Future**

Over the next five years the Trust will see closer integration with providers of health and care across Pennine Lancashire through the Pennine Lancashire Transformation programmes

and across all of Lancashire as part of the Lancashire and South Cumbria Sustainability and Transformation Plan (STP). We will seek a greater role in the provision of prevention of illness, in primary care, and in regional specialist work.

Across the Pennine Lancashire Local Delivery Plan (LDP) area, we will integrate more closely with providers in the primary, community, voluntary and third sectors. We will undertake co-design with Commissioners, creating an 'accountable care system' in Pennine Lancashire. Clinicians of the Trust will increasingly work with their professional colleagues from other providers to form Lancashire-based sustainable networks which determine the standards of care, the governance and the delivery of care pathways.

Our Transformation themes will drive us towards a clinically and financially sustainable integrated organisation. These themes are:

- Service Excellence: delivery of services that provide safe, personal and effective care;
- Financial Performance: financial and business controls that aid the delivery of cost effective services;
- Organisational Excellence: delivery of operational processes, pathways and services that are underpinned by technology that are both productive and efficient; and
- Workforce Excellence: Creation of a transformational approach to workforce development and organisational design that addresses current and future needs of service provision.

We will achieve greater efficiencies, reducing the length of stay for key medical conditions including chronic obstructive pulmonary disease (COPD); reducing theatre times for elective and emergency surgery through increased productivity measures, and reducing our overall bed-base through the introduction of new pathways of care and integrated community care services.

We will continue to improve care in our Trust and community, increasing access to all relevant services, seven days a week, reducing avoidable mortality and improving patient experience.

1.4 **Our Approach to Quality Improvement**

The Trust is committed to the continuous improvement of the quality of care provided and, in so doing, achieving our organisational aim 'to be widely recognised for providing Safe, Personal and Effective care.

Quality monitoring occurs through our corporate and clinical governance structure, reporting to the Trust board via the Quality Committee. The Quality Committee is informed by the Patient Safety and Risk Assurance committee, Clinical Effectiveness Committee, Serious Incidents Requiring Investigation Panel, Health and Safety Committee, Infection Prevention Committee, Internal Safeguarding Board and Patient Experience Committee. Divisional Directors or their deputies attend and report at these committees. Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board'.

In order to ensure that we are delivering safe, personal and effective care we have a robust process for the identification and agreement of key quality priorities. Those that require quality improvement are consolidated into our Quality Improvement Plan including a Harms Reduction Programme, Clinical Effectiveness Reliability and Patient Experience, and monitored for progress through this structure.

Our quality improvement methodology is the '7 Steps to Safe Personal Effective Care'. This is based on the model for improvement and also incorporates lean and other tools. We have a small and developing quality improvement team of facilitators as part of the Quality and Safety Unit, linking with the Quality Committee structure.

A staff development programme in quality improvement skills is in place both internally and through our membership of the Advancing Quality Alliance (AQuA). Professionals in training are supported to develop and participate in quality improvement projects, and support for projects is agreed at the Quality Improvement Triage group.

Dr Damian Riley is the Executive Medical director and the lead for clinical quality.

The lead commissioner 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 CCGs has been further strengthened during 2016-17. Monthly quality review meetings are held, chaired by the Commissioning Support Unit (CSU), with quality leads from all organisations. The focus of these meetings is around clinical effectiveness, risk and safety, quality improvement and the patient and family experience. This communication is enhanced by weekly teleconferences between the lead CCG, CSU and the Trust.

The escalation process for incidents, risks and events of concern has been revised and improved to ensure timely and appropriate communication to all relevant parties.
Evidence is collated from Divisions and presented to one of the bi-monthly subcommittees of the Quality Committee and then to the Trust Board. Following these meetings, validated reports and data are shared with the CCGs and CSU to provide assurance and to support health economy decision making. Reports include:

Complaints
Healthcare Associated Infections (HCAI)
Exception reports against key performance standards.

The quality scorecard developed in 2015-16 has continued to be used this year to facilitate monitoring against a range of quality indicators.

1.5 **Our Quality Account**

Quality Accounts are annual reports from providers of NHS services which provide information about the quality of the services they deliver. Our Quality Account demonstrates our commitment to continuous evidence-based service quality improvement and to explaining our progress in this area to patients, the public and interested parties.

The way in which we report through our Quality Account is set out in legislation and covers:

The Trust's priorities for quality improvement in 2017-18;
Performance during the last year against quality priorities set by the Trust;
Performance during the last year against a range of nationally set quality indicators, initiatives and processes; and
Performance during the last year against a range of other quality indicators, initiatives and processes.

Our Quality Account has been developed over the course of 2016-17 as we have continually monitored and reported against our quality priorities and indicators' both within the organisation and externally to the public, commissioners and regulators and at a national level. We have also invited a variety of representatives of local people to comment on what they think of this Quality Account and what is says about our Trust; their comments and contributions can be found in Part 3 of this report. We also want you to provide us with feedback about this report, or about our services. If you wish to take up this opportunity please contact:

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Royal Blackburn Teaching Hospital
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BLACKBURN
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1.6 Our Regulator's View of the Quality of our Services

On 20 and 21 September 2016 the Care Quality Commission (CQC) visited the Trust to conduct a 'Well-Led' review. Following their review the report was published on 4 January 2017 and the Trust was rated as being Good overall. The CQC scores for each of the main hospital sites and overall are as follows:

Royal Blackburn Teaching Hospital Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Burnley General Teaching Hospital Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

East Lancashire Hospitals NHS Trust Overall - Good	
Safe	Good
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Good

A Quality Summit was held at the Trust on 7 February 2017 to consider the findings of the review and was attended by representatives of NHS Improvement, NHS England, CCG's, local

council, Healthwatch and education organisations, the Chair, CEO and other executive and senior officers of the Trust. The CQC lead inspector also attended.

The summit considered the findings of the inspection and highlighted areas of outstanding and good practice. Areas requiring further development were also identified as follows;

- Review the Duty of Candour implementation and the 10 day timescale for incidents graded at moderate or more harm.
- Ensure safe and accurate medicines administration and documentation.
- Ensure safe access and use of electronic patient records.

All of these areas have been addressed through an action plan and are monitored through the appropriate assurance committee structure.

1.7 Our Chief Executive's Statement on Quality

I am proud to present a Quality Account which demonstrates that our organisation has an intense focus at every level on delivering safe, personal and effective care to patients, service users and their families and is committed to learning from all possible sources on how we can continually improve our care. I am humbled by the commitment demonstrated by all my colleagues, whether involved in delivering direct care or in supporting those that do, to meet the needs of patients in our local community and to work constructively with other organisations to make this a priority.

The last couple of years had seen some fantastic progress in ensuring our patients' needs are met in hospital, avoiding sepsis, reducing falls and pressure ulcers , assessing patients at risk from dangerous blood clots (VTE), maintaining a focus on reducing unexpected deaths and receiving positive feedback from our staff, patients and their families. We also acknowledge there are areas where we will need to continue our focus to maintain the progress that has been made and ensure further quality improvements, particularly in our Emergency Department and the way in which we ensure patients are assessed and prepared for their discharge. This has been reflected in the recent Care Quality Commission inspection findings rating the Trust overall as 'good' and I am particularly proud of the areas where 'outstanding' practice was identified.

The areas we have identified for future improvement will receive particular focus in 2017/18 and we will continue to work to ensure our achievements to date are maintained and every patient we care for and every family member or carer we interact with receives safe, personal and effective care, respecting the individuality of everyone.

To the best of my knowledge all the data and information presented in this 2016/17 Quality Account is true and accurate and the Quality Account has been approved by the Trust Board.

Kevin McGee
Chief Executive

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

Following the publication of the East Lancashire Hospitals NHS Trust's (ELHT) first Quality Strategy in 2014 there have been significant developments within ELHT and the local health economy. The Trust has been re-inspected twice by the CQC; the first inspection culminating in the lifting of special measures and the second leading to both main hospital sites being assessed as 'Good'. This demonstrates the strength of the initial strategy's approach to quality and the adoption of the Trust's vision to be widely recognised for the delivery of Safe, Personal and Effective care. As a result of up-dating the Trust Quality Strategy those three core elements remain its focus, whilst further strengthening governance and reporting arrangements, to provide a clear reporting system from 'Floor to Board'.

Safe Care

The initial strategy in 2014 focused upon the specific Harms Reduction Strategy with clear emphasis upon the strengthening of awareness, reporting and acting upon findings. Whilst this successful approach is to be maintained and strengthened the approach from 2016 – 2018 will have a focus upon the safety of systems and the culture of safety both across the organisation as a whole and in specific teams.

Harms Reduction Programme/Sign up to Safety

To utilise resources effectively a review of the Trust's harms reduction programme and Sign up to Safety pledges has been undertaken in order that these are merged to deliver a reduction in accidents causing harm to patients receiving care at ELHT and contributing to the Sign up to Safety national programme target (reducing incidents causing harm by 50000 in the five year cycle).

A number of these projects will shape the quality improvement collaborative series for 2017-18. A Breakthrough Series Collaborative is a medium-term (usually between 6 and 18 months) improvement methodology that brings together a number of teams from across the hospital to seek improvement in a focused topic area through shared learning, and rapid testing and implementing of changes that lead to lasting improvement.

Safety Culture Survey

a) We are working in collaboration with AQuA to roll out their Safety Culture survey to identify barriers in the reporting of safety concerns and subsequent action being taken.

b) In addition the reliability of systems is being improved with use of Human Factors training for areas identified as being the highest risk.

c) The Prompt to Protect campaign will be launched to promote a culture of openness around safety issues and encourage staff to step in when they feel it is not right and needs challenging.

Mortality Reduction Programme

Whilst ELHT is no longer an outlier for mortality ratios we are continuing to develop the Mortality Reduction Programme. We are introducing an electronic mortality review process

that is part of our patient safety risk management software system (Datix) and which automatically triggers a more detailed review of any deaths which may be of a concern. This more detailed review is in line with the most recent NHS England guidance and includes classification according to the Hogan system for assessing the scale and scope of avoidable hospital deaths. It also incorporates the guidance from the Mazar's review of deaths of service users with a mental health or learning disability diagnosis. The number of avoidable deaths (as per the Hogan classification) and the outcomes of any Learning Disability/Mental Health death investigations will be reported to the Quality Committee.

Personal Care

As an organisation, feedback is a powerful and useful mechanism for improving the quality of care and patient experience, both for individuals and for the wider NHS, as well as contributing to a culture of learning from experience. ELHT want to ensure that patients experience compassionate care that is personalised and sensitive to their needs.

People's views and experiences are gathered in a number of different ways across the organisation including:

a) Friends and Family Test and Patient Surveys results are reported at the Patient Experience Group meeting and via Divisions to share and celebrate good practice and identify areas for improvement. These improvements are displayed in wards and departments in the 'You said, We did' format.

b) Patient and Carer Stories- stories are collected for presentation at Trust Board meetings and as part of quality improvement work. Patient and Carer stories have been used to facilitate learning as part of the Falls Collaborative, 1 to 1 partnership in care and the Dementia Strategy.

c) Patient Forums where patients views and experiences are used to make improvements and to comment on service developments

d) Healthwatch -two local organisations (East Lancashire and Blackburn with Darwen). ELHT supports and facilitates Patient Engagement events and visits to services. We value the patient feedback collected by Healthwatch and are able to review and identify areas for improvement from this engagement.

e) Soft intelligence: NHS Choices/Patient Opinion/CCG / Twitter and Facebook

f) National Surveys including Adult In-Patient Survey, Emergency Dept. Survey, Children and Young Peoples Survey

g) Our Family, Patient and Carer Experience Strategy 2014-16 is being updated using answers to the question 'What Matters to you? ' to inform our next priorities for action.

Clinical Effectiveness

There will be a continued evolution to the approach of ensuring clinical directorates are delivering effective, evidence-based care in a reliable manner. Over the past year the Clinical Effectiveness Team has evolved and is now fully established. This Team has two main functions - to provide assurance of delivery of best practice and to oversee quality improvement activity to improve areas where practice falls below the expected level.

To ensure that directorates are delivering best practice and are aware of the standards expected of them each directorate now has a 'portfolio' of standards against which they monitor their performance.

This portfolio includes:

a) National audits as mandated by the national contract
b) Regional and Local audits as determined by commissioners or regional bodies
c) Local Quality audits (e.g. compliance with local care bundles)
d) Relevant NICE guidance
e) Relevant NCEPOD recommendations
f) Getting It Right First Time data

Monitoring of performance is being developed to make it as 'real-time' as possible. This has meant a switch away from annual one-off measurements or from very intensive large scale data collection (such as Advancing Quality measures) to more frequent, smaller scale sampling and rapid feedback. Systems are being developed in-house to provide IT support to real-time data collection. To support this process within divisions, each division now has in place a Clinical Effectiveness Lead supported by a Governance Lead. They are responsible for developing the directorate portfolio of evidence and ensuring all relevant national guidance is captured. This process is supported corporately by the corporate Clinical Effectiveness Team.

