NHS

East Lancashire Hospitals
NHS Trust

70 YEARS OF THE NHS 1948 - 2018

Quality Account

2017/18

Safe | Personal | Effective

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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 and community healthcare for the people of East Lancashire and Blackburn with Darwen. Our population includes patients who live in several of the most socially-deprived areas of England.

We aim to deliver Safe, Personal and Effective care that contributes to a health gain for our community. Our Trust is located in Lancashire in the heart of North West England, with Bolton and Manchester to the south, Preston to the west and the Pennines to the east. We also provide a regional specialist service to Lancashire and South Cumbria, we serve a combined population of approximately 550,000.

We employ almost 8,000 staff, some of whom are internationally-renowned and have won awards for their work and achievements. Our staff provide care across five hospital sites, and various community locations, using state-of-the-art facilities. We have a total of 996 beds and treat over 700,000 patients a year from the most serious of emergencies to planned operations and procedures.

As well as providing a full range of acute hospital and adult community services, the Trust is also a specialist centre. The specialist services provided are for hepatobiliary, head and neck and urological cancer services and cardiology services. In addition the Trust is a network provider of Level 3 Neonatal Intensive Care.

We are a teaching organisation and have close relationships with our academic partners the University of Central Lancashire, Blackburn College and Lancaster University.

There are two private finance initiative (PFI) schemes for parts of the buildings at Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital sites. 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 vision is to be widely recognised for the delivery of Safe, Personal and Effective care to the local population.

We are committed to ensuring the future of our organisation and services by continually improving our productivity and efficiency. 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 four 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 Integrated Care System (ICS) of Lancashire and South Cumbria.

We will seek a greater role in the provision of prevention of illness, in primary care, and in regional specialist work.

Across Pennine Lancashire we will integrate more closely with providers in the primary, community, voluntary and third sectors. We will undertake co-design with Commissioners, creating an Integrated Care Partnership (ICP) 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
- **Workforce Excellence**
  Creation of a transformational approach to workforce development and organisational design that addresses current and future needs of service provision.

We will develop new acute and emergency pathways and facilities, 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 provide assurance 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. All junior foundation doctors take part in and lead quality improvement projects.

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.

The Trust continues to build on its relationships and communication with lead CCGs over 2017-18. Monthly quality review meetings are held, chaired by CCG, 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 are triaged daily to ensure timely and appropriate communication to all relevant parties. This allows the Trust to identify and nominate appropriate staff to investigate incidents and where appropriate a family liaison officer to support, provide information and feedback to the patient, family and/or carer. 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 2017-18 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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East Lancashire Hospitals NHS Trust
Park View Offices
Royal Blackburn Teaching Hospital
Haslingden Road
BLACKBURN
BB2 3HH

Email: qualityandsafetyunit@elht.nhs.uk

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 7th 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, the Chief Executive Officer (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 and the Trust and CQC have regular engagement meetings.

New CQC Inspection Process

The CQC inspection process has changed from the 1st April 2018 and every provider organisation will be subject to a Well Led review annually. This will be an announced visit but the CQC will be carrying out unannounced inspections that will focus on specific areas as well.

1.7 Our Chief Executive's Statement on Quality

I am proud to present this document which highlights the quality of our services and the intense focus we have at every level to deliver Safe, Personal and Effective care to our patients, service receivers and their families.

We are committed to achieving excellence and refuse to be complacent. We are an organisation that learns from our mistakes, responds to constructive feedback and gathers knowledge 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.

Over the past 12 months we have made significant improvements to the quality and effectiveness of our services despite the fact that demand has been higher than ever before and resources have become increasingly difficult to find. The need for innovation and transformation has never been more important. We are fully supportive of the developments of the ICS and ICP of Lancashire and South Cumbria, which will see much needed change to ensure we meet the expected demands of the future.

Since our Care Quality Commission rating of 'Good', with areas noted of 'Outstanding' practice, there has been a real sense of optimism. Our staff feel that the target of overall 'Outstanding' is within our sights.

To achieve this goal the areas we have identified for future improvement will receive particular focus in 2018/19. We will continue to maintain our achievements to date and make sure that every patient we care for and every family member or carer we interact with receives Safe, Personal and Effective care, always respecting their individuality.

To the best of my knowledge all the data and information presented in this 2017/18 Quality Account is true and accurate and the Quality Account has been approved by the Trust Board.

Kevin McGee

Chief Executive

Mr Kevin McGee, Chief Executive

Part Two
Quality Improvement

2.1 Our Strategic Approach to Quality

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.

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 (2017-19) 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 2017 – 2019 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 50,000 in the five year cycle).

A number of these projects shaped 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 has been launched to promote a culture of openness around infection control 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. Since the 1st December 2017 the Trust has been using the Structured Judgement Review (SJR) methodology and introduced an electronic review process that is part of our patient safety risk management software system (Datix). The new review process is in line with the most recent NHS England guidance: Learning from Deaths and includes an overall score. Any score of 1 or 2 triggers a secondary review process to determine whether or not poor care contributed to the death of a patient. The number of avoidable deaths 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.

We actively encourage feedback in a variety of ways across the organisation including:

a) Friends and Family Test and local patient survey 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 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 Frailty Care Project, 1 to 1 Partnership in Care and the Dementia Strategy.

c) NHS Choices / Patient Opinion / CCG / Twitter and Facebook. We always respond promptly to feedback provided and encourage people to get in touch directly if there are any issues or concerns that we can help to resolve.

d) Complaints, concerns and soft intelligence provide valuable feedback and we encourage patients to share any concerns with staff as soon as possible so that we can help.

e) National Surveys including the annual Adult In-Patient Survey, and national surveys of the Emergency Department, Survey, Maternity and Children and Young People's Survey

f) Patient and Carer Involvement and engagement. The Trust's patient / public members are invited to participate in service reviews and ward environment / cleanliness inspections.

g) Healthwatch – two local organisations (Healthwatch Lancashire and Healthwatch 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.

h) Implementation of our Patient, Carer and Family Experience Strategy 2018-21

Clinical Effectiveness

There is 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 National Institute for Health and Social Care Excellence (NICE) guidance

e) Relevant National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations

f) Getting It Right First Time (GIRFT) 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 Quality and Safety 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 is 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:

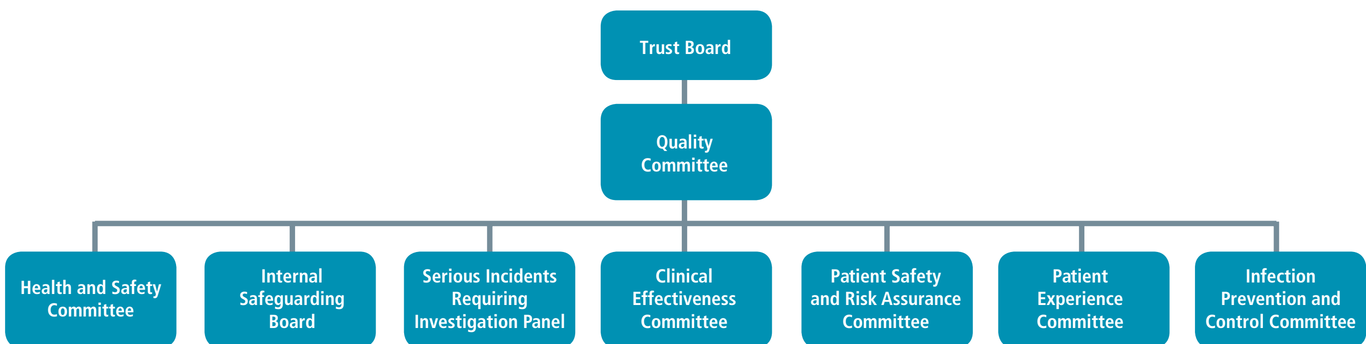
- All new Quality Improvement Projects submitted;
- Quality Improvement Projects deemed to apply to single division;
- Why this decision was made;
- Assurance that impact monitoring plans are in place;
- Quality Improvement Projects deemed to require further review;
- Which Group(s) undertaking further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



2.2 Quality Monitoring and Assurance

To support delivery of our quality improvement work streams, the Trust has defined a meeting structure that supports the flow of information to and from the Trust Board.

The corporate 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 2017-18 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 2017-18, has been managed by way of these reporting functions.

The income generated by the NHS services reviewed in 2017-18 represents 90% of the total income generated from the provision of NHS services by the ELHT for 2017-18 (2016-17 94.5%).

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	Implementation of a Trust-wide approach to support for safe discharge to continuing care	Quality Improvement Collaborative through Model Ward	Report to the Patient Safety & Risk Assurance Committee
Safe Transfer of Care	Implementation of a Trust-wide approach to improve staff and patient handover between care areas and organisations	Quality Improvement Collaborative through Model Ward	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 2017-18 50 national clinical audits and 8 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 46 (92%) 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 initiated or completed during 2017-18 also appears in the table below alongside the percentage of cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Adult Bronchiectasis Audit	BTS	Intermittent	No	100%
Bowel Cancer (NBOCAP)	RCS	Continuous	Yes	100%
Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	NICOR	Continuous	Yes	100%
Cystectomy	BAUS	Continuous	Yes	100%
Diabetes (Paediatric) (NPDA)	RCPCH	Intermittent	Yes	100%
Endocrine & Thyroid National Audit (BAETS)	BAETS	Continuous	Yes	100%
Female Stress Urinary Incontinence Audit	BAUS	Continuous	Yes	100%
Fracture Liaison Service Database (FLSD) (FFFAP)	RCPCH	Continuous	Yes	100%

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Fractured Neck of Femur (care in emergency departments)	RCEM	Intermittent	Yes	100%
Head & Neck Cancer Audit (HANA)	Saving Faces	Continuous	Yes	100%
Inflammatory Bowel Disease (IBD) programme / IBD Registry	IBD Registry	Continuous	No	100%
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	Continuous	Yes	100%
Major Trauma Audit (TARN)	TARN	Continuous	Yes	100%
MINAP: Acute Myocardial Infarction	NICOR	Continuous	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	RCS	Continuous	Yes	100%
National Audit of Dementia	RCPCH	Intermittent	Yes	100%
National Audit of Intermediate Care	NHS Digital	Intermittent	No	100%
National Bronchoscopy Audit	BTS	Intermittent	Yes	100%
National Ophthalmology Audit: Adult Cataract Surgery	RCOphth	Continuous	Yes	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West NHS Healthcare	Continuous	Yes	100%
National COPD Audit	RCP	Continuous	Yes	100%
National COPD Pulmonary Rehabilitation Audit	RCP	Intermittent	Yes	100%
National Core Diabetes Audit	NHS Digital	Intermittent	Yes	100%
National Diabetes Foot Care Audit (NADFCA)	NHS Digital	Continuous	Yes	100%
National Diabetes Inpatient Audit	NHS Digital	Intermittent	Yes	100%
National Emergency Laparotomy Audit (NELA) (Year 3)	RCA	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Hip Fracture Database (FFFAP)	RCP	Continuous	Yes	100%
National Inpatient Falls Audit (FFFAP)	RCP	Intermittent	Yes	100%

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
National Joint Registry (Hip & Knee Replacement)	HQIP	Continuous	Yes	100%
National Lung Cancer Audit (NLCA)	RCPCH	Continuous	Yes	100%
National Maternity and Perinatal Audit (NMPA) (Continuous Audit)	RCOG	Continuous	Yes	100%
National Neonatal Audit Programme (NNAP) – Neonatal Intensive and Special Care	RCPCH	Continuous	Yes	100%
National Pregnancy in Diabetes Audit	NHS Digital	Continuous	Yes	100%
National Prostate Cancer Audit	RCS	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Nephrectomy audit	BAUS	Continuous	Yes	100%
Oesophago-Gastric Cancer (NAOGC)	RCS	Continuous	Yes	100%
Paediatric Bronchiectasis	BTS	Intermittent	Yes	100%
Pain in Children (care in emergency departments)	RCEM	Intermittent	Yes	100%
Percutaneous Nephrolithotomy (PCNL)	BAUS	Continuous	Yes	100%
Procedural Sedation in Adults (care in emergency departments)	RCEM	Intermittent	Yes	100%
Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	NHSBT	Intermittent	Yes	100%
Radical Prostatectomy Audit	BAUS	Continuous	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	SHOTUK	Continuous	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAM	Intermittent	No	100%
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
UK Parkinson’s Audit	Parkinson’s UK	Intermittent	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
FFFAP	Falls and Fragility Fractures Audit Programme
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
NHSBT	NHS Blood & Transplant
NICOR	National Institute for Cardiovascular Outcomes Research
NPDA	National Paediatric Diabetes Audit
RCA	Royal College of Anaesthetists
RCEM	Royal College of Emergency Medicine
RCOG	Royal College of Obstetricians and Gynaecologists
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
TARN	Trauma Audit Research Network

NCEs

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2017-18	Required Sample Submission
Child Health Clinical Outcome Review Programme: Cancer in Children, Teens and Young Adults	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Heart Failure	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Peri-operative Diabetes	NCEPOD	Intermittent	Yes	On-going	100%
Elective Surgery (National PROMs Programme)	NHS Digital	Continuous	Yes	On-going	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: National surveillance of perinatal deaths	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Confidential enquiry into serious maternal morbidity	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: National surveillance and confidential enquiries into maternal deaths	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%

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

The results of 44 national clinical audit reports and 5 national Confidential Enquiry reports were received and reviewed by the Trust in 2017-18. 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 actions 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 Medical Director, 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 actions captured.
- National audit activity which highlights the need for improvement will be reviewed for inclusion in subsequent quality improvement activity plans.
- The Clinical Audit and Effectiveness Team annual report which will continue to focus on lessons learnt to be presented to the Clinical Effectiveness Committee for on-going assurance and monitoring.