QI Triage Group

The Quality Improvements Triage Group has been established as a formal group reporting to the Clinical Effectiveness Committee. It is the engine room for ensuring Division(s) have assurance that plans are in place for monitoring the impact of the quality improvement project, and if necessary to ensure that impacts on others divisions are recognised. It brings together the divisional and quality improvement teams. Its purpose is to examine the detail of quality improvement projects signed off by Directorate and Divisional Teams, ensuring that plans include the specified area for change is articulated with aims and measures as well as details of the support required. Once agreed this will be added to the Trust Quality Improvement Projects Register.

The Clinical Effectiveness Committee receives a regular report from the Quality Improvements Triage Group which details:

- All new Quality Improvement Projects submitted;
- Quality Improvement Projects deemed to apply to single Division;
- Why this decision was made;
- Assurance that impact monitoring plans are in place;
- Quality Improvement Projects deemed to require further review;
- Which Group(s) undertaking further review;
- Timescales in place; and
- Update on previous plans

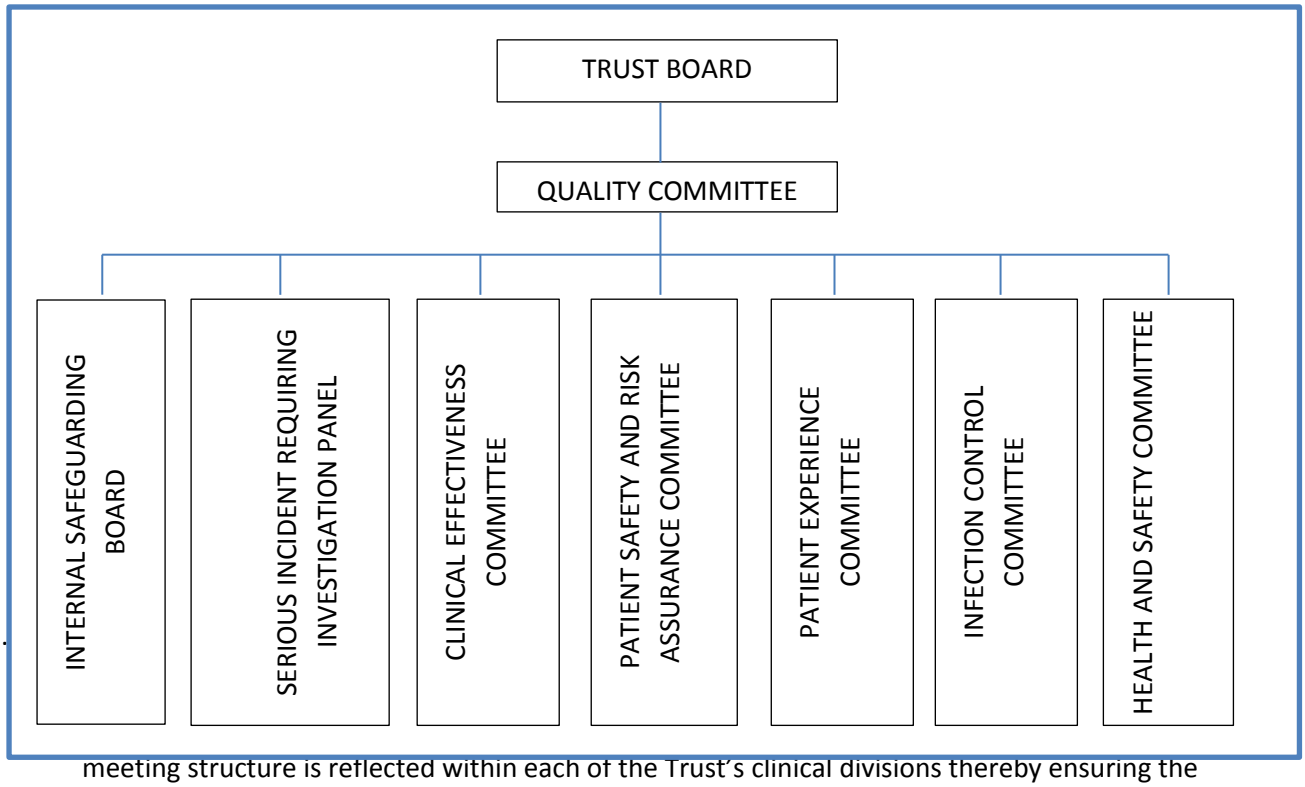
Each Division then provides updates on project implementation for all of the projects within their Division.

Governance Arrangements for Quality

Improving quality is the Board's top priority. It also represents the single most important aspect of the Trust's vision to be widely recognised for providing safe, personal and effective care. The

Trust places quality and safety at the heart of everything we do. Ensuring that our activities offer best quality and high safety levels is becoming our minimum standard rather than an aspiration. This continual drive for quality means our patients, their families and all our stakeholders can have greater confidence in the Trust as we move forward. The Trust has established the governance and committee structure shown in figure 1 to ensure the Board receives assurance in relation to the delivery of the Trust's objectives and that risk to the delivery of safe, personal and effective care is appropriately managed.

Figure 1: Trust Governance Structures for Quality and Safety



2.

meeting structure is reflected within each of the Trust's clinical divisions thereby ensuring the Board has proper oversight of performance at all levels of the Trust, down to ward level. The meeting structure also provides a clear route of escalation for issues that need executive decision. Meetings take place on a regular basis and utilise standardised information to drive and inform the discussion. The data contained within the various performance dashboards showing monitoring of quality improvement areas is a mixture of outcome targets and process milestones that are presented to demonstrate performance at all levels of the Trust.

The Board Assurance Framework (BAF) and the Corporate Risk Register provide assurance to the Board that risks to patient safety, reputation and quality are appropriately managed in a timely way. The risk management process is designed to ensure current and potential future risks to quality are identified and included on the risk register, for example new technologies and changes in policy and funding. There are clear directorate and divisional reporting structures with specific triggers and processes by which risk and mitigating actions are reported and escalated. There is a clear and dynamic process for the management of risk in the organisation and both the BAF and the Corporate Risk Register are regularly reviewed to ensure appropriate, preventative and corrective actions have been taken.

The Trust Board is ultimately accountable for the delivery of quality outcomes and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality and Safety Unit, comprising three specific portfolios of patient safety/clinical risk,

patient experience and clinical effectiveness, which includes the Quality Improvement Team. Similarly, Divisional Directors and Divisional General Managers are responsible for the delivery of quality outcomes within their divisions and the Trust Board holds Divisional Senior Management Teams to account for delivering quality outcomes within their respective divisions. This principle of accountability and responsibility is reflected from Board to Floor and supports the delivery of our quality objectives.

A robust Quality Impact Risk Assessment Process (QIRA) is in place to ensure our Safely Releasing Costs Programme (SRCP) ensures we continue to maintain **Safe**, **Personal** and **Effective** care as we work to reduce our cost base. The Medical Director and Director of Nursing are required to sign off every QIRA. The QIRA assesses the risk associated with each SRCP scheme and it is embedded into the Trust's risk management processes. Through these processes high risk schemes are added to risk registers and are monitored through the processes described above.

During 2016-17 the ELHT provided and/or sub-contracted 8 NHS services. These services have been identified using the CQC'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 products

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 Quality Committee, Patient Experience Committee, Clinical Effectiveness Committee, Patient Safety and Risk Assurance Committee and Operational Delivery 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 2016-17, has been managed by way of these reporting functions.

The income generated by the NHS services reviewed in 2016-17 represents 94.5% of the total income generated from the provision of NHS services by the ELHT for 2016-17.

2.3 Priorities for Quality Improvement 2017 – 18

The Trust co-ordinates a comprehensive rolling programme of quality improvement initiatives and the publication of the Quality Account give us the opportunity to highlight some of the initiatives which we will specifically focus on during the coming year. These are:

Subject	Quality Aim	How achievement will be measured	How achievement will be monitored
Discharge - support for safe discharge to continuing care	Implementation of a Trust-wide approach to improve the safety and experience to patients	Quality Improvement Collaborative	Report to the Patient Safety & Risk Assurance Committee

Safe Transfer of Care - between providers	Implementation of a Trust-wide approach to improve the safety and experience to patients	Quality Improvement Collaborative	Report to the Patient Safety & Risk Assurance Committee
Deteriorating Patient - continuing work from last year	Implementation of a Trust-wide approach to improve the recognition of and response to the deteriorating patient	Use of the Mortality/Cardiac Arrest/Deteriorating Patient score card	Monthly Deteriorating Patient Steering Group reports to Patient Safety & Risk Assurance Committee

2.4 Mandated Statements on the Quality of our Services

2.4.1 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 we also carry 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 2016-17 47 national clinical audits and 10 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 44 (94%) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that ELHT was eligible for, and subsequently participated in are set out in the table below. The National Clinical Audits and National Confidential Enquiries that ELHT participated in, and for which data collection was completed during 2016-17 also appears in the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number or the registered cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
6th National Audit Project of the Royal College of Anaesthetists: Perioperative Anaphylaxis in the UK	RCA	Continuous	Yes	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	NICOR	Continuous	Yes	100%
Adult Asthma	BTS	Intermittent	Yes	100%
Asthma (paediatric and adult) care in emergency departments	RCEM	Intermittent	Yes	100%
Bowel Cancer (NBOCAP)	RCS	Continuous	Yes	100%
Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Consultant Sign-off (Emergency Departments)	RCEM	Intermittent	Yes	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	NICOR	Continuous	Yes	100%
Cystectomy Audit	BAUS	Continuous	Yes	100%
Diabetes (Paediatric) (NPDA)	RCPCH	Intermittent	Yes	100%
Endocrine and Thyroid National Audit	BAETS	Continuous	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	RCP	Continuous	Yes	100%

Falls and Fragility Fractures Audit programme (FFFAP) Inpatient Falls	RCP	Intermittent	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	RCP	Continuous	Yes	100%
Head and Neck Cancer Audit	HANA	Continuous	Yes	100%
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	Continuous	Yes	100%
Major Trauma Audit	TARN	Continuous	Yes	100%
National Audit of Dementia	RCP	Intermittent	Yes	100%
National Audit of Intermediate Care	NHS Digital	Intermittent	Yes	100%
National Audit of Pulmonary Hypertension	BTS	Continuous	No	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Comparative Audit of Blood Transfusion programme: Use of blood in Haematology	NHSBT	Intermittent	Yes	100%
National Comparative Audit of Blood Transfusion programme: Audit of Patient Blood Management in Scheduled Surgery	NHSBT	Intermittent	Yes	100%
National Diabetes Audit: National Foot care Audit	NHS Digital	Continuous	Yes	100%
National Diabetes Audit: National Inpatient Audit	NHS Digital	Intermittent	Yes	100%
National Diabetes Audit: National Pregnancy in Diabetes Audit	NHS Digital	Continuous	Yes	100%
National Diabetes Audit: National Diabetes Transition	NHS Digital	Continuous	Yes	100%
National Diabetes Audit: National Core	NHS Digital	Intermittent	Yes	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 Lung Cancer Audit (NLCA)	RCP	Continuous	Yes	100%
National Ophthalmology Audit	RCOphth	Continuous	TBC	100%
National Prostate Cancer Audit	RCS/CSU	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Neonatal Intensive and Special Care (NNAP)	RCPCH	Continuous	Yes	100%
Nephrectomy audit	BAUS	Continuous	Yes	100%
Oesophago-gastric Cancer (NAOGC)	RCS	Continuous	Yes	100%
Paediatric Pneumonia	BTS	Intermittent	Yes	100%
Percutaneous Nephrolithotomy (PCNL)	BAUS	Continuous	Yes	100%
Radical Prostatectomy Audit	BAUS	Continuous	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	BAUS	Continuous	Yes	100%
Severe Sepsis and Septic Shock - care in emergency departments	RCEM	Intermittent	Yes	100%
Smoking Cessation	BTS	Intermittent	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAM	Intermittent	No	100%
Stress Urinary Incontinence Audit	BAUS	Continuous	Yes	100%

Key to Audit Coordinator abbreviations

BAETS	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BTS	British Thoracic Society
CMP	Case Mix Programme
FFFAP	Falls and Fragility Fractures Audit Programme
FLDB	Fracture Liaison Database
HANA	Head and Neck Audit
HQIP	Health Quality Improvement Partnership
ICNARC	Intensive Care Audit & Research Centre
LeDeR	Learning Disability Mortality Review Programme
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
NNAP	Neonatal National Audit Programme
NPDA	National Paediatric Diabetes Audit
PCI	Percutaneous Coronary Intervention
PCNL	Percutaneous Nephrolithotomy
RCA	Royal College of Anaesthetists

RCEM	Royal College of Emergency Medicine
RCOphth	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCS	Royal College of Surgeons
SAM	Society for Acute Medicine
SSNAP	Sentinel Stroke National Audit programme

NCE's

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2016-17	Required Sample Submission
Child Health Clinical Outcome Review Programme: Chronic Neurodisability	NCEPOD	Intermittent	Yes	On-going	100%
Child Health Clinical Outcome Review Programme: Young People's Mental Health	NCEPOD	Intermittent	Yes	On-going	100%
Child Health Clinical Outcome Review Programme: Cancer in Children, Teens and Young Adults	NCEPOD	Intermittent	Yes	On-going	100%
Elective Surgery (National PROMs Programme)	NHS Digital	Continuous	Yes	On-going	100%
MBRRACE-UK : Perinatal Mortality Surveillance	NPEU	Continuous	Yes	On-going	100%
MBRRACE-UK : Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	NPEU	Continuous	Yes	On-going	100%
MBRRACE-UK : Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	NPEU	Continuous	Yes	On-going	100%
Maternal mortality surveillance	NPEU	Continuous	Yes	On-going	100%
Physical and mental health care of mental health patients in acute hospitals	NCEPOD	Intermittent	Yes	Yes	100%
Non-invasive ventilation	NCEPOD	Intermittent	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 and Confidential Enquiries – United Kingdom
NPEU	National Perinatal Epidemiology Unit

The results of 47 national clinical audit reports and 5 national Confidential Enquiry reports were reviewed by the Trust in 2016-17. 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:

- National Audit reports will continue to be presented at specialty/ multi-specialty

effectiveness meetings or other appropriate forums where lessons learnt, subsequent recommendations and action will be agreed so that practice and quality of care can be improved

- A list of all National Audit Reports received will be collated and shared with the Divisional / Directorate Leads, this will be monitored via Trust Clinical Effectiveness Committee to provide assurance that these reports are being reviewed and lessons learnt, subsequent recommendations and action captured
- National audit activity which highlights the need for improvement will be reviewed for inclusion in subsequent quality improvement activity plans
- The Clinical Effectiveness Team will collate an annual report which will focus on lessons learnt to be presented to the Clinical Effectiveness Committee for on-going assurance and monitoring

208 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2016-17. 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 local audits will continue to be presented and discussed at specialty/multi-specialty audit meetings and/or appropriate forums where lessons learnt are captured, recommendations and actions agreed and shared where required
- Monitoring of action matrices will occur at subsequent audit or designated meetings to ensure that actions are implemented to agreed timescales led by the Specialty Audit Lead
- All specialty audit meeting minutes and action matrices will be shared for discussion at Divisional Effectiveness meetings or appropriate management forums. Outcomes will be included in divisional reporting to the Trust Clinical Effectiveness Committee
- A review of the Trust Clinical Audit Policy will be undertaken to provide clear guidance on the capture of lessons learnt along with subsequent recommendations and action. The policy will link into the New Quality Strategy and provide clear guidance between baseline audit measurement and the Quality Improvement process
- All local clinical audit activity will also be included in the Clinical Audit Annual Report as a record of all activity and lessons learned as a result of audit to improve quality and patient care.

Clinical Audit Best Practice Example

The Breast Screening Unit's audit work has been specifically highlighted in a recent Quality Assurance report issued by Public Health England:

"East Lancashire NHS Breast Screening Service has a comprehensive audit schedule in place which engages both clinical and clerical staff. Audits that have been undertaken are shared regularly across the Trust and nationally via conference presentations and posters. Audits of particular note are the evaluation of resources to improve uptake, evaluation of the quality of surgical specimen images and enhancement of the patient experience. The service is part of the North West Mammography Research Hub based at the University of Salford and has collaborated and independently produced a number of Screening Quality Assurance visit report NHS Breast Screening Programme research projects which have changed radiographic practice both nationally and locally. This is commendable practice".

2.4.2 Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust during 2016-17 that were recruited up to the 10th of March 2017 to participate in research approved by a research ethics committee was 1678 against a target of 1510.

2.4.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of East Lancashire Hospital Trust's income in 2016-17 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.

The following table sets out brief details of the Trust's CQUIN scheme for 2016-17:

Goal Number	Scheme	National/ Local	Description
1	Staff health and wellbeing – a 3 part CQUIN:	National	Healthy food for NHS staff, visitors and patients Improving the uptake of flu vaccinations Introduction of health and wellbeing initiatives for staff
2	Timely identification and treatment of sepsis – a 2-part CQUIN:	National	Emergency Department – timely identification and treatment of sepsis (includes children) – including 3 day review Acute inpatient settings – timely identification and treatment of sepsis
3	Antimicrobial resistance and antimicrobial stewardship – a 2-part CQUIN	National	Reduction in antibiotic consumption per 1,000 admissions Empiric review of antibiotic prescriptions >90% by Q4
4	Saving Babies Lives Year 2	Local	Year 2 scheme, Saving Babies Lives Care Bundles with an aim of reducing the avoidable stillbirth rate
5	Frailty – a 2 part CQUIN	Local	Implementation of the Rockwood Scale to facilitate early consistent recognition and assessment of patients with frailty across the emergency medical pathway. Meeting patient's needs - service user feedback to be designed, conducted, results reported and action planned
6	Refer to Pharmacy	Local	Referral of patients to their chosen pharmacy to access relevant services
7	Local cancer scheme – improving communication for patients on a cancer	Local	Improve the quality of communication and patient experience for patients on a cancer pathway

8	Improving pathways for Hepatitis C	Specialised Commissioning	Mandatory CQUIN for all HCV Operational Delivery Network Lead providers. There are two elements; 1 – Governance and Partnership Working across healthcare providers working in the HCV network. 2 – Stewardship and NICE compliance. Management of resources within a financial budget forecast.
9	Dose banding intravenous SACT	Specialised Commissioning	A national incentive to standardise the doses of Systemic Anticancer Therapy (SACT) in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT in England.
10	NICU – 2 year outcomes	Specialised Commissioning	It is recommended that all preterm babies born more than 10 weeks early (<30 weeks of gestation) should have a follow up evaluation 2 years after their due date (corrected age), to ensure that they are developing normally.
11	Prevention of hypothermia in preterm babies	Specialised Commissioning	The aim of this scheme is the prevention of hypothermia in preterm babies (<34 weeks) by routine monitoring within 1 hour of admission, and by taking corrective action.
12	Data Quality Improvement – Dental	NHS England (North) – Dental and Pharmacy	The introduction of the single operating model for the allocation of codes for oral surgery was shared and implemented during the 2015/16 CQUIN discussions with Providers. This indicator builds on the ground work of the implementation of consistent coding.
13	Managed Clinical Networks/ Clinical Supervision/Dental Leadership	NHS England (North) – Dental and Pharmacy	Specialists/Consultants participation and leadership in local managed clinical networks or to provide clinical supervision to Primary Care Specialist delivery.
14	Strengthening patient and public participation - breast screening	Public Health	Involve patients and the public to improve quality, access, coverage, uptake and the overall patient experience for patients: 1. who actively engage 2. who commit to attending but DNA 3. who do not engage

Further details of the agreed goals for 2016-17 and the following 12 months are available on the NHS England website https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/
East Lancashire Hospitals NHS Trust was one of 32 accredited organisations participating in the Quality Network for Child and Adolescent Mental Health Services (CAMHS) under the auspices of the Royal College of Psychiatrists.

2.4.4 Care Quality Commission Compliance

East Lancashire Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional.
The Trust has subsequent to the Care Quality Commission Well-Led Assessment (2016) received a regulation notice concerning Regulation 20 HSCA (RA) Regulations 2014 Duty of Candour Regulation 20: Duty of Candour.
An action plan to address this area for improvement has been agreed at the Board and shared with Commissioners and the Care Quality Commission.
The Trust has not taken part in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2016-17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 16 to Feb 17 (most recent figures):

Admitted Patient Care	140,348
Outpatient Care	560,833
Accident & Emergency Care	162,488

The percentage of records in the published data - which included the patient's valid NHS number, was:

Performance for Apr 16 to Feb 17 (most recent figures):

Admitted Patient Care	99.8%
Outpatient Care	99.9%
Accident and Emergency Care	99.1%

The percentage of records in the published data - which included the patient's General Medical Practice Code was:

Performance for Apr 16 to Feb 17 (most recent figures):

Admitted Care	100%
Outpatient Care	100%
Accident and Emergency Care	99.9%

2.4.6 Information Quality and Records Management

East Lancashire Hospitals NHS Trust's score for 2016-17 for Information Quality and Records Management assessed using the Information Governance Toolkit is 74%. The overall score achieved for 2015-16 was 71%, showing an achievement of at least level 2 across the board and level 3 in some areas. The intention for 2016-17 is to improve on this score which reflects the steady improvement for Information Governance within ELHT.

2.4.7 Clinical Coding Audit

East Lancashire Hospitals NHS Trust was not subject to a Payment by Results clinical coding audit by the Audit Commission during 2016-17.

2.5 Complaints Management

Feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, individually 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 with the aim of addressing those concerns immediately. The Trust has adopted the principles of good complaints handling, as set out by the Parliamentary and Health Service Ombudsman and which reflect the Trust's own vision and values as follows:

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

These principles are in line with the Trust Vision and Values.

The Trust Board acknowledges the importance of listening to patients' stories directly. As a result, these are now presented at Trust Board meetings.
A Complaints Review Panel is held quarterly, chaired by the Non-Executive Director lead for complaints. This is an in depth review of a randomly chosen complaint to ensure that a robust complaints process has resulted in a thorough and complete investigation, an open and honest response, appropriate action and monitored learning. The outcome of the meetings provides assurance regarding the Trust Complaints Procedure and has led to improvements in the process.
In addition the Board receives weekly reports relating to new issues raised and a complaint has previously been chosen randomly for presentation on a regular basis to the Executive Team. Due to the increase in the number of outstanding complaints, this will be reinstated in 2017-2018. The complaint investigation, response and compliance with Trust Policy is assessed, in order that the process can be continually improved.
The Customer Relations Team deals with concerns raised formally and informally, ensuring that individual concerns are addressed effectively and lessons are learnt from the issues raised. During 2016-17, 1095 PALS enquiries were received from a variety of sources. The team reports key performance indicators to Executive and Divisional leads to closely monitor concerns raised and to ensure a timely response is provided. The Trust received 391 formal complaints during this period. Complainants are contacted as soon as possibly following raising their concerns. During the year the policy has been updated. The changes will ensure that complainants are kept informed and updated and that greater compassion is evident within responses. Further training is planned to raise awareness of complaints requirements and correct procedures to ensure that complaints are dealt with in a timely and appropriately manner, providing assurance that lessons are learned from complaints across the Trust and themes have been identified. Bi-monthly reports now include more detail of these. The Trust has a Share 2 Care news bulletin ensuring that learning is disseminated to all staff and shared within teams.

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 2016-2017, 10 complaints were referred to the Ombudsman, of which 1 was partly upheld but required no further action. 9 are currently being reviewed by the Ombudsman.

2.6 Duty of Candour

The Duty of Candour requirement has been implemented within the Trust by the development of a Standard Operating Procedure for the daily tracking and monitoring of the delivery of duty of candour. A report is published daily and made available to the divisional quality and safety leads, to support clinical teams to deliver the duty of candour regulation requirements to patients in a timely manner. An escalation report is forwarded to the Executive Medical Directorate Team to support a resolution of issues and the delivery of duty of candour. Oversight of the effectiveness of this procedure is vested in the Medical Director and the Associate Director for Quality and Safety with assurance reports to the Trust's quality committee.

2.7 NHS Staff Survey Results

The NHS Staff Survey is conducted by the Picker Institute Europe and the Trust is required to publish the results of two elements of the survey as follows:

Indicator	Question	% Result
KF21	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	85%
KF26	In the past 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	16%

3.0 PART THREE - QUALITY ACHIEVEMENTS, STATUTORY STATEMENTS AND AUDITOR'S REPORT

3.1.1 Achievements Against Trust Quality Priorities

No	Quality Priority Aim	How achievement will be measured	How achievement will be monitored	Achievement at year end

1	Implementation of a Trust wide approach to improve the recognition and the response to the deteriorating patient	Mortality/Cardiac Arrest/Deteriorating Patient score card	Monthly Deteriorating Patient Steering Group reports to bi-monthly Patient Safety & Risk Assurance Committee	*The National Early Warning score has been implemented in adult and paediatric clinical areas. A Deteriorating Patient Score has been developed and is now available to provide information to assist with identifying areas at higher risk.
2	Optimise learning from complaints to improve end of life care	Monitor the number of complaints related to end of life care as a proportion of total complaints. Collate evidence of the learning from complaints to improve end of life care	Regular assurance report to the End of Life Care Strategy Group	* From Aug-Dec 16 164 formal complaints were received by the Trust and of these 26 (16%) included aspects related to end of life care or bereavement. Reports suggest a wide variety of subjects but poor communication seems to be an underlying theme. Identified themes are being addressed and reported to the strategy group every four months.
3	Increase compliance with hand hygiene and infection prevention guidance through "Prompt to Protect" improvement package	Achievement will be measured by way of mystery shopper hand hygiene audits, ward hand hygiene audits, environment audits, NAPF audits	Regular reports to the Infection Prevention Committee	Prompt to Protect package has been refined. Video produced and launched across Trust 6 wards have taken part in improvement package with an average of 24% improvement on the wards in hand hygiene. Improvements have also been shown in basic infection prevention practice.