214 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2017-18. 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 audit activity will continue to be presented and discussed at specialty/multi-specialty effectiveness 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 effectiveness or designated meetings to ensure that actions are implemented to agreed timescales led by the Specialty Effectiveness Lead.
- All specialty effectiveness 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.
- 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.

2.4.2 Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust during 2017-18 that were recruited up to the 29th March 2018 to participate in research approved by a research ethics committee was 1694.

2.4.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of East Lancashire Hospital Trust's income in 2017-18 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. Unlike previous years when the goals were a combination of national and local commissioner agreed CQUIN schemes, the schemes were all National Schemes the majority of which are two year schemes.

The following table sets out brief details of the Trust's CQUIN scheme for 2017-18:

Commissioned by	Scheme	Indicators
National	Improvement of staff health and wellbeing	A) 5% improvement (on 2015) in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress.
		B) Healthy food for NHS staff, visitors and patients.
		C) Improving uptake of flu vaccinations for frontline staff (achieve 70%).
National	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	A) Timely identification of patients with sepsis in emergency departments and acute inpatient settings.
		B) Timely treatment of patients with sepsis in emergency departments and acute inpatient settings.
		C) Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
		D) Reduction in antibiotic consumption per 1,000 admissions.
National	Improving services for people with mental health needs who present to Emergency Department (ED)	In 2017/18 reduce by 20% the number of attendances to ED for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.
National	Personalised Care and Support Planning	Embed personalised care and support planning for people with long-term conditions. In 2017/18 agree/put in place systems and processes to ensure that the relevant patient population can be identified, workforce trained and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.

Commissioned by	Scheme	Indicators
National	Proactive and Safe Discharge	A) Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories.
		B) Emergency Care Data Set (ECDS) – Type 1 or 2 A & E providers to have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017.
		C) Increase proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days by 2.5% across Q3/4 2017/18 from baseline Q3/4 2016/17 OR an increase to 47.5%.
National	Offering advice and guidance	By April 2019, 75% of General Practitioner (GP) referrals are made to elective outpatient specialties which provide access to A & G services.
NHS England Local Area Team	Breast Screening	Strengthening Patient and Public Participation.
Specialised Commissioning	Hospital Pharmacy Transformation and Medicines Optimisation	Trigger 1 – Faster adoption of prioritised best value medicines as they become available
		Trigger 2 – Improving drugs (Myelodysplastic Syndrome (MDS) data quality
		Trigger 3 – Cost effective dispensing routes
		Trigger 4 – Improving data quality associated with outcome databases (SACT and IVIg)
Specialised Commissioning	Nationally Standardised Dose Banding Adult Intravenous SACT	It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of SACT drugs in accordance with a nationally approved set of dose tables.
Specialised Commissioning	Neonatal Community Outreach Team	To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for critical care beds and to enable reduction in occupancy levels.
Specialised Commissioning	Improving HCV treatment pathways through ODN's	Supports the infrastructure, governance and partnership-working across healthcare providers working in HCV networks in their second and third years of operation to achieve the following outcomes: ■ Improvements in engagement of patients ■ The planned rollout, aligned to NICE guidance, of new clinical and cost effective treatments guidance to improve outcomes through Multi-disciplinary team treatment plans ■ Improved participation in clinical trials ■ Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments.

Further details of the agreed goals for 2017/18 and the following 12 months are available on the NHS England website www.england.nhs.uk/publication/cquin-indicator-specification/

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.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 17 to Mar 18 (most recent figures):	
Admitted Patient Care	157,924
Outpatient Care	650,901
Accident and Emergency Care	172,034

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

Performance for Apr 17 to Mar 18 (most recent figures):	
Admitted Patient Care	99.8%
Outpatient Care	99.9%
Accident and Emergency Care	99.0%

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

Performance for Apr 17 to Mar 18 (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 2017-18 for Information Quality and Records Management assessed using the Information Governance Toolkit is 81%. The overall score shows an achievement of at least level 2 compliance across the board and level 3 in some areas. This is compared to an overall score achieved for 2016-17 of 74% and 71% for the year 2015-16. This reflects the steady improvement for Information Governance within East Lancashire Hospitals NHS Trust. The Information Governance Toolkit for 2018-19 has been radically changed to reflect an increased emphasis on cyber security and therefore the scores for 2018-19 will not be comparable but the Trust will aim to maintain an a upward trajectory of improvements in Information management and security.

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.

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 2017-18, 1236 Patient Advice Liaison Services (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 343 formal complaints during this period. Complainants are contacted as soon as possibly following raising their concerns.

The current policy ensures that complainants are kept informed and updated and that greater compassion is evident within responses. Further training is being 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 2017-2018, 11 complaints were referred to the Ombudsman, 4 were not upheld, 3 were partly upheld, 1 was withdrawn and 3 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	(Q16+) 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	84%
KF26	(Q15c) In the past 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	16%

Part Three
Quality Achievements, Statutory Statements and Auditor's Report

3.1 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 (NEWS 2) has been implemented in all admission and inpatient adult areas and in some community settings. Paediatrics are using an age appropriate Early Warning Score (EWS) and maternity have launched their updated version too. A Deteriorating Patient Score Card has been developed and is now available to provide information to assist with identifying areas at higher risk, however this requires further development around the presentation of informatics to staff.
2	Discharge	Implement a Trust-wide approach to support safe discharge to continuing care	Regular assurance report to the Model Ward Steering Group	Diagnostic phase currently on-going. Findings suggest a wide variety of initiatives are on-going across the Trust which require co-ordination. Process mapping sessions are scheduled to identify key themes which will be pulled together into a driver diagram to initiate tests of change on the Model Wards.
3	Safe Transfers of Care	Implement a Trust-wide approach to improve staff and patient handover between care areas and organisations	Regular assurance report to the Model Ward Steering Group	Diagnostic phase currently on-going. Findings suggest a wide variety of initiatives are on-going across the Trust which require co-ordination. Process mapping sessions are scheduled to identify key themes which will be pulled together into a driver diagram to initiate tests of change on the Model Wards.

3.2 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 March 2018
Falls Reduction To reduce the number of inpatient falls across all inpatient areas at East Lancashire Hospitals NHS Trust by 15% by August 2017	All project documentation in place. Collaborative completed and 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 now at full spread in ELHT, monitored via Ward Assurance Checklists, Nursing Assessment Performance Framework (NAPFs) and the Falls Prevention Steering Group. 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. The Falls Prevention Steering Group recommenced in June 2017 to continuously review and act on incidents relating to slips, trips and falls. Falls continue to be low or on a downward trend and monthly rolling trends are shared with wards. Having achieved the original aim the Falls Prevention Steering Group has reconsidered a new target – see 'The Future' section.

Aim	Key Achievements to 31 March 2018
Deteriorating Patient Improve the recognition and response to acutely deteriorating patients with a resultant decrease in unexpected cardiac arrests by 50% by January 2018 To improve the recognition and timely management of sepsis in the emergency department and acute admissions unit 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	Monthly Deteriorating Patient Steering group held. All failure to meet CQUIN sepsis time to antibiotics targets now reported by way of Datix, the Trust's incident reporting system. Fluid Balance Standard Operating Procedure agreed. The fluid balance chart has been redesigned and now in use in adult inpatient areas with regular monitoring of compliance in place which will allow us to build on the improvement work. Acute Kidney Injury (AKI) data is now available on a monthly basis, this is shared with divisions to look at how we improve care and prevent deterioration of AKI for our patients. AKI bundle compliance and actual care is collated by our audit team to aid quality improvement with our high-risk patients. Following new NICE guidance for sepsis all the sepsis bundles across the Trust are now updated and in use. Sepsis bundle compliance tool and actual care delivered based upon NICE guidance is collated by our audit team. This is predominantly around the Emergency Department to aid quality improvement as this is where the highest proportion of patients with high-risk sepsis are identified. Incident reporting via Datix with reviews is a newly implemented process for cardiac arrests. An education programme is underway to ensure real time cardiac arrest data is inputted.
Safer Surgery 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 January 2018	Quality checks of the Brief, Debrief and WHO Safety Checklist. Standardisation of the WHO Checklist across sites. Brief/Debrief forms have been standardised across sites. 10,000 feet has been rolled out to all theatres. Policy reviews to ensure relevant and up-to-date – Swab Count policy; 5 Steps to Safer Surgery policy; Site Marking policy. Brief Boards are being trialled in theatre 4.

Aim	Key Achievements to 31 March 2018
Still Births Reduce the number of avoidable still births by increasing the detection rates of Foetal Growth Restriction and reduce the harm caused to babies during term labour by end Dec 17	Implementation of Placenta Clinic to detecting growth restrictions during pregnancy. Results from an eight-month audit has shown that stillbirth rate at the Trust is at its lowest level for years, seeing a 20% decrease since the clinic commenced and a huge reduction in the number of babies born with undiagnosed growth problems. Detection rates for foetal growth restriction has gone from approximately 50% to 98%. ELHT is currently one of only two Trusts in the North West to offer this service to high risk mothers. The clinic sees around 100 women a month, performing around 1200 scans a year. Development of ELHT Maternity Services Clinical Guideline 68 version 2.0: Detection and Management of Foetal Growth Restriction (2017), ELHT Maternity Services Clinical Guideline 74 version 1.0: Reduced or Changed Foetal Movements (2017) and ELHT Maternity Services Clinical Guideline 5 version 5.0: Antenatal auscultation and electronic foetal monitoring (2017) for clarity.
Hospital Acquired Venous Thromboembolisms (HAVTE) Reduce number of avoidable HAVTEs by 5% by April 2018	Prompt to Protect uses a wide approach of promoting no blame culture, prompting colleagues to quickly identify actions/patients who might need isolation/intervention, monitoring lines & promoting safety. Change package developed and wards have been asked to come forward to be part of the spread plan. Early adopters are being targeted first and there is a plan of action in place for the Infection Control Team to work on spreading and supporting the embedding of the changes. In 2017/18, AMU A, C2, C5, C9, C11, C14A/B, C18 and Rakehead completed the programme – all made improvements in hand hygiene, environment and safety culture on the ward.
Hospital Acquired Infections Prompt To Protect – To improve the rates of hand hygiene across the Trust (all areas) by 20%	Prompt to Protect uses a wide approach of promoting no blame culture, prompting colleagues to quickly identify actions/patients who might need isolation/intervention, monitoring lines & promoting safety. Change package developed and wards have been asked to come forward to be part of the spread plan. Early adopters are being targeted first and there is a plan of action in place for the Infection Control Team to work on spreading and supporting the embedding of the changes. In 2017/18, AMU A, C2, C5, C9, C11, C14A/B, C18 and Rakehead completed the programme – all made improvements in hand hygiene, environment and safety culture on the ward.

Aim	Key Achievements to 31 March 2018
Nutrition & Hydration Reduce risk of patients becoming malnourished: 1) 95% of adults to be screened for malnutrition within 24 hours of admission 2) 95% patients re-screened for Malnutrition every 7 days	NHSI led Nutrition Collaborative commenced – 6 month programme. Initial phase will identify the barriers to screening and ensuring adequate nutrition for patients. Pilot wards identified. Gradual improvement achieved in the timeliness of Malnutrition Universal Screening Tool (MUST) completion. Investigation of errors in report identify when all nursing risk assessments are due by ward area with corrections made. MUST tool adapted for use with the Extramed system as part of the Trust replacement plan for Caradigm system.
Medication Errors Reduction of Medicines Omissions especially for critical medicines Reduction in dosing errors with Insulins	Development of a reporting dashboard to monitor and track medicines omissions through incident reporting. Improvement plan for reduction of Parkinsons drugs omissions. Peri-operative medicines management guidelines. Guidance on managing red flag drugs when the oral route is unavailable has been published and disseminated. Pilot sessions for Pharmacy support to Pre-operative assessment clinics – 23% of patients reviewed were on red flag medicines. Extension of Dedicated Ward Pharmacy system is demonstrating increasing performance in the Trust in for Medicines Reconciliation – 73% of all eligible admissions clinically checked by Pharmacist in Feb 2018.

The Future

Aim	Future Plan
To reduce the number of inpatient falls across all inpatient areas at East Lancs Hospitals NHS Trust by 20% by year 2020	**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.

<table>
<tr><th>Aim</th><th>Key Achievements to 31 March 2018</th></tr>
<tr><td>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 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)</td><td>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)
✓ Recognising and responding to deteriorating patients is one of the Trusts main Quality Improvement priorities for the Harm free Care programme.
✓ 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

The vast majority of our patients with high risk sepsis present in the Emergency Department, A lot of work has already been done in ED to improve our care for sepsis patients and East Lancashire have been recognised by NHS England as being one of the most improved Trusts for this. A sepsis collaborative in ED is planned for 2018 to look at applying a Quality Improvement methodology on how we can further improve the recognition and management of our septic patients.

Collaborative working with divisions looking at AKI incidences and severity, starting with high risk patient clinical areas first we aim to roll out an improvement programme to improve the timely care our AKI patients receive.