3.1.2 Sign Up to Safety

Sign up to Safety is a national patient safety campaign announced by the Secretary of State for Health and launched in June 2014. Its mission is to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Trust signed up to the campaign at its inception and the following tables show the progress that has been made so far and the Trust's plan for its future implementation.

Achievements

Aim	Key Achievements to 31 Mar 17
To reduce the number of inpatient falls by 15% by 1st Sep 16	All project documentation in place Falls project team continue to meet monthly with robust action plan Collaborative completed and now in spread and sustainability stage Falls collaborative work achieved a 36% reduction in falls Falls incident rates continue to be used to track improvement Change package after pilot commenced Oct 16 Falls collaboration outcome video produced which shares a patient and family story and provides guidance for wards and departments Direct training and guidance is provided for wards and departments.
To improve the recognition and response to the acutely deteriorating patient with an aim to decrease unexpected cardiac arrests by 50% as at the end of Dec 17 To improve the recognition and timely management of sepsis in the emergency department and acute admissions unit	Monthly Faculty Meeting (Deteriorating patients and sub-groups all on track. All failure to meet CQUIN sepsis time to antibiotics targets now reported by way of Datix, the Trust's incident reporting system. Early Warning Score tracking system agreed and staff education being rolled out across Trust Intensive Home Support Service collaborative working commenced with regard to EWS being used in the community setting. Fluid Balance Standard Operating Procedure agreed and attached to Clinical Observation Policy Deteriorating patient scorecard under development which is a key for evidencing improvement. Acute Kidney Injury data available on a monthly basis Following new NICE guidance for sepsis involving all charts and bundles across the Trust Work started to monitor bundle compliance tool for sepsis and actual care delivered based upon NICE guidance.
To reduce avoidable surgical related harm incident by 50% by end of Dec 17	Training for removal of surgical drapes completed New observation care tool in accordance with National Safety Standard for Invasive Procedures devised and in use Safety culture conversation tool completed Venous Thromboembolism risk assessment included in all Doctor and Nurse handover Agreed draft of education tool to share lessons learnt Early bird project to reduce late starts for theatre lists being tested
To reduce stillbirth rate by 31 Dec 15	Care bundle designed to tackle stillbirth and early neonatal deaths Trained a Midwife Ultra-sonographer who provides a 'one-stop service' for women with fetal growth restriction Guidelines and Standard Operating Procedures enhanced to support patient pathway for care and service delivery Introduction of a Medaphor Scan Trainer which is a virtual desktop ultrasound training simulator which allows training to be achieved without the use of clinical equipment A portable Sonosite scanner was obtained through an external funding bid to improve bedside scanning. All staff have been trained on Symphysis-fundal height measurement All patients referred for fetal growth restriction are rechecked to ensure the referral is appropriate and a scan is required Information is recorded which generates exact birth centiles for each

	baby following birth. To date there has been a 53% reduction in avoidable stillbirths between 2012 and 2015

The Future

Aim	Future Plan
To reduce the number of inpatient falls (with harm) by 20% by end Dec 18 To reduce the number of inpatient falls (regardless of harm) by 15% by end Dec 17	**Rationale** ✓ Part of our Quality Strategy ✓ Part of our Harms Reduction Programmes ✓ In line with NICE clinical guidance 161 falls are the most common & serious problem ✓ Most expensive cost to the NHS (approximately £2.3 billion per year) ✓ One of the highest reported patient safety incidents at East Lancashire NHS Trust ✓ Common Complication: The risk of falling is greater in hospital than in the community setting due to acute illness, increased levels of chronic disease and different environments Building on from the achievements following the original Sign up to Safety Plan and having met the aim of 15% reduction, this updated aim will focus on falls reductions across the whole Organisation and will also focus on falls in general (not just falls with harm). We recognise there is potential for psychological harm from falls as well as physical harm. The falls breakthrough collaborative series model was used and a falls faculty is in function. The focus will shift to ensuring the interventions spread across the Organisation are sustained, staff education and patient education.
Deteriorating Patients: Acute Kidney Injury (AKI) & Sepsis Improve the recognition and response to acutely deteriorating patients with a resultant decrease in unexpected cardiac arrests by 50% by end Dec 17 by introduction of national EWS, improving compliance and introduction of Goals of Care Improve the recognition and	**Rationale** ✓ Failure to act or recognise patient deterioration was identified as the most frequently occurring type of incident in thematic reviews of NRLS data (NRLS 2014) ✓ Part of our Harms Reduction Programmes ✓ Failure to recognise patient deterioration is a common cause of patient harm (NHS England) ✓ Over 123,000 people in England suffered from sepsis, and estimates suggest that there are around 37,000 deaths per year associated with it (NHS England 2015) ✓ Sepsis costs the NHS £2 billion per year (Gov.uk 2015) ✓ 100,000 deaths in secondary care are associated with AKI & 1/4 to 1/3 have potential to be prevented There have been many improvements and achievements since the original sign up to safety plan was created. One of the biggest challenges has been having a broad set of measurements to help evidence all the changes implemented actually let to a reduction in harm caused to deteriorating patients who have AKI and/or sepsis. The decision has been made to combine both aims under one pledge as they form part of a wider work-stream and are linked together.

subsequent timely management of sepsis in the emergency department and acute admissions units so that standardised mortality for sepsis is within the expected range. This will be monitored by ensuring 100% of patients with high risk (NICE) sepsis receive antibiotics within 1 hour Improve the recognition and management of AKI and reducing avoidable harm by decreasing the % of patients who develop AKI 2 and 3 during their Hospital stay after 48 hours (% to be agreed)	This is a large transformational undertaking that requires further in-depth scoping. This needs to be supported by scoping and analysing data gathered on harm caused by unrecognised patient deterioration for AKI and sepsis, including both quantitative (reliability measures data) as well as qualitative observational data, together with learning from best practice. The sepsis collaborative will develop an evidence based quality improvement package to change practice and care through providing a model of optimal care and the methods to implement it. The chances of surviving sepsis depend to a large extent in receiving successful treatment for the infection that led to sepsis, including broad-range antibiotics and any other treatment necessary to eliminate the cause of infection but timely care is vital as mortality increases with delays. This project will focus on developing robust recognition strategies determined by entry route, successfully implementing and embedding the Trust sepsis care bundle, and ensuring reliable delivery of basic sepsis care (the 'Sepsis Six') through education and increased awareness in order to improve recognition and timely management of severe sepsis and sepsis shock.
Reduce the number of avoidable still births by increasing the detection rates of Fetal Growth Restriction and reduce the harm caused to babies during term labour by end Dec 17	**Rationale** ✓ Fetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity ✓ Part of our Harms Reduction Programmes ✓ NHS set out a national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020 ✓ MBBRACE perinatal enquiry showed how undetected poor fetal growth is a factor in stillbirth ✓ Evidence and experience tells us more must be done to tackle stillbirths in England The Perinatal Institute administers the Gestation Network which provides tools for assessment of foetal growth and birth weight by defining each pregnancy's growth potential through the Gestation Related Optimal Weight (GROW) software. GROW charts: • Improve the antenatal detection of fetal growth problems • Avoid unnecessary investigations and • Reduce anxiety by reassuring mothers when growth is normal. The effectiveness of any method used in foetal growth surveillance can be compromised if protocols for standardised fundal height measurement and referral for further investigation are not followed. Great progress has been made on staff training on plotting/correct measurement, the use of GROW centile calculator and referral for detected FGR. The majority of the key milestones that were set out in the original sign up to safety plan have been achieved with a 53%

<table>
<tr><td></td><td>reduction in avoidable still births and an increase of FGR which is currently above the national average at East Lancashire NHS Trust.
Practice is continuously audited against the “Saving babies lives” care bundle which focuses on 4 elements:
<table>
<tr><td>Smoking cessation during pregnancy</td><td>Surveillance for fetal growth restriction</td></tr>
<tr><td>Reduced foetal movement</td><td>Foetal monitoring during labour</td></tr>
</table>
The plan is to continue to sustain these improvements and incorporate avoidable harm caused to babies during labour, such as early neonatal deaths and severe brain damage. This is in line with national guidance from Royal College of Obstetricians and Gynaecologists: Each Baby Counts. National and regional perinatal confidential enquiries into unexplained stillbirths have found sub-optimal care factors contributed to babies’ deaths in three quarters of cases. Around half of deaths might have been avoided with better care. Enquiries show wide variation of ways in which maternity units review and learn from such deaths and therefore opportunities to avoid repeated mistakes are missed. When done well, the review process into why a baby dies can highlight areas where future care can be improved and also provide good information for parents about why their baby died. In fact, if the UK could match mortality rates achieved in Sweden and Norway, the lives of at least 1,000 babies could be saved every year. The overarching aim of this programme is the development and maintenance of a web-based tool to implement standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales and provide training and on-going IT support for users.</td></tr>
<tr><td>To improve the safety culture in Theatres through the use of the “5 Steps to safer surgery” for all planned/ elective operating lists and all patients to have a quality brief/debrief and a compliant WHO checklist completed by end Dec 17</td><td>Rationale
✓ Over 9 million surgical related incidents per year
✓ Part of our Harms Reduction Programmes
✓ Forms part of never event guidance (NHS England)
✓ WHO checklist forms part of national requirements (NPSA)
✓ New national safety standards for invasive procedures

The (WHO) Surgical Safety Checklist is designed to reduce the number of errors and complications resulting from surgical or invasive procedures by improving team communication and by verifying and checking essential care interventions. A key component of this project will be to develop and build a sustainable safety culture across theatre areas and the use of an appropriate patient safety culture tool together with the introduction of quality observational audits.
The original aim was to reduce the number of surgical related avoidable harm. On review of the data, it was established the figures for patient related “moderate and above” reported harm were very low and challenging to demonstrate an improvement on. It was concluded a focus shift to the quality and reliability of the 5 steps to safer surgery would allow improvement to be demonstrated and would help reduce risks to harm as well as actual harm.</td></tr>
<tr><td>To improve the quality and</td><td>Rationale
✓ Bank and agency use costs the NHS over 714 million per year</td></tr>
</table>

experience of patients receiving enhanced levels of care and also reduce the cost of bank and agency spend for 1-1 care by 20% across the Trust by end Dec 17	✓ Part of our Harms Reduction Programmes ✓ A number of harm related incidents occur when the right level of observation is not in place ✓ Better partnership needed with family and relatives who are carers/provide support ✓ Lord Carter's preliminary report of NHS productivity identified specialling – or 1:1 nurse care – as an area where greater consistency could improve care and reduce costs This is an additional aim that has been added to the Sign up to Safety improvement plan due to the high risk of harm associated with this area, high levels of cost and potential for improving patient experience. People are living longer with many chronic or long term conditions that are generally managed in their home setting with support from family and/or relatives. It is important this partnership in care continues for people who come into Hospital. Improving the quality, experience and cost for 1:1 care was an improvement initiative directed nationally by the Trust Development Authority (TDA). The project started November 2015 and there was a wide range of staff representing East Lancashire NHS Trust at the national events. • The overall objectives for this improvement area are: • Improve the quality of 1:1 care by improving the provision of care given • Improve the experience of 1:1 care by improving the level of engagement with patients and involving their families and carers in decision making • Improve the standards of 1:1 care by reviewing existing processes and reducing variation • Reducing the cost of bank and agency spending though robust processes and better utilisation • At East Lancashire NHS Trust, we put patients at the heart of everything we do and strive to improve quality and increase value. There have been many improvement initiatives generated as part of this project all with the aim of improving how we deliver care to our patients. Some of the intended outcomes from these initiatives are: • Increased patient satisfaction and feedback by striving to provide personal care • Reduced need for agency or bank staff by creating a partnership with families instead • Providing holistic care by seeking meaningful engagement with patients and their families or carers • Improved communication between clinical staff, patients and families or carers • High quality care provided by nursing staff due to new robust processes to support this Improved and correct levels of enhanced care such as 1-1 care arrangements can also help deliver more consistent, patient-centred

	care and greater involvement of patients' relatives and carers, and provide Nurses with more support to take key decisions about patients' requirements. It is recognised the initial small scale testing on 3 pilot wards led to an achievement of over 60% reduction in bank and agency spend for 1-1 care through the use of new interventions. This project is currently at the spread and sustainability stages and the challenge of reducing cost across the Organisation is complex. There are many factors, variables and pressures that influence the level of spending all of which need to be understood better. The shift to offering families/relatives the opportunity to be part of the enhanced levels of care needed will also require a culture shift as well as the better creation of support for people who do choose to provide this.

Each of the aims outlined above have common improvement drivers:

- Improve patient safety and reduce the incidents of avoidable harm
- Improve patient outcomes through the provision of clinically effective and reliable care to every patient
- Improve the experience of patients and service users
- Improve the safety culture of the Trust through leadership and staff engagement
- Promoting a culture of openness, learning and transparency

Each aim for reducing harm will follow a structured process and have a multi-disciplinary team approach to achieving it. Providing safe, personal and effective care is our Trust vision which we aim to support by continuing to strengthen and develop our safety improvement plan.

3.2 Achievement Against National Quality Indicators

3.2.1 Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator was introduced by the Department of Health in 2011 and reports on risk adjusted ratios of deaths that occur in hospitals 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 latest published SHMI data up to September 2016 for East Lancashire Hospitals NHS Trust is:

SHMI Outcomes	As at 30 Sep 16
East Lancashire NHS Trust SHMI Value	1.05
East Lancashire NHS Trust SHMI Banding	As Expected
National SHMI	100
Best performing Trust SHMI	0.69
Worst performing Trust SHMI	1.17

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

Our process requires that all deaths are subject to a primary mortality review, followed by a secondary review where appropriate.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services by:

- 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
- Alerting conditions are identified and subject to internal audit. Where cause is not identified, external review is requested.
- In 2017-18 these actions will be consolidated and fully embedded within the Trust.

3.2.2 Percentage of Patient Deaths with Palliative Care Coding

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator. The SHMI makes no adjustments for palliative care. This is because there is considerable variation between Trusts in the coding of palliative care. Using the same data as the SHMI this indicator presents crude percentage rates of death that are coded with palliative care at either diagnosis or treatment speciality level.

East Lancashire Hospitals NHS Trust percentage of deaths with palliative care coding	26.5%
National percentage of deaths with palliative care coding	29.7%
Trust with highest percentage of deaths with palliative care coding	54.8%
Trust with lowest percentage of deaths with palliative care coding	0.6%

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

Our process requires that all deaths are subject to a primary mortality review, followed by a secondary review where appropriate.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services by: (Copied from 2016 Account)

- 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
- Alerting conditions are identified and subject to internal audit. Where cause is not identified, external review is requested.

3.2.3 Patient Recorded Outcome Measures

Patient Recorded Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering four clinical procedures PROMs calculate health gains after surgical treatment using pre and post-operative surveys.

The four procedures are:

- Groin Hernia
- Hip Replacement
- Knee Replacement
- Varicose Veins

PROMs measures a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected pre-op and 6 months after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients; this data has been collected by all providers of NHS funded care since April 2009.
The following tables set out the percentage of ELHT patients identified as achieving an 'improved post-operative adjusted average health gain' in comparison with the national figures for each of the 4 PROMs procedures using the EQ-5D measure of health gain. The 'EQ-5D Index' scores are a combination of five key criteria concerning patients' self-reported general health: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

3.2.3.1 Groin Hernia Surgery

Groin Hernia Surgery	2012-13	2013-14	2014-15	2015-16	2016-17*
ELHT	54.6%	48.6%	56.3%	55.2%	58.5%
National Average	50.2%	50.5%	50.7%	50.9%	51.7%

3.2.3.2 Hip Replacement Surgery

Hip Replacement Surgery	2012-13	2013-14	2014-15	2015-16	2016-17*

ELHT	48.6%	87.4%	94.0%	92.0%	100.0%
National Average	57.2%	89.4%	89.5%	89.6%	90.4%

3.2.3.3 Knee Replacement Surgery

Knee Replacement Surgery	2012-13	2013-14	2014-15	2015-16	2016-17*
ELHT	89.5%	78.6%	84.5%	85.3%	87.5%
National Average	87.5%	81.4%	81.0%	81.6%	82.4%

3.2.3.4 Varicose Vein Surgery

Varicose Vein Surgery	2012-13	2013-14	2014-15	2015-16	2016-17*
ELHT	79.4%	59.1%	49.1%	56.3%	58.3%
National Average	78.8%	51.9%	52.0%	52.6%	51.5%

*Provisional data

Note: 2015-16* figures are provisional for the period April 2014 to March 2016 and the 2016-17* figures are provisional covering the period April to September 2016 (published February 2017).

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

ELHT has a process in place to ensure patients receive a pre-operative questionnaire at pre-assessment, the process is explained to the patient and completed questionnaire collated for submission.

Patients can decline to complete the questionnaire (optional); in these cases questionnaires are still collated to monitor ELHT submission rates and inform where education and patient information may be required.

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

A verbal request sheet has been scripted to ensure standardisation of information given to maintain and improve participation rates.

Ensuring the process at pre-assessment is checked on a weekly basis to maintain and improve on current figures where required.

Random spot checks to be continued to prevent a decline in participation rates, feedback will be given on a weekly basis to the Pre-op assessment coordinator via email.

If a questionnaire is not completed at pre-op assessment then the Surgical Day Unit (SADU) will aim to complete.

3.2.4 Readmissions Within 28 Days of Discharge

The following table sets out the Trust's performance during 2016-17 for emergency admissions within twenty-eight days of discharge. We have used Dr foster data which provides national benchmarking from the National Hospital Episodes Statistics data. The HSCIC do not provide data on readmissions at the level of detail required. Figures shown are as at 25 Apr 17.

All Ages	2013-14	2014-15	2015-16	2016-17
Readmission Rate	8.40%	8.74%	8.79%	8.48%
Age Band	2013-14	2014-15	2015-16	2016-17
0-15	11.15%	11.22%	12.06%	11.36%
16+	7.80%	8.19%	8.05%	7.86%

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

The overall ELHT 28 day readmission rate produced by Dr Foster is 8.48% which is below the Dr Foster risk adjusted expected rate of 8.73% and has reduced on last year. Compared to local acute hospitals, the Trust is middle of the group; however the rate is higher than the national rate of 8.1%.
For the 0-15 age group, the rate is 11.36% which is higher than the expected rate of 9.8% and the national rate of 8.7%.
For the 16+ age group the rate is 7.86% which is below the expected rate of 8.5% and better than the national rate of 8% reflecting good performance and safe, personal and effective care in terms of discharge planning.

East Lancashire Hospitals NHS Trust is taking the following actions to improve this ratio and so the quality of its services by:

A multi-agency group led by commissioning, called the Lancashire Pennine Paediatric Pathways group is established and has a detailed action plan of which a key focus is to reduce admissions to the hospital. Within ELHT there is a readmissions action plan with a working group to support delivery. A number of audits, including one external audit, have been completed to feed into this action plan.

Key actions taken to date:

1. Introduction of 'common childhood illnesses' guide, to support parents manage illness and reduce parental anxiety and hence need for support. This is now used by all agencies in East Lancashire so that the same messages are shared.

2. Hot clinics have been set up, for urgent paediatric consultant input –as an alternative to admission. Slots are accessed directly from GPs.

3. Telephone advice line for GPs directly accessing a consultant paediatrician – to help GPs manage care in practice rather than referring back to hospital.

4. Appointment of second respiratory nurse specialist and epilepsy nurse specialist – to reduce readmissions for respiratory illness and epilepsy admissions.

5. Open Access policy changed from direct open access for all children for 48 hours, to 24 hours open contact or until GP opens (e.g. until 9am the next working day). Patients have to call unit for advice first and details of this service have been removed from general information leaflets.

6. Coding of some semi-planned activity coded as an emergency readmission now coded as either elective planned or outpatient first attendance – to appropriately reflect the admission type.

7. Consultant presence in COAU extended until 10pm Monday- Friday – to support more senior decision making.

8. Extended Community Children's Nursing service to a longer day / 7 day service (was previously Mon-Fri 8am-6pm service).

9. Care pathways for croup, bronchiolitis, fever in under 5's and gastroenteritis established. An asthma pathway has also been developed in Emergency Department.

10. Discharge process tightened so that all discharges are reviewed at Consultant level.

Next steps:

1. Coding of COAU/CMIU attendances being reviewed by Trust and commissioners. There is acceptance that our outlying position is due to coding, but the issue of financial impact still needs to be managed.

2. A tender is currently advertised to introduce respiratory nurses in general practice – to support more care outside hospital setting (service to be in place within next 6 months). As respiratory illness is the main factor in our readmission rate, this should have an impact on our rate.

3. Pilot of GPs referring directly to Children's Community Nursing service instead of COAU/CMIU – pilot being extended to more practices across the area.

4. Patient survey planned for parents re-attending COAU/CMIU when alternative provision appropriate and available. To look at options of managing parental anxiety and parental choice.

5. Consultant Paediatric sessions in ED – to provide more senior paediatric expertise at the 'front door' and help deflect children to the appropriate service.

3.2.5 Responsiveness To Personal Needs of Patients

The Picker Institute was commissioned by 83 Trusts nationally to undertake the Inpatient Survey 2016. A total of 1250 patients from East Lancashire Hospitals NHS Trust were sent a questionnaire. 1221 were eligible for the survey, of which 437 returned a completed questionnaire, giving a response rate of 36%. The response rate for the inpatient survey conducted in 2016 was 36%. This survey has highlighted the many positive aspects of the patient experience.

- Overall: 81% rated care 7+ out of 10.
- Overall: treated with respect and dignity 79%.
- Doctors: always had confidence and trust 77%.
- Hospital: room or ward was very/fairly clean 97%.
- Hospital: toilets and bathrooms were very/fairly clean 94%.
- Care: always enough privacy when being examined or treated 90%

The tables below set out the Trust's performance in 2016 for inpatients:

The Trust has improved significantly on the following questions:
Lower scores are better
NONE

The Trust has worsened significantly on the following questions:

Lower scores are better

	2015	2016
Hospital: did not always get enough help from staff to eat meals	33 %	47 %
Surgery: anaesthetist / other member of staff did not fully explain how would put to sleep or control pain	12 %	19 %

Your results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Planned admission: should have been admitted sooner	18 %	25 %
Hospital: patients using bath or shower area who shared it with opposite sex	7 %	12 %

Your results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Admission: had to wait long time to get to bed on ward	42 %	36 %
Hospital: patients in more than one ward, sharing sleeping area with opposite sex	11 %	5 %
Hospital: food was fair or poor	44 %	39 %
Hospital: not offered a choice of food	30 %	20 %
Hospital: did not always get enough help from staff to eat meals	47 %	36 %
Doctors: did not always get clear answers to questions	36 %	30 %
Doctors: did not always have confidence and trust	23 %	18 %
Care: wanted to be more involved in decisions	52 %	44 %
Care: not enough (or too much) information given on condition or treatment	25 %	19 %
Care: staff did not do everything to help control pain	38 %	29 %
Discharge: was delayed	47 %	41 %
Discharge: did not always know what would happen next with care after leaving hospital	54 %	48 %
Discharge: not fully told purpose of medications	31 %	25 %
Discharge: not told how to take medication clearly	30 %	24 %
Discharge: not fully told of danger signals to look for	64 %	57 %
Discharge: family not given enough information to help	60 %	53 %
Overall: not treated with respect or dignity	21 %	16 %
Overall: did not receive any information explaining how to complain	67 %	60 %

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

- Continued effort is required to engage and listen to the care experience of patients, their carers and families and to respond to this feedback.
- The sample this year showed a continuation of the high proportion of non-elective patients surveyed.
- Continuing challenges around the increase in numbers of patients attending Emergency Departments and requiring admission.

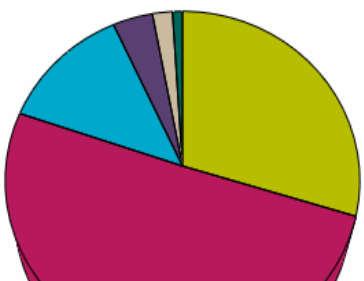
East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

- Implement continuous Quality Improvement projects including the Future Hospitals Programme which aims to support the re-design of services for frail older people across the Care Continuum
- The introduction of seasonal menus in line with ELHT Food and Drink Strategy. All menus have been nutritionally analysed and approved by qualified dieticians. As part of our Soil Association accreditation that launched in January 2017 over 50% of the provisions that we use in patient meal production is sourced locally. National CQUIN 2016/17 Healthier food for NHS Staff, Patients and visitors has required us to remove or change some product categories, these include, Pre sugared breakfast cereals, soft drinks with high sugar content, some confectionary, replacement of savoury snacks with high fat and salt content. All products have been assessed and replaced or removed.
- We have also compiled an ELHT Food and Nutrient Standard ratified by the nutritional steering group as part of our Food and Drink Strategy, The standards will facilitate the achievement of consistently effective catering services, prompting a refined approach to menu development and compliance with various national requirements.
- The development of a patient/carer information booklet for patients admitted to hospital.
- Continue to engage and work with our patients, their families and carers around our provision of services to maintain the quality delivered.