The collaborative work evidenced to improve care on AKI, fluid balance, sepsis and NEWS 2 will be published in a change package providing the rationale and methods to implement and embed the recommendations for improving recognition and response for the deteriorating patient.

To complement the work around prevention and recognition of the deteriorating patient an initiative to implement bedside nursing handovers has commenced. This is a patient safety initiative to improve the communication not only between nurses but their patients and families too. It means nurses will not passively receive information but will actively question staff and involve patients and review documentation. This will be a small project that feeds into the Model Ward work. The Model Ward is looking at ways to standardise best practice and reduce variance across the Trust to improve the safety and experience for our patients.</td></tr>
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<table>
<tr><th>Aim</th><th>Key Achievements to 31 March 2018</th></tr>
<tr><td>Reducing stillbirths forms part of the “Saving Babies Lives: Care Bundle for Reducing Stillbirth and Neonatal Death”</td><td>
Rationale
✓ Foetal 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 foetal 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 foetal 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 Foetal Growth Restriction (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% 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 foetal 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>
</table>

Aim	Key Achievements to 31 March 2018
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	**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 ■ 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.

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.

3.3 Achievement against National Quality Indicators

3.3.1 Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) was introduced by the Department of Health in 2011-12 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 trend data up to September 2017 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Rolling 12 months to Sep-17
East Lancashire NHS Trust SHMI Value	1.069
East Lancashire NHS Trust % of deaths with palliative care coding	31.5
East Lancashire NHS Trust SHMI banding	2 (as expected)
National SHMI	100
Best performing Trust SHMI	0.727
Worst performing Trust SHMI	1.247
Trust with highest % of deaths with palliative care coding	59.8
Trust with lowest % of deaths with palliative care coding	11.5

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

Our process requires that all deaths in alerting diagnostic groups, low risk deaths and a proportion of deaths following readmission are subject to a structured judgement 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. This will be supported by the introduction of systematic audit and performance management.

3.3.2 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	29.9%
National percentage of deaths with palliative care coding	31.5%
Trust with highest percentage of deaths with palliative care coding	59.8%
Trust with lowest percentage of deaths with palliative care coding	11.5%

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
- Introduction of the new Structured Judgement Review (SJR) methodology to review clinical care of patients who have died, to ensure risks identified, recorded, investigated, and key themes are identified and acted on in line with National guidance on Learning from Deaths
- 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.

3.3.3 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

From October 2017 NHS England has taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROMs collections as these are perceived to be delivering limited value, NHS England will continue with hip and knee surgery PROM collections.

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.

3.3.3.1 Groin Hernia Surgery

Groin Hernia Surgery	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18*
ELHT	54.6%	48.6%	56.3%	55.2%	53.5%	59.3%
National Average	50.2%	50.5%	50.7%	50.9%	51.3%	52.9%

3.3.3.2 Hip Replacement Surgery

Hip Replacement Surgery	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18*
ELHT	48.6%	87.4%	94.0%	92.0%	91.5%	Insufficient Data
National Average	57.2%	89.4%	89.5%	89.6%	89.1%	Insufficient Data

3.3.3.3 Knee Replacement Surgery

Knee Replacement Surgery	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18*
ELHT	89.5%	78.6%	84.5%	85.3%	83.4%	Insufficient Data
National Average	87.5%	81.4%	81.0%	81.6%	81.1%	Insufficient Data

3.3.3.4 Varicose Vein Surgery

Varicose Vein Surgery	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18*
ELHT	79.4%	59.1%	49.1%	56.3%	56.3%	55.6%
National Average	78.8%	51.9%	52.0%	52.6%	51.9%	54.7%

**Provisional data

Note: 2016-17** figures are provisional for Hip and Knee Replacement. All 2017-18* figures are provisional covering the period April to September 2017 (published February 2018). For 2017-18 Hip and Knee replacement surgery there is insufficient data both at a local and national level to chart improvement rates for these procedures and measures.

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.

3.3.4 Readmissions within 28 Days of Discharge

The following table sets out the Trust's performance during 2017-18 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 Health and Social Care Information Centre (HSCIC) do not provide data on readmissions at the level of detail required. Figures shown are as at 11 Apr 18.

All Ages	2013-14	2014-15	2015-16	2016-17	2017-18
Readmission Rate	8.40%	8.74%	8.79%	8.44%	7.90%
Age Band	**2013-14**	**2014-15**	**2015-16**	**2016-17**	
0-15	11.15%	11.22%	12.06%	11.36%	10.57%
16+	7.80%	8.19%	8.05%	7.86%	7.34%

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 7.90% which is below the Dr. Foster risk adjusted expected rate of 8.6% and has reduced on last year. Compared to local acute hospitals, the Trust is middle of the group and the rate is lower than the national rate of 8.6%.

- For the 0-15 age group, the rate is 10.57% which is higher than the expected rate of 9.7% and the national rate of 10.0%.
- For the 16+ age group the rate is 7.34% which is below the expected rate of 8.4% and better than the national rate of 8.3% 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 developed a detailed action plan of which the key focus was to reduce admissions to the hospital.

Key actions taken to date to manage readmission rate:

1. Introduction of 'common childhood illnesses' guides, 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 and has recently been set up as a mobile phone App.
2. Hot clinics have been set up, for urgent paediatric consultant input – as an alternative to admission or readmission. 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. This is in addition to Advice & Guidance processes.
4. Appointment of a second respiratory nurse specialist and epilepsy nurse specialist – to reduce readmissions for respiratory illness and epilepsy admissions.
5. The pathway has been improved for our key admission reason of respiratory care. Work is on-going in Primary Care and as part of multi-disciplinary pathway redesign.
6. A pilot of a Children's Hub – which is a multi-disciplinary community hub is on-going – which has shown initial reduction in admissions and need for secondary care interventions.
7. The Community Children's Nursing (CCN) service has been extended so that GPs can refer directly to the CCN rather than hospital for care. Previously referrals to the community team were only from hospital.
8. Open Access policy to our Observation Unit has 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.
9. Consultant presence in COAU extended until 10pm Monday-Friday – to support more senior decision making.

10. Extended Community Children's Nursing service to a longer day / 7 day service (was previously Mon-Fri 8am-6pm service).
11. Care pathways for croup, bronchiolitis, fever in under 5's and gastroenteritis established. An asthma pathway has also been developed in Emergency Department.
12. Discharge process tightened so that all discharges are reviewed at Consultant level.
13. From November – end March, additional consultant paediatricians were placed for twilight shifts in our Emergency Department and Urgent Care Centre (UCC) to deflect patients being admitted/readmitted. By placing senior decision making at the front door, the emergency pathway was altered in a safe and appropriate way.

3.3.5 Responsiveness to Personal Needs of Patients

The Picker Institute was commissioned by 81 Trusts nationally to undertake the Inpatient Survey 2017. A total of 1250 patients from East Lancashire Hospitals NHS Trust were sent a questionnaire. 1229 were eligible for the survey, of which 406 returned a completed questionnaire, giving a response rate of 33%. This survey has highlighted the many positive aspects of the patient experience:

- Overall: 84% rated care 7+ out of 10.
- Overall: treated with respect and dignity 83%
- Hospital: room or ward was very/fairly clean 96%
- Hospital: always had enough to drink 96%
- Care: always enough privacy when being examined or treated 92%

The tables below set out the Trust's performance in 2017 for inpatients:

The Trust has improved significantly on the following questions: Lower Scores are better		
	2016	**2017**
Hospital: did not always get enough help from staff to eat meals	47%	31%
Care: wanted to be more involved in decisions	52%	44%
Procedure: questions beforehand not fully answered	25%	17%
Discharge: did not always get enough support from health or social care professionals	46%	34%
Discharge: did not definitely know what would happen next with care after leaving hospital	54%	47%
The Trust has worsened significantly on the following questions: Lower Scores are better		
	2016	**2017**
The Trust has not worsened significantly on any questions this year		

The results were significantly better than the 'Picker Average' for the following questions: Lower Scores are better		
	Trust	**Average**
Discharge: did not always get enough support from health or social care professionals	34%	45%
The results were significantly worse than the 'Picker Average' for the following questions: Lower Scores are better		
	Trust	**Average**
A&E Department: not given enough privacy when being examined or treated	27%	21%
Admission: had to wait a long time to get a bed on ward	47%	34%
Hospital: bothered by noise at night from other patients	44%	38%
Hospital: food was fair or poor	44%	39%
Hospital: not always offered a choice of food	27%	20%
Doctors: talked in front of patients as if they were not there	27%	22%
Nurses: Sometimes, rarely or never enough on duty	45%	40%
Care: staff contradicted each other	36%	30%
Care: did not always have confidence in decisions made	32%	27%
Care: not enough or too much information given on condition or treatment	24%	19%
Care: staff did not do everything to help control pain	37%	29%
Overall: did not receive any information explaining how to complain	64%	57%

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 Frailty Care Programme which supports the re-design of services for frail older people across the Care Continuum.
- The Development of "Always Events" within the Trust based on feedback from patients about "what matters" to them.
- The launch 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.
- Development of a Trust-wide and divisional action plan to address the issues raised and which will be monitored by the Patient Experience Group.

3.3.6 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.

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

Your 2017/18 quarter 4 organisation score is 81%

Your organisation (n=1517)

(green)	Extremely likely/likely
(amber)	Neither likely nor unlikely
(red)	Unlikely/Extremely unlikely

The quarter 4 results of the staff friends and family test reflect that 81% of staff respondents would recommend the Trust as a place to receive care during the reporting period.

The Trust scored 3.86 for the overall staff engagement score on the 2017 national survey which is significantly above the national average of 3.79 for UK acute Trusts in 2017. The national staff survey also highlighted that ELHT remains in the best 20% for staff satisfaction with the quality of work and care they are able to deliver outlined in key finding 2 of the National Staff Survey.

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 employee engagement sponsor group chaired by the Chief Executive to ensure the Trust is an exemplar of best practice in this field.

3.3.7 Friends and Family Test Results (Inpatients and 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, Emergency Department attenders, and also how these results compare with other Trust's nationally for the period April 2017 to March 2018.

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Inpatient % patient response rate												
ELHT	49	48	43	50	48	51	50	48	52	49	46	48
Nat Ave	26	26	26	26	26	25	25	25.5	22	23	24.5	23
A&E % patient response rate												
ELHT	21	20	17	19	17	16	20	19	20	20	21	22
Nat Ave	12.5	12.5	13	13	14	12.5	13	13	12	12	13	12.8
Combined inpatient and A&E patient response rate												
ELHT	32	31	27	30	29	29	32	31	32	31	31	32
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 2017 to March 2018.

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Inpatient % recommend												
ELHT	98	98	98	98	98	98	98	98	98	99	99	98
Nat Ave	96	96	96	96	96	96	96	96	96	96	96	96
A&E % recommend												
ELHT	76	78	78	75	81	83	83	81	82	83	80	82
Nat Ave	87	87	88	86	87	87	87	87	85	86	85	84
Combined inpatient and A&E recommend												
ELHT	89	91	91	89	91	93	92	92	92	92	91	91
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 Short Message Service (SMS) text messaging the response rates for ED attenders increased and exceeds the national average.

The Trust also receives 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.

3.3.8 Venous Thromboembolism (VTE) 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 (2017-18) Data submitted from Trust to NHS UNIFY system. Data access available at: https://improvement.nhs.uk/resources/vte-risk-assessment-data-q3-201718/ VTE data collection responsibility has moved to NHS Improvement from April 2017		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year to Date
East Lancashire NHS Trust	Number of VTE assessed admissions*	30,218	29,880	30,723	30,599	121,420
	Total admissions	30,525	30,237	31,175	30,841	122,778
	% of admitted patients risk assessed for VTE(rounded to nearest decimal)	98.99%	98.82%	98.55%	99.22%	98.89%
National	Number of VTE assessed admissions	3,527,950	3,534,454	3,558,413	3,407,417	14'028'234
	Total admissions	3,705,992	3,710,563	3,731,670	3,579,797	14,728,022
	% of admitted patients risk assessed for VTE (rounded to nearest decimal)	95.20%	95.25%	95.36%	95.18%	95.24%
Best performing Trust	(The Trusts reporting 100% all have small numbers of admissions)	4 NHS Trusts at 100%	1 NHS Trust at 100%	1 NHS Trust at 100%	2 NHS Trust at 100%	**
Worst performing Trust		79.84%	71.8 %	76.08%	67.04%	**

**Includes agreed exemption cohort of patients in this category*
***Information not available at the time of publication of Quality Account June 2018*

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

- Systems and processes are in place at ELHT for risk assessing all appropriate patients utilizing the national VTE risk 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 just above 95% in 2012, to above 97% since July 2013, above 97.5% since July 2014, above 98% since July 2016 and currently above 98.5% across the first three quarters of 2017/18.