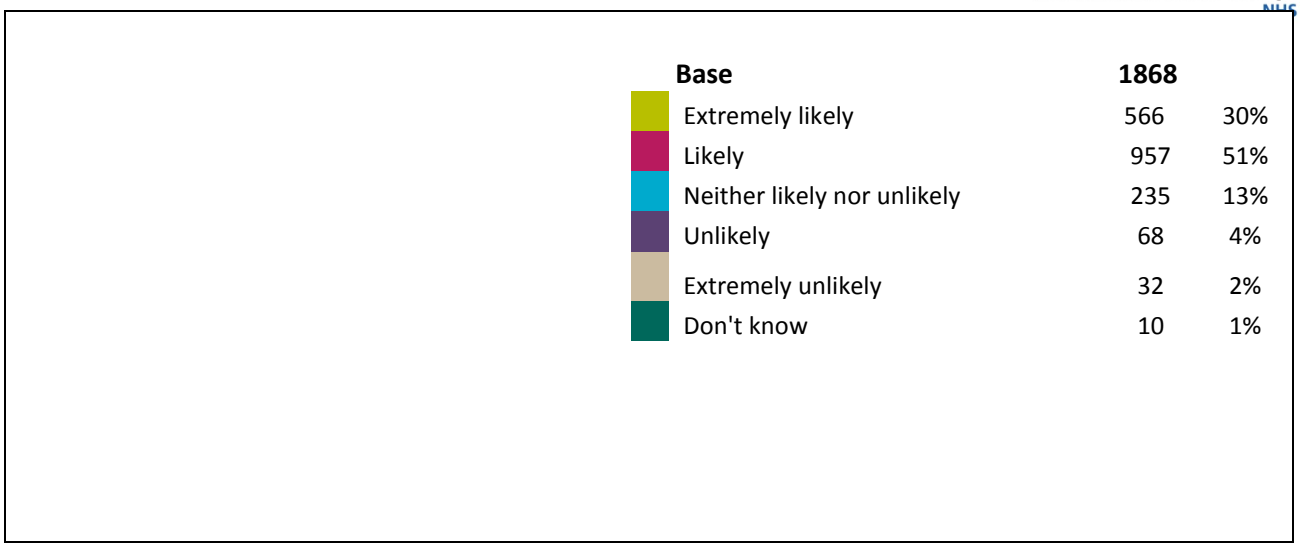
3.2.6 Recommendation from Staff As A Provider Of Care

The data made available to the East Lancashire Hospitals NHS Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This provides an indication of whether our staff feel the Trust provides a positive experience of care for our patients.
The results reflect a 4% rise in those members of staff who would recommend the Trust as a place to receive care during the reporting period. The Trust scored 3.86 in this area on the national survey in 2016 an improvement on the previous year's score of 3.80. The national average for UK acute trusts in 2016 was 3.81.

Q1 - How likely are you to recommend this organisation to friends and family if they needed care or treatment?



Safe



The survey is not undertaken in the 3rd quarter of the year when the Staff Survey is completed.

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

Data is received from NHS England and the Picker Institute and has been checked locally by the Staff Health, Wellbeing and Engagement Department.

The East Lancashire Hospitals NHS Trust intends to take the following actions to improve this percentage and so the qualities of its service by:

- Continuing to embed the Employee Engagement Strategy to drive further improvements in staff experience and engagement.
- Continuing focused work on the ten key enablers which have been identified to enhance levels of employee engagement together with the additional three behavioural indicators used to demonstrate high employee engagement levels.
- Continuing to promote, gather, analyse and action staff suggestions, involvement and feedback from employees within the organisation.
- Continuing to monitor and review our approach to employee engagement through the sponsor group chaired by the Chief Executive to ensure the Trust is an exemplar of best practice in this field.

3.2.7 Friends And Family Test Results In The Emergency Department

In April 2013, the Department of Health introduced the Friends and Family Test 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. Currently inpatients, including surgical day case attenders, accident and emergency attenders, maternity, outpatient attenders and community service users are asked this question.

The following table sets out the East Lancashire Hospitals NHS Trust's response rates for inpatients, accident and emergency attenders, and also how these results compare with other Trust's nationally for the period April 2016 to March 2017.

	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Inpatient % patient response rate												
ELHT	46%	54%	50%	48%	51%	43%	43%	41%	51%	53%	47%	47%
Nat Ave	25%	26%	26%	26%	25%	25%	25%	25%	23%	24%	Not available	
A&E % patient response rate												
ELHT	22%	20%	20%	20%	22%	21%	21%	18%	19%	21%	21%	22%
Nat Ave	13%	13%	13%	12%	14%	13%	13%	13%	11%	12%	Not available	
Combined inpatient and A&E patient response rate												
ELHT	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%
Nat Ave	Not available											

The following table sets out the percentage of Inpatients and Emergency Department attenders who would recommend the service and how these compare with other Trusts nationally for the period April 2016 to March2017

	April 2016	May 2016	June 2016	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017
Inpatient % recommend												
ELHT	99%	98%	99%	99%	98%	98%	99%	98%	98%	98%	98%	97%
Nat Ave	96%	96%	96%	96%	95%	95%	95%	95%	95%	96%	Not available	
A&E % recommend												
ELHT	80%	76%	76%	75%	74%	76%	77%	76%	76%	76%	82%	80%
Nat Ave	86%	85%	86%	85%	87%	86%	86%	86%	86%	87%	Not available	
Combined inpatient and A&E recommend												
ELHT	91%	89%	90%	89%	88%	89%	89%	89%	90%	89%	92%	90%
Nat Ave	Not available											

The 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.

Since the introduction of SMS text messaging the response rates for A&E attenders increased and exceed the national average.

The Trust also gets a consistently high score on the willingness to recommend the service.

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

Continue to regularly monitor the response rates and provide advice and support to specific areas so that information is collected and recorded in a timely manner.

3.2.8 Venous Thromboembolism Assessments

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 (2016-17) Data submitted from Trust to NHS UNIFY system Data access available at : www.england.nhs.uk/statistics		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year to Date
East Lancashire NHS Trust	Number of VTE assessed admissions*	29,123	29,758	29,171	30,166	118,218
	Total admissions	29,403	30,131	29,827	30,708	120,069
	% of admitted patients risk assessed for VTE(rounded to nearest decimal)	99.05%	98.7%	97.8%	98.23%	98.46%
National	Number of VTE assessed admissions	3,541,365	3,542,103	3,528,825	3,569,283	14,197,615
	Total admissions	3,699,507	3,708,745	3,689,505	3,736,134	14,849,760
	% of admitted patients risk assessed for VTE (rounded to nearest decimal)	95.7%	95.1%	95.64%	95.53%	95.61%
Best performing Trust	(The Trusts reporting 100% all have small numbers of admissions)	3 NHS Trusts at 100%	3 NHS Trusts at 100%	5 NHS Trusts at 100%	2 NHS Trusts at 100%	Not Available
Worst performing Trust		80.6 %	77.8%	76.4 %	63.02%	Not Available

**Includes agreed exemption cohort of patients in this category*

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

- Systems and processes are in place for risk assessing all appropriate patients utilizing the National VTE assessment tool on admission.
- The Trust monitors quarterly VTE performance figures routinely using an electronic system with real time capture of data on admission from Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS).
- Trust VTE performance has consistently improved from above 95% in 2012, to above 97% since July 2013 and above 97.5% since July 2014.

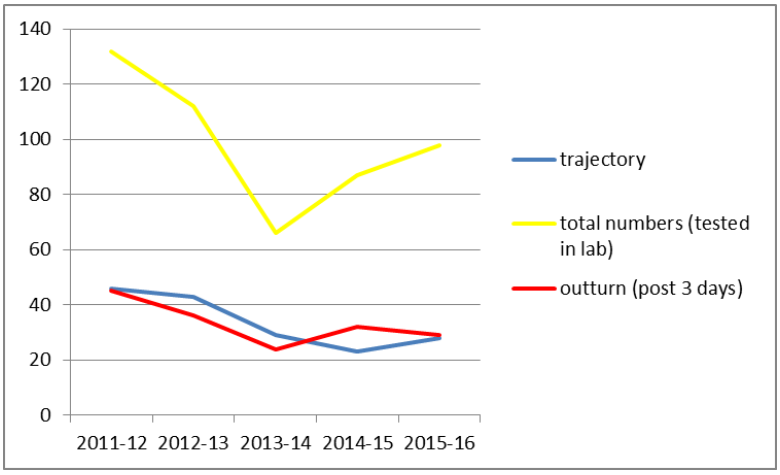
East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

- 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)
- Each of the Trusts Divisions participates in a rolling programme of clinical audit to ensure effective compliance with VTE assessment.
- VTE Quality Improvement Facility developed in 2016 that leads on focused quality improvement projects in low performing ward areas.

3.2.9 **Clostridium Difficile Rates**

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.

Clostridium difficile toxin positive results 2011/12 – 2016/17



	CDI rate cases per 100,000 bed days 14/15	CDI rate cases per 100,000 bed days 15/16	CDI rate cases per 100,000 bed days 16/17
National rate (Ordinary Acute Trusts)	15.0	14.9	13.2
ELHT rate	10.5	9.4	10.1
Best performing Trust nationally	5.1	4.1	2.8
Worst performing Trust nationally	40.2	36.4	34.1

East Lancashire Hospitals 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. Each case both pre and post 3 days of admission is discussed at the C. Difficile multidisciplinary CCG meeting to determine lapses in care.

East Lancashire 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 continuing the post infection review process to enable any lapses in care across the Health Economy to be identified and rectified. The Trust will continue with its current approach of zero tolerance to hospital acquired infections and will aim to further reduce this rate year on year and so improve the quality of its services and patient experience

3.2.10 **Patient Safety Incidents**

NHS Trusts are required to submit the details of incidents which involve patients to the National Reporting and Learning System (NRLS) on a regular basis. The Trust uploads data via the NRLS on a monthly basis. The NRLS publishes Patient Safety Incident Reports by organisation bi-annually showing comparative data with other large acute trusts. ELHT is able to use this information to understand its reporting culture; higher 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 set out in the table below has been extracted from NRLS reports and sets out the Trust's performance over the last six reporting periods. The table also compares the Trust's performance against similar large acute organisations in the cluster data.

Patient safety incidents per 100 admissions	**Oct 2013 to Mar 2014**	**April 2014 to Sept 2014**	**Oct 2014 to Mar 2015**	**April 2015 to Sept 2015**	**Oct 2015 to March 2016**	**April 2016 to Sept 2016**
ELHT number reported	8015	8190	7563	6732	6579	7010
ELHT reporting rate	52.8	55.7	48.2	44.18	42.05	44.9
Cluster average number	4493	4196	5458	4647	4818	4995
Cluster average reporting rate	33.2	35.9	31.2	39	39.6	40.7
Minimum value for cluster	787	35	443	1559	1499	1485
Maximum value for cluster	8015	12020	12784	12080	11998	13485
Patient safety incidents resulting in severe harm	**Oct 2013 to Mar 2014**	**April 2014 to Sept 2014**	**Oct 2014 to Mar 2015**	**April 2015 to Sept 2015**	**Oct 2015 to March 2016**	**April 2016 to Sept 2016**
ELHT number reported	35	29	28	18	16	13
ELHT % of incidents	0.4	0.4	0.4	0.3	0.2	0.2
Cluster average number	20	15.5	17.3	15	13.7	13.4
Cluster average reporting rate	0.5	0.9	0.4	0.4	0.3	0.3

Minimum value for cluster	0	0	1	1	0	0
Maximum value for cluster	102	74	128	89	85	75
Total incidents across cluster	762	2168	2373	2052	1862	1826
Cluster % of incidents	0.4	0.4	0.4	0.3	0.3	0.3
Patient safety incidents resulting in death	**Oct 2013 to Mar 2014**	**April 2014 to Sept 2014**	**Oct 2014 to Mar 2015**	**April 2015 to Sept 2015**	**Oct 2015 to March 2016**	**April 2016 to Sept 2016**
ELHT number reported	5	3	6	8	8	6
ELHT % of incidents	0.1	0	0.1	0.1	0.1	0.1
Cluster average number	5.7	4.9	5.2	5	5.7	5
Cluster average reporting rate	0.1	0.2	0.1	0.1	0.1	0.1
Minimum value for cluster	0	0	0	0	0	0
Maximum value for cluster	14	27	24	22	37	36
Total incidents across cluster	216	683	716	665	780	690
Cluster % of incidents	0.1	0.1	0.1	0.1	0.1	0.1

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

The overall number of incidents reported by the trust over the last three reporting periods has reduced gradually although there is a slight increase since April 2016-September 2016 but still showing a reduction since October 2013. This data demonstrates a reduction in harm caused to patients as a result of the Trust's comprehensive quality improvement and harms reduction programmes.

The Trust does however consistently report higher numbers of incidents compared with similar Trusts in the cluster, this demonstrates an open and honest culture within the Trust as incident reporting is positively encouraged.

The introduction of the Serious Incident Requiring Investigation Panel has focused on the identification of lessons learned and actions taken following review of serious incident investigations to ensure services are improved and harm is reduced.

The Trust is not an outlier in terms of severe harms and deaths due to patient safety incident.

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

Further investment in incident reporting training to new and existing employees
Further investment in root cause analysis training to ensure accurate and effective outcomes from investigations

Linking of the complaints process to incidents process to ensure a combined approach to the investigation of harm

Daily triage of incidents that are reported to review the grading and to sure an appropriate level of investigation.