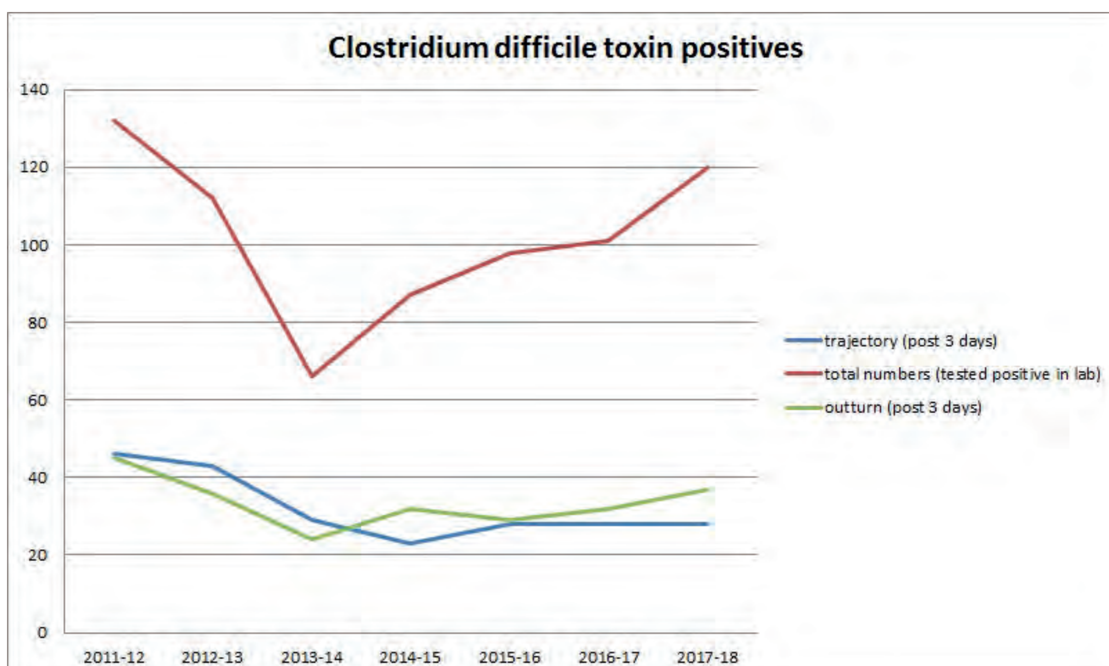
East Lancashire Hospitals NHS Trust is taking the following action to improve performance, and so the quality of its services:

- 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 cross organisational clinical audit to ensure effective compliance with VTE assessment.
- VTE Quality Improvement Faculty developed in 2016 leads on focused quality improvement projects to enhance the robustness of the VTE risk assessment on admission.
- Trust has invested in developing an electronic VTE risk assessment tool through Hospedia system based on the National Tool and this development phase is now complete with further initial testing phase completed in April 2018. Pilot phase of implementation of the electronic VTE tool is anticipated to commence shortly by June 2018.
- Trust VTE prevention Information leaflet for patients has been updated again to enhance patient awareness regarding VTE and prevention and patient involvement in VTE prevention strategies including Risk assessment on admission.

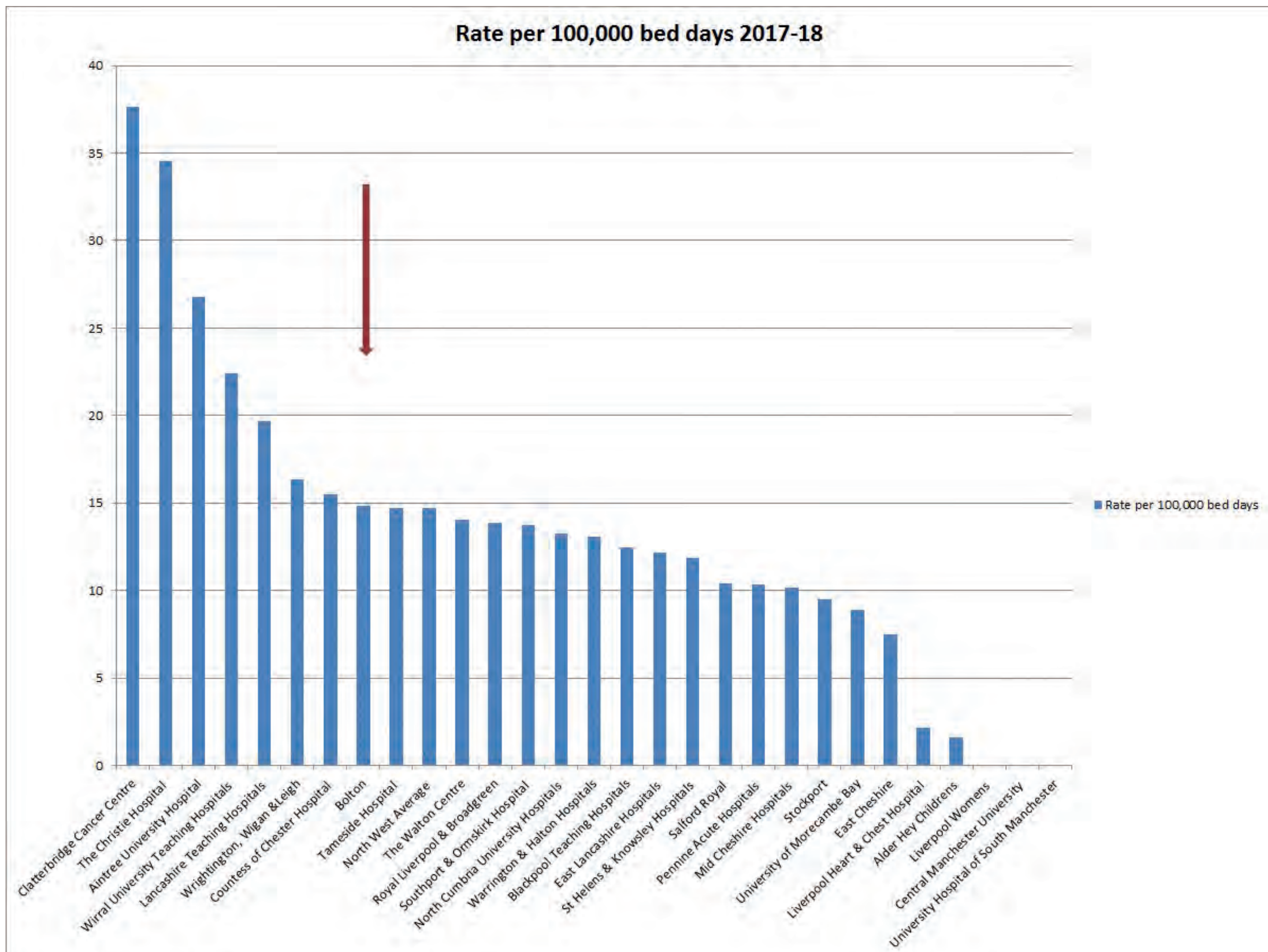
3.3.9 Clostridium Difficile Rates

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 – 2017/18



North West Clostridium difficile rates per 100,000 bed days March 2017 to Feb 2018



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.

3.3.10 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 weekly basis. The NRLS publishes Patient Safety Incident Reports by organisation biannually showing comparative data with other large acute Trusts. East Lancashire Hospitals NHS Teaching Trust 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.

	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	Oct 2016 to March 2017	April 2017 to Sept 2017
Patient safety incidents per 100 admissions							
ELHT number reported	8190	7563	6732	6579	7010	7122	7032
ELHT reporting rate	55.7	48.2	44.18	42.05	44.9	44.8	45.5
Cluster average number	4196	5458	4647	4818	4995	5122	5226
Cluster average reporting rate	35.9	31.2	39	39.6	40.7	41.1	43
Minimum value for cluster	35	443	1559	1499	1485	1301	1133
Maximum value for cluster	12020	12784	12080	11998	13485	14506	15228
Patient safety incidents resulting in severe harm							
ELHT number reported	29	28	18	16	13	8	14
ELHT % of incidents	0.4	0.4	0.3	0.2	0.2	0.1	0.2
Cluster average number	15.5	17.3	15	13.7	13.4	13.8	13
Cluster average reporting rate	0.9	0.4	0.4	0.3	0.3	0.3	0.3
Minimum value for cluster	0	1	1	0	0	0	0
Maximum value for cluster	74	128	89	85	75	67	92
Total incidents across cluster	2168	2373	2052	1862	1826	1872	1821
Cluster % of incidents	0.4	0.4	0.3	0.3	0.3	0.3	0.3
Patient safety incidents resulting in death							
ELHT number reported	3	6	8	8	6	8	2
ELHT % of incidents	0	0.1	0.1	0.1	0.1	0.1	0
Cluster average number	4.9	5.2	5	5.7	5	5.5	5
Cluster average reporting rate	0.2	0.1	0.1	0.1	0.1	0.1	0.1
Minimum value for cluster	0	0	0	0	0	0	0
Maximum value for cluster	27	24	22	37	36	31	29
Total incidents across cluster	683	716	665	780	690	751	661
Cluster % of incidents	0.1	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 from the previous 3 years. However, we have seen a gradual increase since April 2016 and this is due to staff awareness and positive encouragement around the importance of reporting all levels of incidents across the Trust so that learning can be shared. 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. The introduction of the Serious Incident Requiring Investigation (SIRI) 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.

The 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
- Linking of incidents with inquests to ensure appropriate escalation and investigation is carried out
- Daily triage of incidents that are reported to review the grading and to ensure an appropriate level of investigation is carried out.

3.3.11 Never Events

A Never Event is a serious incident that is recognised as being entirely preventable if all the correct guidance is followed and all our systems work to create a safe situation for patients and staff. Over 2017-18 the Trust has reported 7 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Wrong Site Surgery	4
Wrong Site Block	1
Retained Foreign Body	1
Misplaced Naso Or Oro-gastic Tube	1

The never events have all involved different teams, in different settings, at different times. Each one has been investigated and in all incidents we found important learning that has been shared with staff across the Trust, with our commissioners and the patient and/or family.

- The Trust has produced a special edition of the Trusts Share to Care bulletin on the outcome and learning of the Never Events
- Outcome of investigations and action plans discussed at teams Share to Care meetings
- Posters designed, developed and displayed around awareness of system failures
- Detailed action plan for each incident own by divisions, updated and assurance provided to Executive Management Team on a weekly basis
- Outcome of investigation is shared with the patient and/or family members

Learning from Never Event Incidents

On seven occasions within 2017-18 the Trust has not met the expectations of Safe, Personal and Effective care in regards to Never Events. The Trust has identified a number of key changes in systems and processes within teams and across the organisation. These include:

- Updated WHO (World Health Organisation) pre operation checklist with the introduction of mystery-shopper style spot checks in theatres
- New WHO checklist for invasive biopsy and imaging has been introduced
- The Trust has updated our Site Marking Policy for surgery and its Specimen Management Policy
- Introduction of 10'000 feet that empowers all theatre staff irrespective of grade or seniority, to call 'Ten Thousand Feet' to reduce the noise level and increase concentration if they feel safety is potentially being compromised
- Introduction of 'ID Me' campaign to minimize the risk of error if staff are not meticulous about checking patient's ID
- White-boards in theatres are to be amended to include staff roles within the theatre
- Naso-gastric care bundle to emphasise a restriction on x-rays to confirm replacement after 4pm

3.3.12 Learning from Deaths

Since 1st December 2017 East Lancashire Hospitals NHS Trust has been using the Structured Judgement Review (SJR) methodology to review clinical care of patients who have died. This methodology attributes a score to particular elements of care and an overall score for patient's care. A score of 1 or 2 identifies a concern that care was poor and a secondary review process (based on SJR methodology) is triggered to determine whether or not this poor care contributed to the patient's death. If this is felt to be the case a full Root Cause Analysis (RCA) of the case is undertaken and presented to the Trust's Serious Incident Requiring Investigation (SIRI) Panel.

Prior to November 2017 the process for reviewing mortality involved all deaths undergoing a Primary Mortality Review with those meeting agreed criteria and undergoing a more detailed Secondary Mortality Review.

This process was superseded with the adoption of the Learning from Deaths recommendations with a more focused approach and more focused use of the limited reviewer resource.

	Year	2017-18
Total number of deaths 2017-2018	Q1	450
	Q2	400
	Q3	496
	Q4	586
Total		**1932**

		PMR	SMR	SJR
Number of SJR's/undertaken SMR's	Q1	191	5	0
	Q2	134	4	0
	Q3	94	19	33
	Q4	0	2	42
Total		**419**	**30**	**75**

		No of Cases	%
Number of cases and % of total number where issues with care may have contributed to death (SJR score 1 or 2 or Hogan score of 5 or 6)	Q1		
	Q2		
	Q3	2 of 33	6%
	Q4	0 of 42	0%
Total		**2 of 75**	**3%**

The learning points from SJR reviews are collated into areas of good practice and also areas for improvement.

Areas of learning the trust have identified as requiring improvement are:

i. Fluid balance

ii. Management of Acute Kidney Injury

iii. Timeliness of antibiotic administration (sepsis patients)

iv. Recognition and response to the deteriorating patient

v. Decision making at the end of life

These themes are collated with learning from other clinical governance functions/claims, complaints, incident reviews) and help to inform the Harms Reduction and Quality Improvement Projects. Section 3.1.2 and 3.1.1 of the Quality Account describes what achievements have been made against areas of learning and what future improvement plans the Trust will be focusing on in 2018/19.

3.3.13 Seven Day Service Meeting the Clinical standards

East Lancashire Hospital Trust recorded the following results in the Autumn 2017 National audit of the 4 priority 7 day standards:

Standard 2: All emergency admissions have a thorough clinical assessment by suitable consultant as soon as possible, at the latest within 14 hours from admission.

- Seventy one percent of emergency admissions were assessed by a suitable consultant within 14 hours of admission.

	5 patients recorded as being seen by Consultant within 14 hours of admission
Spring 2017	52%
Autumn 2017	71%

The other standards were not included within the audit.

Standard 5: Hospital inpatients have scheduled seven-day access to diagnostic services, within 1 hour for critical patients, within 12 hours for urgent patients, within 24 hours for non-urgent patients.

- East Lancashire Hospitals is fully compliant with this standard.

Standard 6: Hospital inpatients have timely 24 hour access, seven days a week, to consultant directed interventions including Critical care, Interventional radiology, Interventional endoscopy, Emergency general surgery.

- East Lancashire Hospitals is fully compliant with this standard apart from interventional radiology for 8 hours of the night. Informal networked arrangements are in place for this period.

Standard 8: All patients with high dependency needs should be reviewed twice daily by a Consultant. All other acute inpatients should be reviewed once every 24 hours seven days per week by a consultant, unless agreed and documented that they would not benefit from this.

- This standard is currently being audited. It was last audited in March 2017 when 87% of patients received daily consultant review, 50% of patients requiring twice daily consultant review had that documented.

The following changes have been implemented that will increase the number of patients receiving consultant review within 14 hours:

- Increased consultant acute physician input to Acute Medical Units from 8am each morning.
- Evening board round in surgical and children's admission units.
- Updated protocols of care in Urology.
- Real-time tracking for patients of time from admission to consultant review.

In addition a formal arrangement for overnight interventional radiology is being finalised with Lancashire Teaching Hospitals NHS Foundation Trust.

The Trust is also progressing plans for increased consultant input into emergency surgical care.

3.4 Other Quality Achievements

3.4.1 Ten Thousand Feet

'Ten Thousand Feet' is a staff-led service improvement initiative that is now in use in theatres cross ELHT. Initially created by Gibbs and Smith (2016), ELHT is the first Trust in the UK to officially employ this strategy. Derived from the aviation industry, it empowers all theatre staff irrespective of grade or seniority, to call 'Ten Thousand Feet' to reduce the noise level and increase concentration if they feel safety is potentially being compromised. When called it enables all personnel present to focus entirely on their essential operational activities and avoid non-essential conversations.

3.4.2 Unicef Baby Friendly Gold Standard

East Lancashire has become the first area in the country to receive the prestigious Baby Friendly Initiative 'Gold' standard from the United Nations Children's Fund (Unicef) UK. This accolade recognises the excellent advice and support families with new babies in East Lancashire receive around nurturing and feeding their babies.

3.4.3 Placenta Clinic

ELHT's Placenta Clinic was shortlisted for an iNetwork Healthcare Innovation Award in 2017 and a Patient Safety Award in 2018 for their exceptional work in detecting growth restrictions during pregnancy.

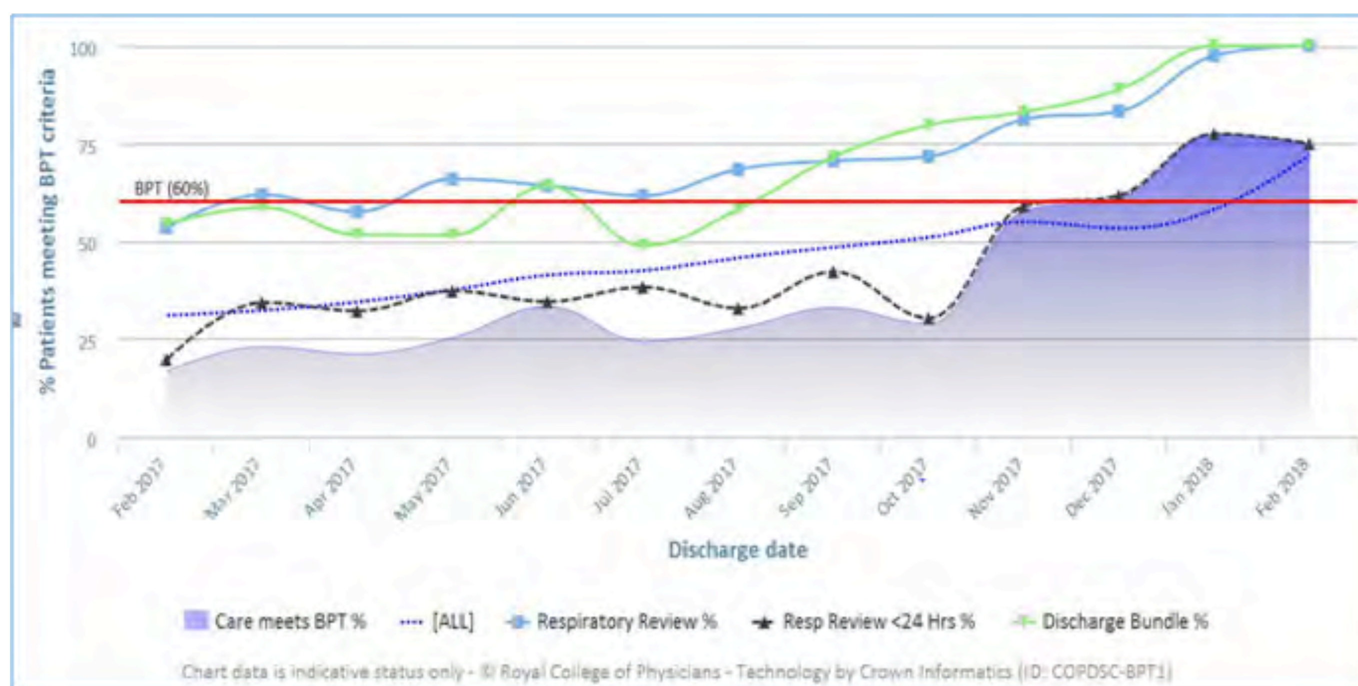
The clinic was established by Mr Martin Maher, Consultant Obstetrician, with the aim to reduce stillbirths by diagnosing growth restrictions which can be caused by problems with the placenta. Careful surveillance helps consultants and midwives time a small baby's delivery perfectly so that when they enter the world they are given the best opportunity to grow to be healthy happy babies.

Results from an eight-month audit has shown that stillbirth rate at the Trust is at its lowest level for years, seeing a 20% decrease since the clinic commenced and a huge reduction in the number of babies born with undiagnosed growth problems. Detection rates for foetal growth restriction has gone from approximately 50% to 98%.

ELHT is currently one of only two Trusts in the North West to offer this service to high risk mothers. The clinic sees around 100 women a month, performing around 1200 scans a year.

3.4.4 Respiratory Assessment Unit (RAU)

In October 2017 the RAU opened with the purpose to streamline respiratory assessment and treatment for ambulatory patients. In the first 6 months over 1300 patients were treated and 74% went home the same day. Analysis of the first 3 months data shows over 2000 bed days saved for the trust, compared with the similar 3 month period the year before, along with an improvement in delivering best practice care for COPD from 17% to 61% across the entire trust.



3.4.5 Red to Green

Multi-disciplinary teams across the Trust are working together to improve the patient experience and reduce the length of time people spend in hospital. Ward B4 was the first to implement Red2Green in August 2017 and with a subsequent roll-out programme for all wards in place.

The concept of a 'Red2Green' approach is based on a simple method used to reduce unnecessary waiting for patients. Each day a patient spends in hospital should contribute towards their recovery and discharge. Days where no recovery-enhancing treatment is given are classed as 'red days', whereas days that add value and move a patient closer to discharge are 'green days'.

3.4.6 PJ Paralysis

'PJ paralysis' is a national campaign that the Trust has embraced which focuses on encouraging patients to be more mobile by changing out of their pyjamas into day-time clothes. Every day a patient spends in bed in their pyjamas results in muscle wastage. This means the patient takes longer to recover and cannot be discharged as early as they could have been.

3.4.7 Mental Health in our care

An initiative to improve the experience of mental health patients in our care, in particular in Acute Medical Unit (AMU) A, AMU B and ED, has been led by Rev David Anderson, Hospital Chaplain and Registered Nurse and supported by the Quality Improvement Team. A series of educational workshops with staff, improved links with third sector organisations and partners, and greater awareness about the type/nature of support available through accurate and relevant patient information has supported an improvement in patient safety and patient experience, and reduced readmission rates.

3.4.8 PLACE Assessment

Excellent marks for food, cleanliness, environment and other standards have been awarded to the Trust in the latest Patient-Led Assessment of the Care Environment (PLACE) report. Our food rating is now 81.94%, a significant rise on the previous year's score of 77.74%. The increase is due largely to commitments made in the Trust's food and drinks strategy which has improved the nutritional value of food served at each of our hospitals. The Trust's PLACE ratings also saw improved scores for disability domain (87.15%) and dementia-friendly domain (84.95%), both of which scored well above the national averages. In addition, our assessments for cleanliness and condition (95.46%) and appearance and maintenance (92.69%) remain impressively high.

3.4.9 Refer-to-Pharmacy

ELHT innovated the world's first fully integrated hospital-to-Pharmacy services referral system which went live in October 2015 and continued to demonstrate excellent results. Refer-to-Pharmacy allows the hospital Pharmacy Team to refer patients to their community pharmacist or to the domiciliary medicines support team for a home visit. Patients then receive further support getting the best from their medicines with the aim of improving their adherence, which results in better health outcomes and keeps them healthy at home. Since March 2017 we have also been making hospital admission notifications for care home residents and blister pack users to prevent unnecessary dispensing and medicines waste whilst a person is in hospital. We have started asking new questions of community pharmacists to understand more about the outcomes of their patient interactions.

Results include:

- **6,714 patient referrals** made from ELHT to community pharmacies.
- **127 patients prevented from harm** through identification of unintentional GP prescribing errors.
- **187 hours saved** by community pharmacies not dispensing prescriptions.
- **546 medicines** (@ £10/item) not dispensed and wasted.

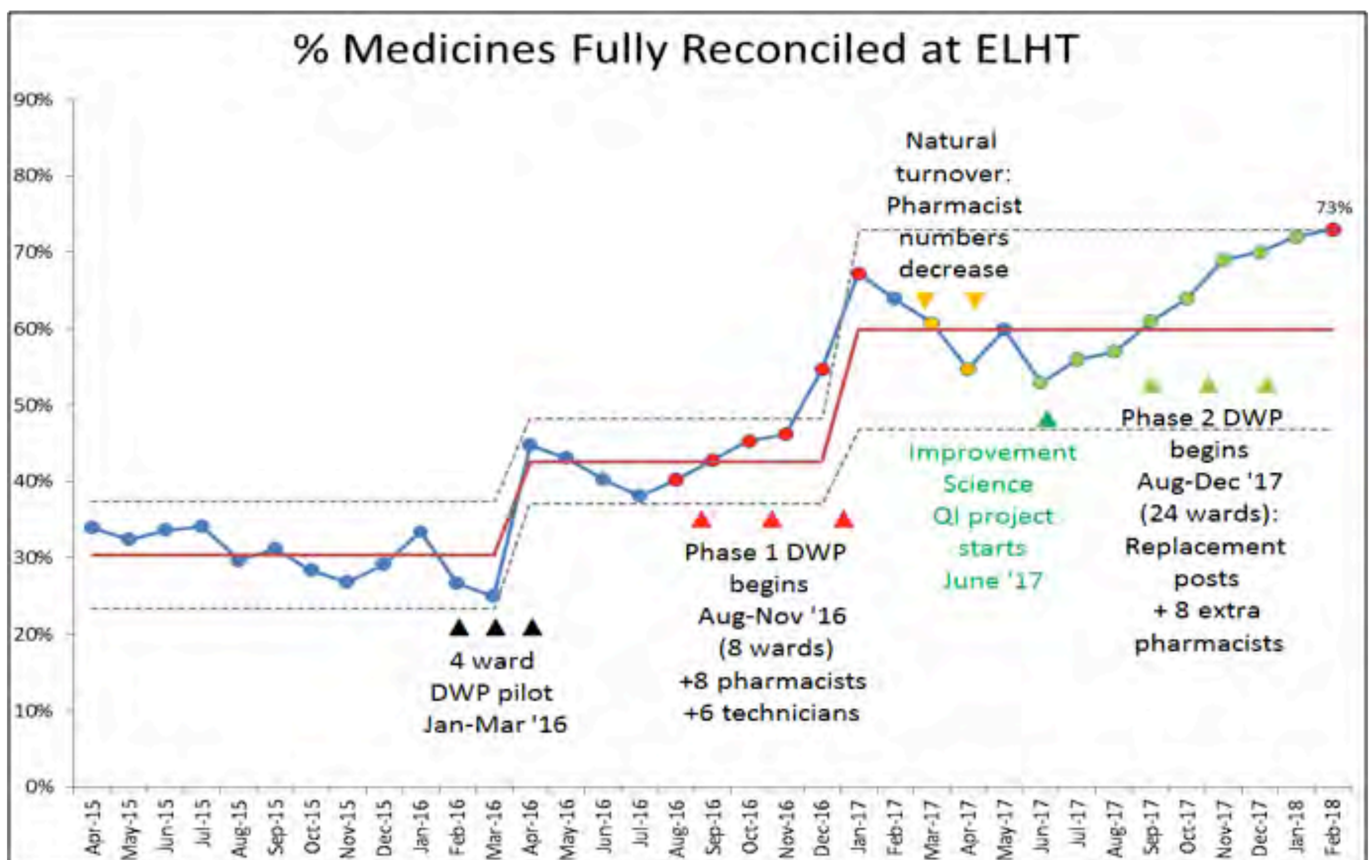
3.4.10 Dedicated Ward Pharmacy

Dedicated Ward Pharmacy (DWP) is an ELHT workforce transformation and quality improvement project. The aim of this project is to improve the proportion of accurate medicines reconciliations to 90% by May 2018 by having a pharmacist and a pharmacy technician dedicated to a single ward all day, Monday-Friday.