3.3. Other Quality Achievements

3.3.1 'Getting It Right First Time' (GIRFT)

The Trust's Trauma and Orthopaedics Directorate is spearheading a new approach to joint replacement surgery that is bringing improvements in team working and improved patient outcomes. 'Getting It Right First Time' (GIRFT) is a recent innovation designed for hospitals to make improvements in elective orthopaedics, that ensures high quality care and better access for patients within the financial constraints of the NHS. ELHT are now using the GIRFT process to perform four joint operations (hip or knee replacements) on a single theatre list.

3.3.2 Landmark Robotic Cancer Surgery

In January 2017, ELHT surgeons performed the 100th prostatectomy (removal of the prostate gland) operation using robotic assisted surgery at the Royal Blackburn Teaching Hospital. In a milestone for the treatment of prostate cancer in Lancashire, Consultant Urological Surgeon Mr Mohammed Masaarane successfully operated on a 56-year-old patient from Preston using our da Vinci® Robot to remove a cancerous prostate gland.

Advanced surgery using the robot makes it possible to remove tumours far more precisely than the hand of even the most skilled surgeon. For the patient, robotic assisted surgery is less invasive, less painful and results in faster recovery and fewer surgical complications.

Affectionately known as 'Leo' by Theatres staff, the £1.6 million robot delivers more precise cancer removal resulting in less pain, a shorter recovery period and hospital stay as the surgery is far less invasive; less requirement for radiotherapy; improved long term outcomes for continence and a faster return to normal daily life.

Robotics surgery at ELHT encompasses a growing number of surgeons from across the county, and, following the first head and neck cancer procedure using robotic assisted surgery in December 2016, there is the potential to perform more surgical specialties including, but not limited to, gynaecology, colorectal (bowel) and hepatobiliary (liver).

3.3.3 Refer-to-Pharmacy

'Refer-to-Pharmacy', is an award-winning electronic tool which gives patients a bespoke appointment with their local community pharmacist on discharge from hospital and continues to go from strength to strength.

Refer-to-Pharmacy, with the backing of the Royal Pharmaceutical Society (RPS), is the first of its kind in England and essentially sees patients who are being treated in its hospital visited by a hospital pharmacist or pharmacy technician and an electronic referral appointment set up with the community pharmacist with all their medication information for when they return home, to ensure that they are taking their medicines correctly.

The system underlines the Trust's commitment to closer working between hospital and community pharmacists. Patients often start new medicines in hospital or have their doses changed, which can lead to potential problems when they return home as their medication at home or repeat prescription slips are not up to date with any changes.

By receiving an electronic referral from the hospital pharmacy team using the Refer to Pharmacy system, the community pharmacist is alerted to a patient's discharge and the vital information about medication changes, which they can then use to support patients at a time

that suits both and ensuring continuity of care. Working together the pharmacy teams help patients get the best from their medicines and stay healthy at home.

This initiative has been shortlisted in three categories for the prestigious Value in Healthcare Awards, which are sponsored by the Health Service Journal, and are to be announced and presented in May 2017.

3.3.4 Large Business of the Year

ELHT was named 'Large Business of the Year' at Nelson and College College's Apprenticeship Awards in June 2016 for its on-going work to provide employment opportunities for the area's young adults. The Trust currently employs more than 150 apprentices who help to provide essential hospital services such as laundry, administration, maintenance and customer service.

3.3.5 Neuro Rehabilitation

Some of ELHT's most seriously injured patients now benefit from the opening of a specially adapted apartment at Burnley General Hospital's Rakehead Centre. The stylish one-bed apartment, built thanks to a £40,000 investment by the Trust, helps patients with serious neurological problems to live independently in the days before they leave Rakehead Rehabilitation Centre and return to the real world.

Refurbished by our Estates team in just four months, the Rakehead apartment features a spacious living area, bathroom, bedroom and specially modified kitchen where patients cook their own food using height adjustable worktops and retractable cupboard shelving. Helping neuro rehab patients adapt to independent living before discharge, Rakehead Centre staff also encourage patients staying in the apartment to live as close to their 'normal' life as possible, which includes doing their own shopping, washing and having friends and family visit them.

3.3.6 Flu vaccinations

Staff at the Trust have shown their commitment to patient safety with over 84% of them receiving flu vaccinations giving the Trust its highest uptake rate ever and placing it as the top Acute Trust in the country.

3.3.7 Health and Wellbeing Passport

A new 'Health and Wellbeing Passport' to help children and young people with a learning disability communicate better with doctors and other health providers has been introduced. Developed by ELHT, NHS Blackburn with Darwen and NHS East Lancashire Clinical Commissioning Groups (CCGs), the Health and Wellbeing Passport can help doctors and nurses who care for children and young people with learning disabilities and/or complex needs know more about the patient, providing a better understanding of the support they require. This makes a visit to the hospital less stressful for the child or young person with learning disabilities. Formatted as a colourful and informative booklet, the passport is designed to offer additional information that can benefit a child's care. This includes their likes and dislikes, how they communicate and how to reassure them. The booklet will support the child or young person's clinical records and will ensure the child or young person doesn't have to repeat their history several times, making life easier for them.

Clinical staff will have to hand all the information required to care for the child or young person, especially if there is no parent or carer available. An 'About Me' card will also be given out with

the passport that signals to anyone that comes into contact with the child or young person to show that they have a learning disability and may need further assistance.

The passport and 'About Me' card can empower a young person to be more independent, and improve the communication between the patient and the carer. The passports are distributed via the local community children and young people's mental health teams at both Royal Blackburn and Burnley General hospitals.

3.3.8 Dementia Friends

ELHT have signed up over 1,000 Dementia Friends at the Trust! Dementia Friends education is provided by the Trust's Dementia Champions and aided by Training Managers who have all completed Dementia Champion training. Becoming a 'Dementia Friend' is part of the biggest ever initiative from The Alzheimer's Society to change people's perceptions of dementia. Staff learn the five key messages about dementia, which they build on as they learn more about dementia. Our aim is to see every ward and department have at least one Dementia Friend.

3.3.9 Falls Response Service

The Falls Response Service (FRS) is a collaboration between East Lancashire Hospitals NHS Trust and North West Ambulance Service which has enabled 78% of patients to remain in their home after a fall instead of being conveyed and/or admitted to hospital after an emergency call. FRS is able to respond to falls in a Paramedic's car, often arriving at the scene quicker than an ambulance would. They carry out an initial assessment to determine initially if the patient is medically stable and, if this is the case, the occupational therapist and paramedic work closely together utilising their combined skills and knowledge to develop a treatment plan to support the individual to remain at home. In just 18 months the service has prevented over 1,100 patients from being conveyed and/or admitted to hospital after an emergency call when it is medically safe for them to remain at home.

The service was introduced as a pilot in January 2015 to help reduce the number of hospital admissions in people who have fallen at home. Since then the service has gone from strength to strength, winning an award at the Occupational Therapy Show in October 2015 and being shortlisted for the CDL Award for Entrepreneurship at the Advancing Healthcare Awards in March 2017. In addition the service has been shortlisted for a Value in Healthcare Award in the 'Improving value in the care of frail older patients' category.

3.3.10 Falls Collaborative

Harm caused to patients due to falls was becoming an increasingly significant problem. To tackle this, ELHT conducted a Break-Through Series (BTS) collaborative aimed at reducing harm to our most vulnerable patients - the frail and elderly. The aim of the collaborative was to reduce the number of inpatient falls by 15% on pilot wards by August 2016.

During the period of testing and adapting different ideas that could help reduce inpatient falls, the 5 pilot wards involved have gone above and beyond achieving their aim of reducing inpatient falls achieving:

- 36% reduction for all inpatient falls and
- No patients had moderate or above harm caused to them due to a fall

The next stage of the project is to spread the 'Let's Eliminate Avoidable Falls' (LEAF) change package, developed from the Falls Collaborative, to every ward across the hospitals. Quality Improvement coaching, facilitation and guidance will be provided to support each ward to embed the change package, with a stretch aim of reducing the number of falls across the Trust by 15%. This will be supported with falls data provided to each ward areas in a run chart on a monthly basis.

3.3.11 **Falls Prevention Film**

The Trust's Community Falls Team, based at Pendle Community Hospital, have partnered with Nelson and Colne College and Pendle Senior Group to release a new film to alert Lancashire's 250,000 senior citizens to the dangers of, and practical advice on how to avoid, falling. Titled 'Falls Prevention: A Guide', the film is the creation of seven Year 2 BTEC Photography and Media students and also features members of the Community Falls Team and Pendle Seniors Group. The film aims to educate families and older people on practical steps to avoid falls by highlighting key issues that lead to a tumble and includes real-life experiences of older people from Pendle. Statistically, one in three people over 65 will have at least one fall in a year and nearly a third of a million people need hospital treatment. The practical advice shown in 'Falls Prevention: A Guide' could help thousands of older people avoid the pain and suffering of a fall.

3.3.12 **Pressure Ulcer Collaborative**

The Pressure Ulcer Collaborative (PUC) began in April 2014. Teams from across ward areas and the community nursing teams were invited to work together with the aim of:

- Reducing grade 2 hospital and community acquired pressure ulcers by 15%
- Eliminating grade 3 and 4 hospital and community acquired pressure ulcers

At its culmination, the collaborative had achieved:

- Total elimination of grade 2 hospital acquired pressure ulcers in PUC ward areas
- Total elimination of acquired grade 3 and 4 pressure ulcers in all pilot areas
- The development of a specific Care Home support and training package by the district nursing teams of Accrington and Clayton, Kiddrow Lane and St Peter's Centre areas to develop relationships of care with care home staff and managers.
- 'Time for Turn' resource- highlighting the time for turning individuals at risk of Pressure Ulcers.

An output of the collaborative is the development of a 'Change Package' which introduces the changes that teams have tested and implemented in their work areas to reduce the number of pressure ulcers acquired by patients whilst in their care. The learning from the collaborative is being spread across the trust in a bid to replicate the improvements seen on the pilot wards and support the aim of eradicating acquired pressure ulcers completely within ELHT acute and community services.

3.3.13 **1:1 Care**

The Trust is leading a national directive to improve the quality and experience of 1-1 care for vulnerable patients.

1-1 care supports patients at risk of harm or who need someone to stay with them at specified times to maintain their safety. With the use of quality improvement methodology, a four month

trial took place on Wards C5 and B22 at Royal Blackburn Hospital, and Ward 16 at Burnley General Hospital.

The results transformed the way 1-1 care is provided and the learning has been shared with other hospitals in England who are also trying to improve the quality and experience of 1-1 care. 1-1 care changes were successfully trialled on the three wards: including communication aids for staff, an activity log to support engagement and stimulation with patients who receive 1-1 care, and a Risk Assessment Tool to ensure our patients receive the right care at the right time.

The Trust's focus on providing high quality services and improving the patient experience has also had a positive effect on cost savings. During the four month trial, the pilot wards achieved a 68% reduction in the cost of agency/bank staff needed to provide 1-1 care.

3.3.14 **Midwife-led Sonographer Service**

An innovative new service that aims to quickly detect foetal growth restriction in mums-to-be and reduce stillbirths has been launched at the Lancashire Women and New-born Centre. The Trust now has a Midwife-led Sonographer service that aims to detect foetal growth restriction in mums-to-be, and reduce stillbirths. The detection rate for Foetal Growth Restriction is above the national average (in Q2 Jul-Sept 2016 detection rate was 44% compared to the national average of 39%). Outcome measures for avoidable stillbirths per year show there has been significant improvement in reduction, year on year. Comparing 2012 to 2015, there has been a 53% reduction in avoidable still births.

The service is run by midwife, Julie Dimbleby, whose role it is to scan mums-to-be who are referred by community midwives following growth concerns when their baby is measured at antenatal appointments. The women are referred directly to Julie without having to wait for a departmental ultrasound scan appointment.

Midwife Julie and Antenatal Clinic Manager, Caroline Broome, have been the driving force behind the new service which was the result of a year of training for Julie at Birmingham City University in 'Third Trimester Foetal Surveillance' and clinical practice within the department. Upon completion of her training the Friends of Serenity charity kindly contributed over £1000 to the sonographer service.

Previously, women identified with growth concerns in the community setting would have to wait for a departmental ultrasound scan appointment with a sonographer; the midwife sonographer service ensures the women are seen within 72 hours, with 35 slots available each week. This service is of huge benefit to the women in East Lancashire and is unique in the local area and ensures that all women receive the best possible antenatal care. Julie has also been approached by a number of other Trusts keen to find out more about how the service operates and the expected results.

3.3.15 **Elective Care Centre**

Local NHS patients requiring surgery or minor procedures were welcomed to the Trust's new East Lancashire Elective Centre at Burnley General Hospital. Phase 1 of the new £1 million centre, featuring an additional 14 beds for short stay surgery and a purpose-built procedure room, opened on schedule at the beginning of October 2016.

In addition, the East Lancashire Elective Centre will feature an extra Endoscopy Suite – the 4th at BGH – a patient-centred infusion suite and extra treatment room as the Trust gears up for an

anticipated increased demand for day surgery and minor procedures. Investment in these facilities means ELHT have extra capacity to perform more surgery and provide better treatment for patients.