Results to date have shown patients getting better faster, leaving hospital sooner and a reduction in re-admission rates. Interventions recorded at the time revealed big improvements in medicines safety, patient experience and fewer medicines being dispensed.

The run chart below shows the percentage of fully reconciled medicines has increased significantly since the project commenced, and also highlights the interventions that have taken place at various points in time, and their subsequent impact.

DWP was shortlisted for a Patient Safety Award in 2018.



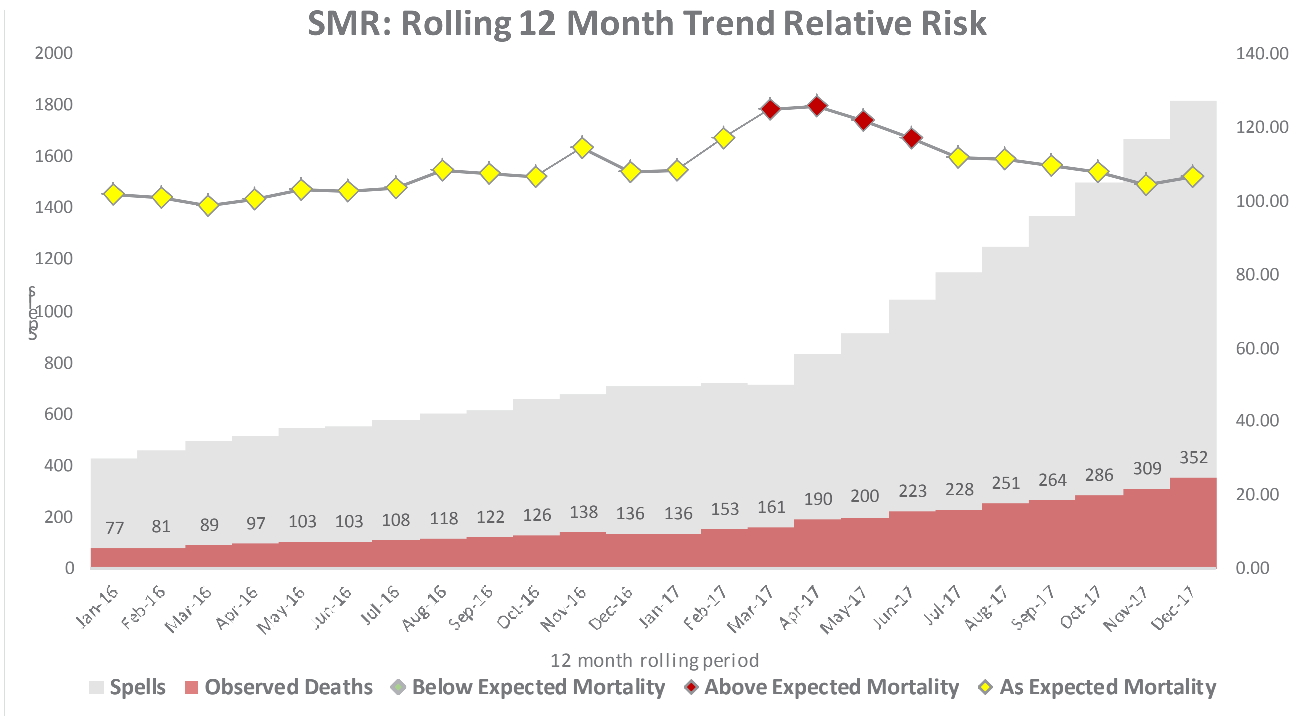
3.4.11 'Getting It Right First Time' (GIRFT)

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.

3.4.12 Sepsis Care Bundle

East Lancashire has been recognised by NHS England as being one of the most improved Trusts for timely recognition and treatment of sepsis. Our monthly monitoring of bundle compliance with the sepsis 6 interventions to improve the chance of survival also demonstrates high standards of timely care for antibiotic delivery is regularly achieved.

Sepsis (N=50)	January 2018 (n=50)		
	Num	Den	%
Early warning Score within 60 mins	50	50	100.00
Oxygen Commenced within 60 mins (NEW MEASURE from AUGUST) [2]	32	32	100.00
Blood Cultures Obtained within 60 mins (NEW MEASURE from AUGUST) [2]	49	50	98.00
Broad spectrum antibiotics given within 60 mins. (High Risk)	36	36	100.00
Antibiotics reviewed within 72 hours (NEW MEASURE added from JULY) [1]	50	50	100.00
IV Fluids Commenced within 60 mins (NEW MEASURE from AUGUST) [2]	48	50	96.00
Initial Lactate Obtained within 60 mins (NEW MEASURE from AUGUST) [2]	47	50	94.00
Fluid balance commenced where Sepsis was diagnosed (NEW MEASURE from JANUARY 2018) [3]	20	50	40.00
Composite process Score	**332**	**368**	**90.21**



3.4.13 Flu Vaccinations

Staff at the Trust have shown their commitment to patient safety with over 92% of them receiving flu vaccinations giving the Trust its highest uptake rate ever and placing it as the top Acute Trust in the country.

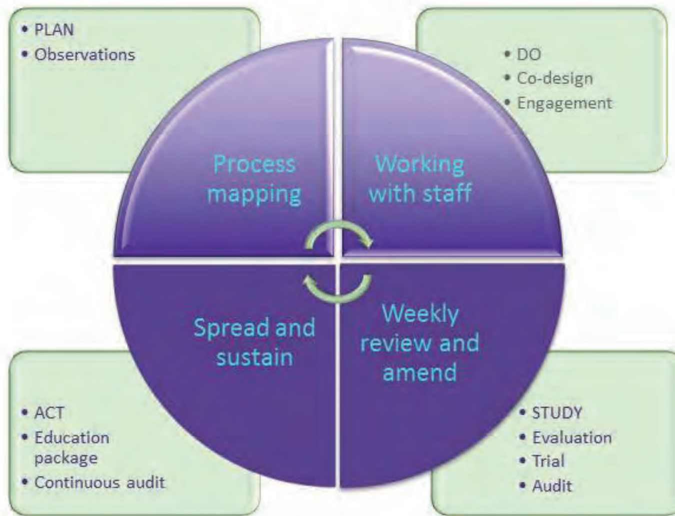
3.4.14 Fluid Balance

There has been a huge drive across the Trust over the last 12 months to engage staff in the fluid balance work and the importance of accurate fluid balance charting. Ward staff have been involved with the redesign of the chart and the development of an audit tool. This has been trialled on three wards where a significant increase in fluid balance charting has been demonstrated. A minimum of 27% up to 100% increase in compliance of the elements being monitored. In addition to support the education, a change package has been developed and rolled out across the trust.

The Problem:

2016:

- Case note reviews demonstrating poor fluid balance documentation
- Incident reviews demonstrating poor fluid balance documentation
- No formal education
- No guidance 'Who?', 'When'
- No accountability
- No compliance monitoring
- Nationally recognised issue



The Solution:

Total Balance =

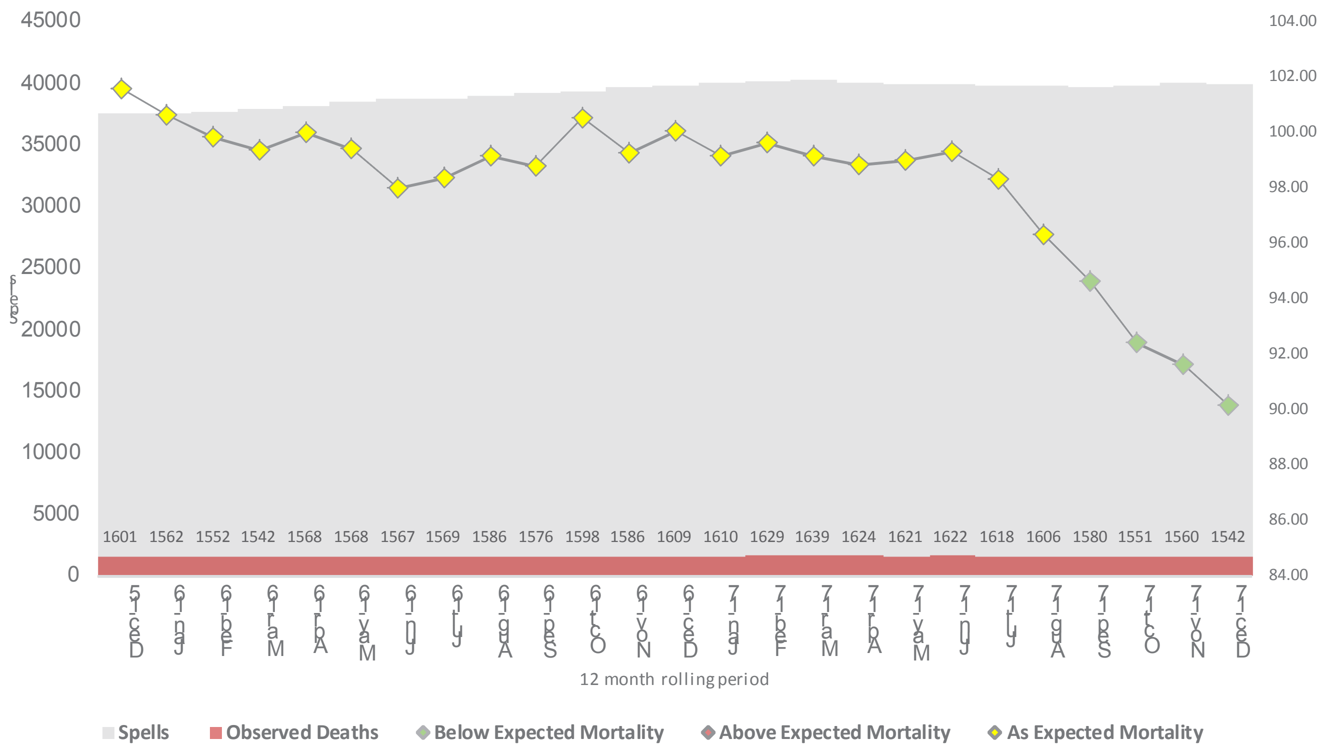
Fluid Balance Chart

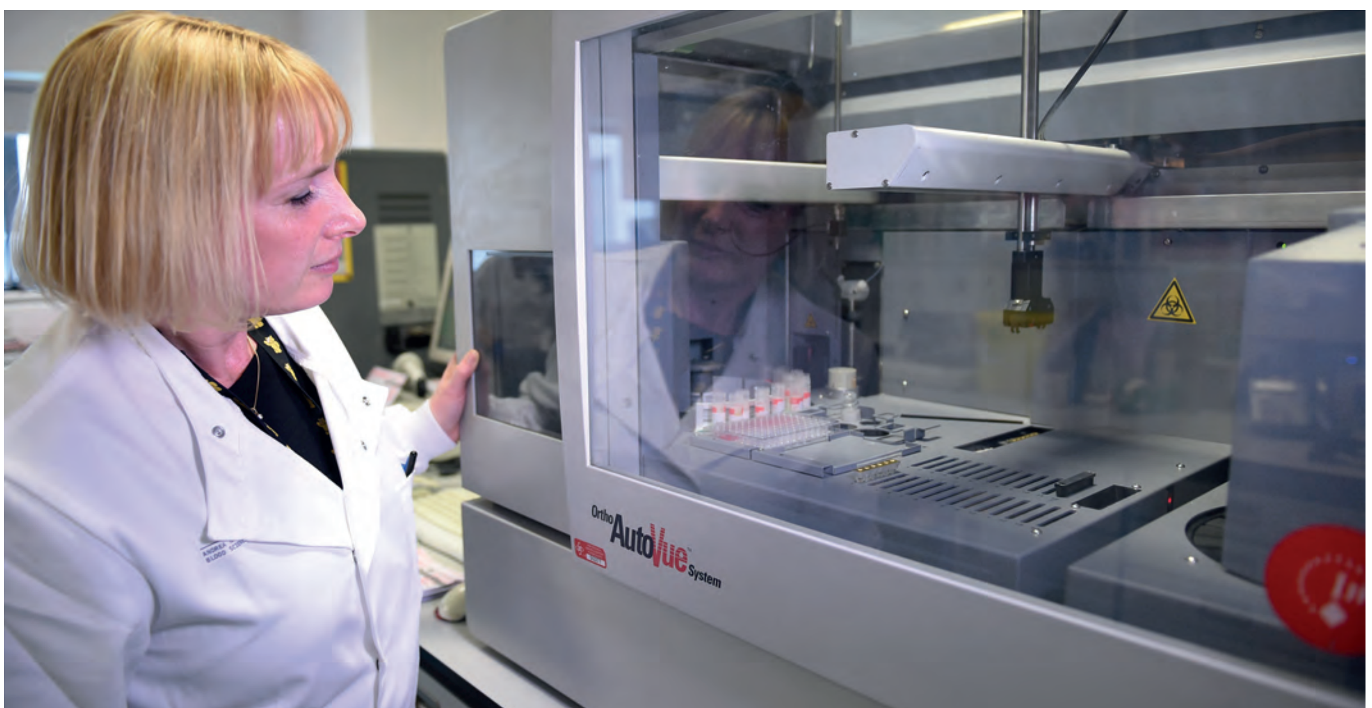
Total Balance =

3.4.15 Falling Mortality (Dr Foster)

Hospital Standardised Mortality Ratio (HSMR) has continued to demonstrate an improved picture. There are no outlying diagnostic groups within our HSMR dataset. Our mortality steering group oversees all of our mortality data and identifies all groups where further detailed analysis and action planning is required. As a result of this work the number of outlying groups within all of the mortality datasets has decreased significantly.

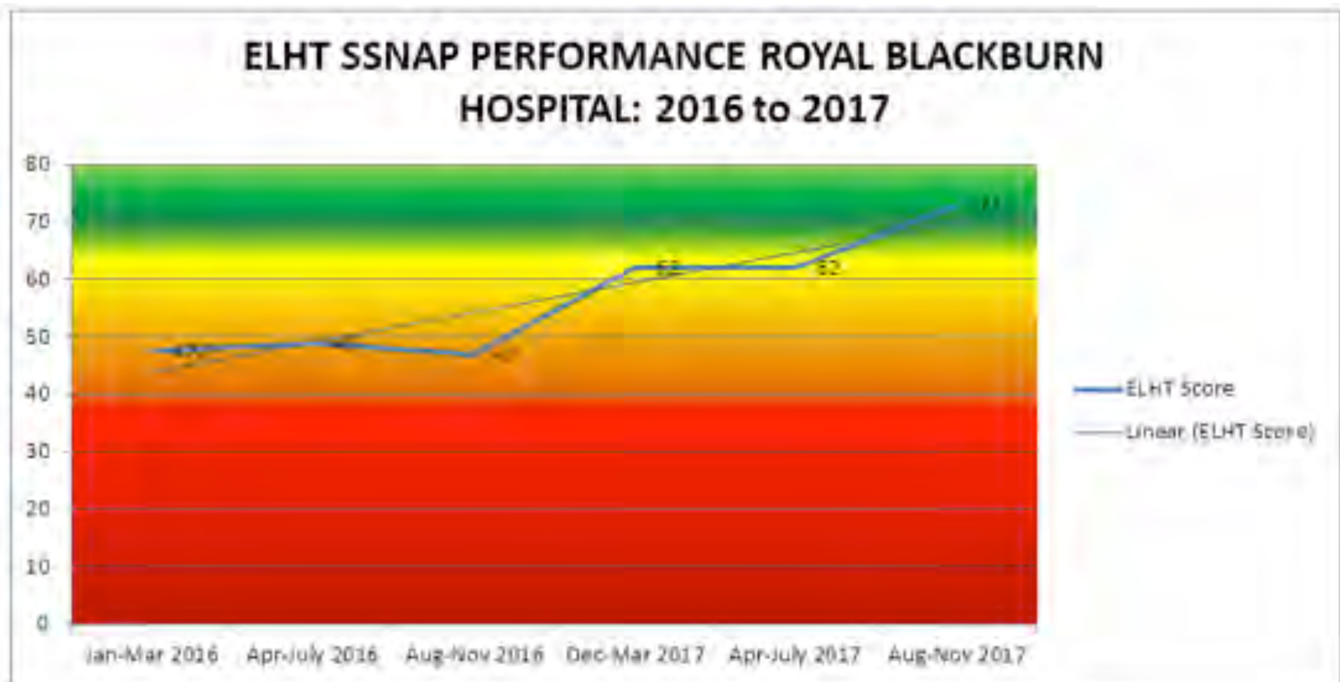
HSMR: Rolling 12 Month Trend Relative Risk (Latest model)





3.4.16 Continually Improving Stroke Care (Sentinel Stroke National Audit Programme – SSNAP)

Under the monitoring of the stroke steering group all elements of stroke care have seen a sustained improvement; mirrored by an improvement in mortality from cerebrovascular disease. This is reflected in Stroke Sentinel Audit Performance data with progression for a score of E to B/C. The appointment of two nurse consultants in stroke care have also facilitated this improvement with more rapid specialist review, CT scanning, more specialist therapy provision and more time spent on dedicated stroke wards.



3.4.17 Emergency Laparotomy and National Emergency Laparotomy Audit (NELA)

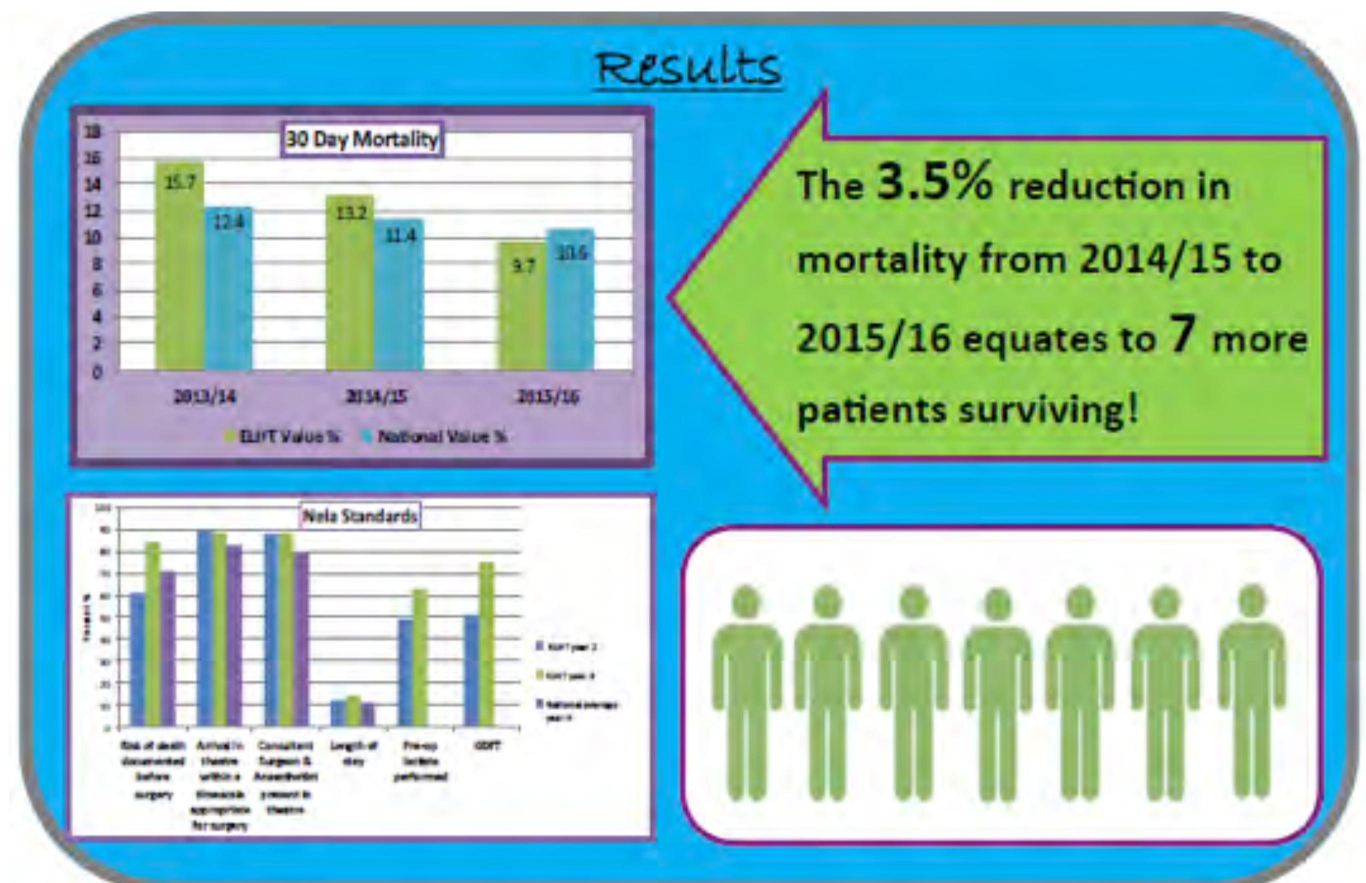
We continue to demonstrate real improvement in how we care for patients who require major abdominal surgery in an emergency. Through the hard work of our ward, theatre and QI teams we are proud to have seen great improvements since NELA began, including a significant drop in our adjusted mortality rate from 13.2% to 9.7% in the last report 2015/16 (to below the national average of 10.6%).

Our latest quarterly results confirm that we are performing well in most of the core fields being surveyed, achieving more than 80% adherence to guidelines in 7 of the 9 areas, and we have captured an estimated 87.8% of our cases in our latest monthly report.

Over the years we have developed our own methods to help us improve. The Emergency Laparotomy Booking Form and an 'intraoperative standards' aide-memoire sticker were introduced to ensure that evidence-based and timely care is given, and the appropriate data are collected so risk can be assessed, discussed with the patient and are available for post-operative planning.

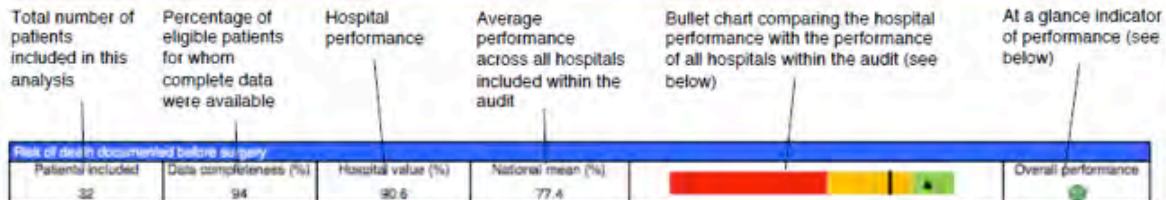
Last year patient information packs were introduced, promoting patient autonomy and involvement in decision making. This was soon followed by the release of our Emergency Laparotomy Enhanced Recovery Pathway which guides the emphasis on patient care at every opportunity.

New booking procedures and pre-printed consent forms are among improvements planned for the near future.



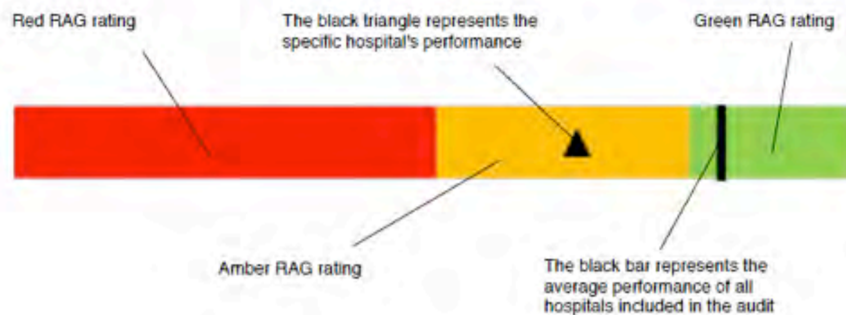
National Emergency Laparotomy Audit - Hospital Performance Indicators

Overview



Interpreting bullet charts and symbols

Bullet charts:



Current RAG rating thresholds:

Green ≥ 85%, Amber ≥ 55%, Red < 55%:

Case ascertainment

CT scan reported before surgery by a consultant radiologist
Risk of death documented before surgery
Arrival in theatre within a timescale appropriate for urgency
Consultant presence in theatre when risk of death ≥5%
Post-op admission to critical care when risk of death >10%

Green ≥ 80%, Amber ≥ 50%, Red < 50%:

Post-op admission to critical care when risk of death ≥5%
Assessment by a geriatrician if aged 70 or over

At a glance indicators of overall RAG rated performance:

A green circle indicates a hospital is performing well or as expected

A yellow triangle indicates a hospital could perform well if some improvements were made

A red diamond indicates a hospital should take steps to improve care

Royal Blackburn Hospital — **1 December 2015 - 30 November 2016**

Estimated number of cases expected (based on historical HES data):	214
Number of locked cases included in Year 3 of the National Emergency Laparotomy Audit:	211
Number of cases entered but left unlocked:	2

Estimated case ascertainment (Data available for English hospitals only)

		Hospital value (%)	National mean (%)	Overall performance
		98.6	81.8	

CT scan performed and reported before surgery by a consultant radiologist (Note: includes all eligible patients, including those who did not have a CT performed)

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
203	96	72.4	79.5	

Risk of death documented before surgery

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
211	100	83.9	70.7	

Arrival in theatre within a timescale appropriate for urgency

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
155	84	88.4	82.7	

Consultant surgeon and consultant anaesthetist both present in theatre when the risk of death ≥5%

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
131	100	88.5	79.2	

Consultant surgeon present in theatre when the risk of death ≥5%

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
131	100	93.1	90.9	

Admitted to critical care following surgery when the risk of death ≥5% (Excludes patients who died in theatre or with a decision to palliate)

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
130	100	89.2	79.1	

Admitted to critical care following surgery when the risk of death >10% (Excludes patients who died in theatre or with a decision to palliate)

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
88	100	93.2	86.6	

Postoperative assessment of patients aged 70 years and over by a care of the older person specialist

Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
38	50	0.0	19.4	

Unplanned return to theatre after emergency laparotomy (Crude value, not risk-adjusted)

Patients included	Data completeness (%)	Hospital value (%)	National median (%)	
207	98	5.3	8.3	

Unplanned critical care admission from the ward within 7 days of surgery (Crude value, not risk-adjusted)

Patients included	Data completeness (%)	Hospital value (%)	National median (%)	
207	98	5.3	3.2	

Median length of stay following surgery in patients surviving to hospital discharge (Crude value, not risk-adjusted)

Patients included	Data completeness (%)	Hospital value (days)	National median (days)	
184	98	14.0	11.0	

Risk-adjusted all-cause mortality within 30 days of surgery

Patients included		Hospital value (%)	National mean (%)	Overall performance
211		9.7	10.6	

Information for hospitals:

These plots represent patients having an emergency laparotomy during the first 3-month period of the fifth year of NELA data collection. It is hoped quarterly reporting will allow hospitals to make use of their most recent NELA data and to track their performance over time.