3.3.16 **Kate Granger Compassionate Care Award**

Royal Blackburn Hospital porter John Jackson won the first ever prize at the NHS England Kate Granger Compassionate Care Awards. John was crowned the winner in the 'individual' category out of three nominees, who were all shortlisted from over 100 nominations across the country. The award, which recognises a member of NHS staff who demonstrates outstanding care for their patients, was presented to John for his influential role in ELHT's bereavement service. John became ELHT's first 'bereavement champion' for his commitment towards patients and families. His involvement in the bereavement group which ranged from introducing new equipment and procedures designed to improve the dignity of the deceased patients he take to the mortuary, to offering psychological support for colleagues following the deaths of children, has been appreciated by staff and those under his care.

The Kate Granger Compassionate Care Awards are named after the late Dr Kate Granger who worked tirelessly to raise awareness around compassion in the NHS through her #hellomynameis campaign.

3.3.17 **Value in Healthcare Awards 2017**

In addition to the four nominations described above the Trust has also been shortlisted in two further categories of the Awards.

Reflecting the high standard of East Lancashire's NHS maternity services the Trust's initiative to improve stillbirth care and reduce avoidable stillbirths has been recognised in the 'Obstetrics and Gynaecology' category.

The Trust has been innovative in having a pharmacist based on every ward which results in faster discharges and shorter hospital stays for inpatients and this has been rewarded with a shortlisting in the 'Pharmacy and Medicines Optimisation' category.

3.4 **Statements from Stakeholders**

3.4.1 East Lancashire Clinical Commissioning Group – Chief Nurse and Director of Quality Blackburn with Darwen Clinical Commissioning Group – Clinical Director for Quality and Effectiveness

East Lancashire Clinical Commissioning Group (EL CCG) and Blackburn with Darwen Clinical Commissioning Group (BwD CCG) welcomes the opportunity to comment on the 2016/17 Quality Account for East Lancashire Hospitals Trust (ELHT).
ELHT has demonstrated its continued commitment in 2016/17 to making improvements in quality and safety with a clear focus on delivering safe, personal and effective care.
The CCGs commend the progress made by the Trust and were delighted with the Trusts Care Quality Commission (CQC) rating of 'Good' following the 'Well Led' review in September 2016.
The CCGs will continue to work with and support delivery of the CQC action plan, with oversight through the monthly Quality Review Meetings.

Quality Priorities for 2016/17

Within the 2015/16 Quality Account the Trust identified 3 quality improvement priorities for 2016/17:

1) Implementation of a Trust wide approach to improve the recognition and the response to the deteriorating patient – the Trust has worked hard to establish a Deteriorating Patient Score, use of which is evident within incident investigations and care management of patients.
2) Optimise learning from complaints to improve end of life care – the CCGs are pleased to see enhanced learning from complaints and themes and trends being used to inform action plans.

3) Increase compliance with hand hygiene and infection prevention guidance through 'Prompt to Protect' improvement package – the CCGs commend the work completed by the Trust around infection prevention and the improved compliance with hand hygiene and basic infection prevention.

In addition the Trust has also performed well against the pledges made to 'Sign up to Safety'.

The CCGs applaud the Trust on the success of the falls collaborative and the reduction of falls by 36%.
Saving Babies Lives has been a Local CQUIN scheme over the last 2 years. The CCGs are pleased that the Care Bundle is embedded within the service and combined with other initiatives in the service has led to a 53% reduction in avoidable stillbirths.

Quality indicators and CQUIN 2016/17

ELHT has achieved 15 of the 24 national quality indicators included within their contract. There have been unprecedented operational pressures observed nationally, with increased attendance impacting on bed availability and Trust wide flow.

ELHT had a challenging target for reduction in Clostridium Difficile infections in 2016/17 and recorded 32 cases against a trajectory of 28 cases. The Trust continues to perform well against the national rate and remain one of the better performing ordinary acute trusts. The trajectory for 2017/18 remains at 28 cases and the CCGs will continue to work with the Trust on post infection reviews to share learning across the Health Economy.

MRSA had a zero tolerance target for 2015/16 with ELHT reporting a single case in December 2016.

The Trust has met all cancer waiting time targets within 2016/17. The Trust and CCGs continue to work together on pathway redesign and on the delivery of the cancer action and implementation plan, to improve services for patients.

The Trust has performed well against the requirements of the 2016/17 CQUIN scheme and met all requirements for Quarter 1-3. At the time of writing, submission of sepsis and antibiotic reduction evidence is awaited to allow reconciliation of Quarter 4.

The CCGs are pleased that issues continue to be resolved as they arise and the number of new complaints remains below the target of 0.4 formal complaints per 1,000 patient contacts. The CCGs have noted and discussed the increase in the number of outstanding complaints and will continue to monitor the position via monthly Quality Review Meetings with the Trust.

ELHT continue to be a high reporter of incidents demonstrating the open and honest culture within the Trust. Through quality improvement initiatives there has been a reduction in harm caused to patients. The Trusts Serious Incidents Requiring Investigation (SIRI) panel, which the CCG attend, has matured and provides a good level of challenge and support to identify root causes and lessons learned from incidents. Staff training in Root Cause Analysis has improved the quality of incident investigations and will be further bolstered in 2017/18 via Human Factors training.

The CCGs are pleased with the improvements the Trust has made with their mortality performance and downward trend for mortality. The CCGs attend the Trust's Mortality Steering Group and are alerted to and provided with action plans for any outlying areas.

The CCGs are encouraged by the Trust's Staff Survey Results, with improvements noted in a number of areas. There was a high response rate from staff and the survey results reflect improved engagement and staff experience.

The Picker inpatient survey results have seen some deterioration from the previous year. The Trust continues to utilise patient feedback to inform strategies for the improvement in performance and quality of services.

ELHT has participated in 94% 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.

Priorities for 2017/18

The CCGs support the priorities set out for 2017/18 within the Quality Account.

Discharge issues have been a theme recorded through the CCG Connect Soft Intelligence System and also an area highlighted through the Picker Inpatient Survey and it is positive to see a Trust wide approach to improving safety and patient experience in this area.

The CCGs look forward to continuing to work with ELHT over the coming year to ensure that the services commissioned are of a high quality standard and provide safe, personal and effective care.

3.4.2 Healthwatch Lancashire – Chief Executive

Thank you for providing Healthwatch Lancashire with the opportunity to comment on your Quality Account.
Bearing in mind that Healthwatch Lancashire's response is presented from a 'lay person' perspective, I offer the following for your consideration:

Your introduction 1.1, is helpful in gaining a picture of the Trust in 2016/17. I am pleased to see your inclusion in 1.3, referring to the Sustainability and Transformation Plan and Local Delivery Plan for Pennine Lancashire, though feel you could have capitalised more on what this means to the people who use and visit your services.

Congratulations on your CQC rating and we hope to see your 'responsive' rating aligning to the other 4 domains in the future.

I read with interest 2.2, Quality Monitoring and Assurance and 2.5 Complaints Management. As one of the local Healthwatch organisations who provides your Trust with independent local intelligence relating to your service delivery, I would be keen to explore how we progress our current arrangements in ensuring the flow of intelligence from our engagement with patients, families and visitors of your Trust is received, digested and acted on, thus providing a mechanism to evidence that the service user voice is truly valued.
The case studies contained within 3.3, Other Quality Achievements provide interesting reading and assurances that the Trust is continually seeking to explore innovative ways of delivering services for its patients. Have any of these achievements been as a result of the Trust listening to the patient/service user voice? If so, have you considered how this can be included in celebrating the achievements?

The report contains a significant amount of information related to the Trust's performance; whilst I appreciate this is an essential element of the document, the information presented may seem overwhelming for a 'lay person'. Therefore, I would suggest the Trust provides a 'reader friendly' version of the Quality Account, particularly useful if the Trust and the health and social care sector in general wishes to engage widely with its local communities to share its 'case for changes' messages.

Finally, Healthwatch Lancashire wishes the Trust success as it moves forward into 2017 and beyond and I look forward to your response.

Healthwatch Blackburn with Darwen – Chief Executive

Healthwatch Blackburn with Darwen welcome the opportunity to comment on the 16/17 Quality Account. It is interesting to read 1.1-1.2 and is useful to be fully informed of the trusts position.

I would also like to congratulate you on your CQC rating and this is in line with some of the feedback that we as a Healthwatch receive.
In regard to 2.5 we are continuing to improve our working relationship with the Trust and would like to continue to work closely with the trust and partners in order to ensure high standards of care for the residents of Blackburn with Darwen.

In regard to 3.1.2 it is great to see the reduction of falls by 36% and that the Trust is further committed to reducing falls and improving overall safety.

As already mentioned this document contains a large amount of information and it would be useful for a 'simple' type of document to be made available for members of the public to easily understand the position of the Trust that is vital to those individuals and families.

Healthwatch Blackburn with Darwen look forward to working with you in 17/18 and wishes you well in achieving your targets.

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 Regulations 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 incorporating the above legal requirements.

In preparing the Quality Account, 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 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 that they have complied with the above requirements in preparing the Quality Account.
Signed By Order of the Board:

Chairman:

Chief Executive

Date:

GLOSSARY

Term	Explanation
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Advancing Quality Alliance	The Advancing Quality Alliance was established to support health and

	care organisations in the North West to deliver the best health, wellbeing and quality of care for all by being a trusted source of quality improvement expertise for the NHS and wider health and social care systems.
Antimicrobial	An agent that kills microorganisms or inhibits their growth
Board Assurance Framework (BAF)	The BAF is a key framework which supports the Chief Executive in completing the Statement on Internal Control, which forms part of the statutory accounts and annual report, by demonstrating that the Board has been properly informed through assurances about the totality of the risks faced by the Trust.
Care Bundle	A group of interventions which are proven to treat a particular condition
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 Commissioning Group	Clinical Commission Groups are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Clostridium Difficile Infection (CDI)	A type of infection
Commissioning for Quality and Innovation (CQUIN)	A payment framework linking a proportion of a Trust's income to the achievement of quality improvement goals
Commissioning Support Unit	Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners, for example by providing business intelligence services and clinical procurement services.
COPD	Chronic Obstructive Pulmonary disease – This is the name used to describe a number of conditions including emphysema and chronic bronchitis
Datix	An electronic system that supports the management of risk and safety involving patients and staff
Dr Foster Guide	A national report that provides data on patient outcomes in hospitals in the UK
DNA	Did Not Attend
Duty of Candour	The Duty of Candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.
Healthcare Acquired Infection	Healthcare acquired infections are caused by viral, bacterial, and fungal pathogens; the most common types are bloodstream infection (BSI), pneumonia (eg, ventilator-associated pneumonia [VAP]), urinary tract infection (UTI), and surgical site infection (SSI).
Healthwatch	Healthwatch England is the national consumer champion in health and care and has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.
HCV	Hepatitis-C virus
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
Local Delivery Plan (LDP)	The Local Delivery Plan defines how the Sustainability and Transition Plan is to be implemented within a specific geographic area such as Pennine Lancashire for the Trust
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 Early Warning Scores (NEWS)	A tool to standardise the assessment of acute illness severity in the NHS
National Reporting and Learning System (NRLS)	A national electronic system to record incidents that occur in NHS trusts in England
NHS England	A body that oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and social Care Act 2012
NHS Improvement	A body that supports foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NHS Number	A twelve digit number that is unique to an individual and can be used to track NHS patients between NHS organisations
National Institute for Health and social Care Excellence (NICE)	A body to improve outcomes for people using the NHS and other public health and social care services by producing evidence-based guidance and advice for health, public health and social care practitioners. NICE develops quality standards and performance metrics for those providing and commissioning health, public health and social care services and provides a range of information services for commissioners, practitioners and managers across the spectrum of health and social care
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)	An electronic system used by acute trusts to record patient information such as contact details, appointments and admissions
Patient Advice and Liaison Service (PALS)	A service that offer confidential advice, support and information on health-related matters
Payment by Results	A form of financing that makes payments contingent upon 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
Quality Impact Risk Assessment Process (QIRA)	A robust process to ensure that our Safely Releasing Costs Programme ensures the Trust continues to maintain Safe, Personal and Effective care as it works to reduce its cost base.
Quality and Safety Framework	The means by which quality and safety is managed within the Trust including reporting and assurance mechanisms
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
Rockwood Scale	A tool for assessing frailty in the elderly.
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
Strategic Executive Information System (STEIS)	An information management system utilised to performance manage serious untoward incident investigations
Summary Hospital Mortality Indicator (SHMI	The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die
Sustainability and Transition Plan (STP)	The Sustainability and Transformation Plan is a statement of the healthcare challenges in Lancashire and South Cumbria and how we are working together to overcome them. Its purpose is to encourage further thinking about potential solutions.
Systemic Anticancer Therapy	Systemic Anti-Cancer Therapy (SACT) encompasses both biological therapy (therapies which use the body's immune system to fight cancer or to lessen the side effects that may be caused by some cancer treatments) and cytotoxic chemotherapy (a group of medicines containing chemicals directly toxic to cells preventing their replication or growth, and so active against cancer).
Venous Thromboembolism (VTE)	A blood clot forming within a vein