This version will be will be made publically available via the NELA website. Feedback from participating hospitals is welcome.

All cases taken to theatre between 1 December 2017 and 28 February 2018 have been included, regardless of whether they are locked or unlocked on the NELA web tool.

Only cases where the necessary data are available have been included in the denominator for each individual analysis.

The results for process measures for which fewer than 10 cases have available data will not be reported. Instead 'Hospital value (%)' will be marked as 'insufficient data', no hospital value will be placed on the bullet chart, and 'Overall performance' will be marked as 'n/a'. Hospitals are therefore encouraged to enter data as contemporaneously as possible to maximise the numbers of eligible patients for each analysis.

Standards that depend on a pre- or post-operative risk assessment were previously judged against the P-POSSUM mortality risk for a particular patient. From Year 5 onwards, risk is quantified by the highest predicted mortality given by clinical judgement, P-POSSUM or NELA Risk Adjustement models. In cases where there is incomplete data, a patient is considered "high risk" (predicted mortality >5%) for the purpose of RAG rating.

Royal Blackburn Hospital	1 December 2017 - 28 February 2018
Estimated number of cases expected per quarter (based on historical HES data):	54
Total number of cases entered into the National Emergency Laparotomy Audit in this quarter:	36
Cases locked:	25
Cases unlocked:	11

Measure	Patients included	Data completeness (%)	Hospital value (%)	National mean (%)	Overall performance
Estimated case ascertainment			67.3	67.5	
CT scan performed and reported before surgery by a consultant radiologist (Note: includes all eligible patients, including those who did not have a CT performed)	35	97	68.6	78.8	
Risk of death documented before surgery	36	100	80.6	78.3	
Arrival in theatre within a timescale appropriate for urgency	30	86	80.0	83.5	
Consultant surgeon and anaesthetist present in theatre when the risk of death ≥5% (Highest of P-POSSUM/NELA Risks & Clinical Judgement)	28	100	89.3	83.0	
Consultant surgeon present in theatre when the risk of death ≥5% (Highest of P-POSSUM/NELA Risks & Clinical Judgement)	28	100	92.9	91.8	
Consultant anaesthetist present in theatre when the risk of death ≥5% (Highest of P-POSSUM/NELA Risks & Clinical Judgement)	28	100	96.4	88.1	
Admitted to critical care following surgery when the risk of death ≥5% (Highest of P-POSSUM/NELA Risks & Clinical Judgement; Excludes patients who died in theatre or with a decision to	27	96	92.6	75.5	
Admitted to critical care following surgery when the risk of death >10% ((Highest of P-POSSUM/NELA Risks & Clinical Judgement; Excludes patients who died in theatre or with a decision	23	96	95.7	84.2	
Postoperative assessment of patients aged 70 years and over by a care of the older person specialist	2	15	Insufficient data	23.6	n/a

3.5 Statements from Stakeholders

East Lancashire Clinical Commissioning Group – Deputy Chief Officer 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) welcome the opportunity to comment on the 2017/18 Quality Account for East Lancashire Hospitals Trust (ELHT).

The Trust has continued to build on their quality strategy and approach throughout 2017/18, ensuring all areas for development identified in their last CQC inspection have been actioned. The CCGs continue to support the Trust in preparation for inspection, with participation in the mini CQC style visits and were pleased that the last series of visits were extended to Community Services.

Within the 2016/17 Quality Account the Trust identified 3 quality improvement priorities for 2017/18:

1) Discharge – support for safe discharge to continuing care

The CCGs would have liked to have seen further progress made in this quality improvement priority. Whilst it is encouraging that there are a number of initiatives on-going across the Trust, there is still a need to coordinate and process map the changes. The CCGs welcome the additional planned work to ensure that discharge is safe and timely.

2) Safe transfer of care between providers

The CCGs would have liked to have seen further progress made in this quality improvement priority and welcome the additional planned work to progress this area.

3) Deteriorating patient

The Trust has made good progress in their use of care bundles. The Acute Kidney Injury bundle is now being monitored at Ward level and there has been successful implementation of new measures for the Sepsis bundle and improved usage of Datix to review themes and trends.

In addition to the quality priorities identified for 2017/18 the Trust has made excellent progress in other Quality Improvement initiatives.

The CCGs congratulate the Trust on achievements made to stroke services, with the Stroke Sentinel Audit Programme (SSNAP) progressing from a score of E to B/C. The CCGs also applaud the Trust's innovative approach to quality improvement, which has led to recognition for the Placenta Clinic which was shortlisted for an iNetwork Healthcare Innovation Award and the refer-to-pharmacy scheme, which continues to demonstrate positive outcomes for patients.

ELHT has achieved 11 of the 22 applicable national and operational standards included within their contract. In 2017/18 the NHS has experienced exceptional operational pressures, with National performance across all measures deteriorating. Despite these pressures, ELHT has performed well against the referral to treatment incomplete standard with performance of 91.92% against the 92% target and has met all Cancer performance targets. Performance against the 4 hour A&E standard has been more challenging and the wider Health Economy continues to work together in order to make improvements, overseen by the A&E Delivery Board.

It is positive that given the pressures the readmission rate within 28 days of discharge has continued to reduce in 2017/18 and a number of schemes, including the dedicated ward pharmacy, appear to be having a positive impact on this position.

The Trust had a challenging target for reduction in Clostridium Difficile infection in 2017/18 and recorded 37 cases against a trajectory of 28 cases. The Trust continues to perform well on rate of infection per 100,000 bed days and remain below the North West average. Joint working between the Trust and CCGs continues in relation to post infection reviews and a focussed campaign is currently taking place in the Trust.

ELHT have achieved 89.31% of the National CQUIN scheme, with the potential to achieve a further 7.29% for the 'Reducing the impact of serious infections' indicator where evidence is currently awaited. The CCGs would like to congratulate the Trust in their response to Flu vaccination for front line staff, where the Trust was the highest performing Acute Provider in the country and achieved 92%.

ELHT has participated in 92% of National Clinical Audits and 100% of National Confidential Enquiries and are committed to the delivery of evidence based safe care. The Trusts clinical audit forward plan has been shared with the CCGs as part of routine Quality Review Meetings and it is positive that this will have a focus on adherence to NICE guidance and alerts.

Resolution of issues as they arise is a key focus for the Trust and has led to a low complaints rate. The Trusts visions and values are reflected in their approach to Patient Experience with clear oversight by the Trust Board. There are a number of complaints with responses overdue from the 25 day timeframe and the CCGs would welcome focussed attention in reducing this backlog.

Throughout 2017/18, the Trust and CCGs have worked closely together to reduce the number of open Serious Incidents. The Trust's Serious Incident Requiring Investigation (SIRI) has continued to mature with a good level of challenge to identify the true root cause and lessons learned. Human Factors training has been held in the Trust and will continue to be offered to investigators to help understand the effects of teamwork, tasks, equipment, workspace and culture and environment on human behaviour in clinical settings.

The Trust has reported 7 Never Events in 2017/18. Detailed Root Cause Analysis work from these incidents has highlighted a number of themes, including cultural issues and the CCGs are working with the Trust on the development of an overarching action plan which will support the work to embed the learning across the whole organisation. Duty of Candour was highlighted as an area of development by the CQC. The Trust has strengthened their systems throughout the year with closer oversight by the Medical Director. Adherence to Duty of Candour timescales is monitored by the CCGs as part of monthly Quality Review Meetings and through the Trust's SIRI Meetings.

ELHT have continued to perform well in the NHS Staff Survey, with improvements on their previous year's scores. This is a clear indication of a well led organisation and demonstrates improvements in staff engagement.

The CCGs are pleased with the continued improvements seen in mortality rates, with the Summary Hospital Level Mortality Indicator (SHMI) within the expected range and Hospital Standardised Mortality Ratio (HSMR) significantly better than expected. There has been good progress made with Learning from Deaths and it is positive that the learning points are being used to inform harm reduction and quality improvement projects. The CCGs have welcomed the opportunity to sit on the Trust's Mortality Steering Group and will continue to attend the monthly meetings in 2018/19.

The CCGs support the priorities set out for 2018/19 within the Quality Account and 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.

Healthwatch Blackburn with Darwen – Chief Officer

Healthwatch Blackburn with Darwen welcome the opportunity to comment on the 17/18 Quality Account. It is interesting to read 1.1-1.2 and is useful to be fully informed of the trusts position.

In regard to 2.3 we are continuing to improve our working relationship with the Trust and are planning to carry out some patient experience engagement work on discharge of dementia patients to assist the Trust with their continuous quality improvement.

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 18/19 and wishes you well in achieving your targets.

Healthwatch Lancashire – Chief Executive Officer

What do you like about the 2017/18 Quality Accounts?

We feel that the Quality Accounts are very well presented and that the Introduction is useful as it provides context. We are happy to see Discharge as a priority as this is something we have found to be an issue, particularly in social care settings where there is a shortage of beds. We feel it is positive that feedback is being encouraged actively from wide range of sources.

What do you dislike about the 2017/18 Quality Accounts?

There are no elements we dislike however we would request an amendment within the Healthwatch section on page 14. Currently it states that the two relevant Healthwatch organisations are East Lancashire and Blackburn with Darwen. It would be more accurate to state the organisations as Healthwatch Lancashire and Healthwatch Blackburn with Darwen, as Healthwatch Lancashire covers areas other than East Lancashire. (amendments have been made to Quality Account on receipt of this feedback).

What suggestions do you have for additional content for 2017/18?

We would be interested if the types of complaint could be expanded further, detailing themes and seriousness, and how these have informed organisational priorities. More information on Healthwatch activities and findings is available and would provide a broader view.

What other comments or suggestions for improvements would you like to propose?

As the voice of the public we might suggest creating a short public facing document including the salient points and executive summary to be published alongside this document.

What would you suggest are the Trust's priorities for quality improvements for 2018/19?

We would suggest that the report is worded clearly to reflect that patient safety and service are the main priorities from which the organisation's reputation derives. We would also suggest that the Trust could look in more detail at how seldom or never heard communities access their services to identify further priorities (e.g. the Traveller community will access hospital differently from military veterans differently from young people etc.)

Do you consider that the draft document contains accurate information in relation to NHS services provided by the Trust?

Yes. Based on our activities in Accident and Emergency departments, RBH children's ward and PLACE activities we would consider the information to be accurate.

Do you consider that any other information should be included relevant to the quality of the NHS services provided by the Trust?

We have no additional suggestions.

3.6 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.
Always Event	Always Events refer to aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time.
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 (CCG)	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 (CSU)	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
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.
EQ-5D	Instrument for measuring quality of life
Family Liaison Officer (FLO)	Acts as a single point of contact for the relevant person, patient, next of kin in regards to liaise with on the investigation of a serious incident

Get It Right First Time (GIRFT)	A programme to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improvement patient outcomes
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
Lean	Lean is a system of continuous process improvement, which is increasingly being applied to health services in the UK and overseas to: improve the quality of patient care; improve safety; eliminate delays; and reduce length of stay.
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
MBBRACE	Mothers and babies: reducing risk through audits and confidential enquires across the UK
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
Never Event	Never Event are serious medical errors or adverse events that should never happen to a patient
NHS England (NHSE)	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 (NHSI)	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

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential survey and research.
Nursing Assessment Performance Framework (NAPF)	Measures the quality of nursing care delivered by individuals and teams and is based on the 6Cs Compassion in Practice values.
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
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
Red Flag Drugs	Within ELHT specific drugs/drug classes are identified as those where timeliness of dosing is crucial and these are known as *RED Flag drugs*. Healthcare professionals involved in the medication administration process must make every effort to secure the timely availability of these drugs for dosing
Research Ethics Committee	A committee that approves medical research involving people in the UK, whether in the NHS or the private sector
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
Structured Judgement Review (SJR)	A methodology for reviewing case records of adult patients who have died in acute general hospitals. The primary goal is to improve quality through qualitative analysis of mortality data.
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
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
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
WHO Checklist	A checklist that identified three phases of an operation, before induction of anaesthesia, time out, sign out that helps minimize the most common and avoidable risks endangering the lives and well-being of surgical patients
10'000 Feet	'Ten Thousand Feet' is a staff-led service improvement initiative that is now in use in theatres cross ELHT to reduce the noise level and increase concentration if staff feel safety is potentially being compromised.

Notes

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