QUALITY ACCOUNT

2022 - 23

1.0 PART ONE – INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

Our patients are at the heart of everything we do at the Trust. We pride ourselves in delivering **Safe**, **Personal** and **Effective** care that contributes to improving the health and lives of our communities.

As a leading provider of integrated healthcare services across East Lancashire and Blackburn with Darwen, we deliver a wide range of health services to a population of 566,000 people, many of which live in several of the most socially deprived areas of England. Our services cover an area of approximately 1,211 square kilometres.

We employ over 10,000 people, working across five hospitals and various community sites within our six geographical areas. These areas are Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale.

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

The Trust currently has 1,041 beds and treats over 700,000 patients a year from the most serious of emergencies to planned operations and procedures, using state-of-the-art facilities.

Our absolute focus on patients as part of our vision “to be widely recognised for providing safe, personal and effective care” has been demonstrated in the Trust’s continued progress and being rated ‘Good with areas of outstanding’ by the Care Quality Commission (CQC).

Over 250 dedicated volunteers working across our services give their time and skills freely to support us. They work alongside Trust colleagues to provide practical support to our patients, their families and carers, and visitors to the Trust. Their enthusiasm and experience make a huge difference to our patients’ experience.

As a teaching organisation, we work closely with our major academic partners, the University of Central Lancashire, Lancaster University and Blackburn College. Together we nurture a workforce of tomorrow's doctors, nurses and allied health professionals.

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 are committed to improving and investing 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 and objectives are key to our operating principles and improvement priorities which help to guide the way we work and what we strive to achieve.

Our values underpin those, ensuring our services are the very best they can be for our patients and our environments are respectful and supportive for all.


Strategic Framework
Our Vision
To be widely recognised for providing safe, personal and effective care
Our Values
• We put patients first • We respect the individual • We act with integrity
• We serve the community • We promote positive change
Our Behaviours
• Taking responsibility • Building trust and respect • Working together
• Excellence • Keeping it simple
Our Goals
Deliver safe, high quality care
Secure COVID recovery and resilience
Compassionate and inclusive culture
Improve health and tackle inequalities in our community
Healthy, diverse and highly motivated people
Drive sustainability
System Working
SPE+ Improvement Practice
Delivery Programmes
Supporting Strategies
Clinical Strategy
Quality Strategy
Health Equity Strategy
People Plan
Green Plan
Enabling strategies (Estates/Digital/Finance/Education, Research and Innovation)
Safe | Personal | Effective
www.elht.nhs.uk

1.3 Our Future

Putting Quality at the heart of everything we do – Delivering Safe, Personal and Effective Care.

As health and care organisations in Pennine Lancashire we have, for many years, shared a common purpose to integrate our service provision and work together effectively to improve health outcomes for our residents.

We have worked closely with partners within the Healthier Pennine Lancashire (Pennine Lancashire Place Based Partnership (PBP)), working with primary, community, voluntary and faith sectors. Trust clinicians increasingly work with their professional colleagues from other organisations to provide Lancashire-based sustainable networks which determine the standards of care, the governance, and the delivery of care pathways.

As part of the new Place Based Partnership working across both Blackburn with Darwen and Lancashire, we will continue to work collaboratively to:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high-quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of our Pennine Lancashire financial allocation and resource

We will work collaboratively with partner organisations to develop out of hospital health care and a number of specific health priorities locally including a focus on ageing well, mental health, and improvements in elective and emergency care.

With organisations across the wider Lancashire and South Cumbria system, we will be an active partner in developing a joint service vision to improve outcomes in population health and healthcare. We will support wider system priorities including tackling inequalities in outcomes, experience, and access, enhancing productivity and value for money and to help support broader social and economic development.

Our quality commitments focus on initiatives that will:

- **Provide Safe care** - Reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.
- **Provide care that is Personal** – Deliver patient centred care which involves patients, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.
- **Provide Effective care** – Deliver consistent effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes.

Strengthening Our Partnerships

Working in partnership across Place Based Partnerships within Blackburn with Darwen and Lancashire (PBPs), the Lancashire and South Cumbria Provider Collaborative Board (PCB) and wider Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB) has been a fundamental part of our improvement journey so far and will continue to underpin all our work as we continue that journey.

Our drive to improve the quality of care delivered across our communities will see the Trust work increasingly though partnerships across our localities. We will further develop our role as part of an integrated offer, working more closely with our commissioners and with other local providers, including GPs, Community and Mental Health Trusts, and colleagues in Social Care.

This drive to improve care through collaboration is reflected in the Integration and Innovation White Paper, which outlines the requirements for system working. We will work as part of a joined-up system across Lancashire and South Cumbria ICB contributing to and learning from best practice across the region and working to ensure equity of care for our communities.

As our partners at ICB and Place develop their new structures, plans and priorities for coming years, so too we will adjust and develop our plans to ensure that our priorities and underpinning delivery is aligned. This will ensure that our combined partnership contribution to improving the health and wellbeing of the population of East Lancashire is maximised.

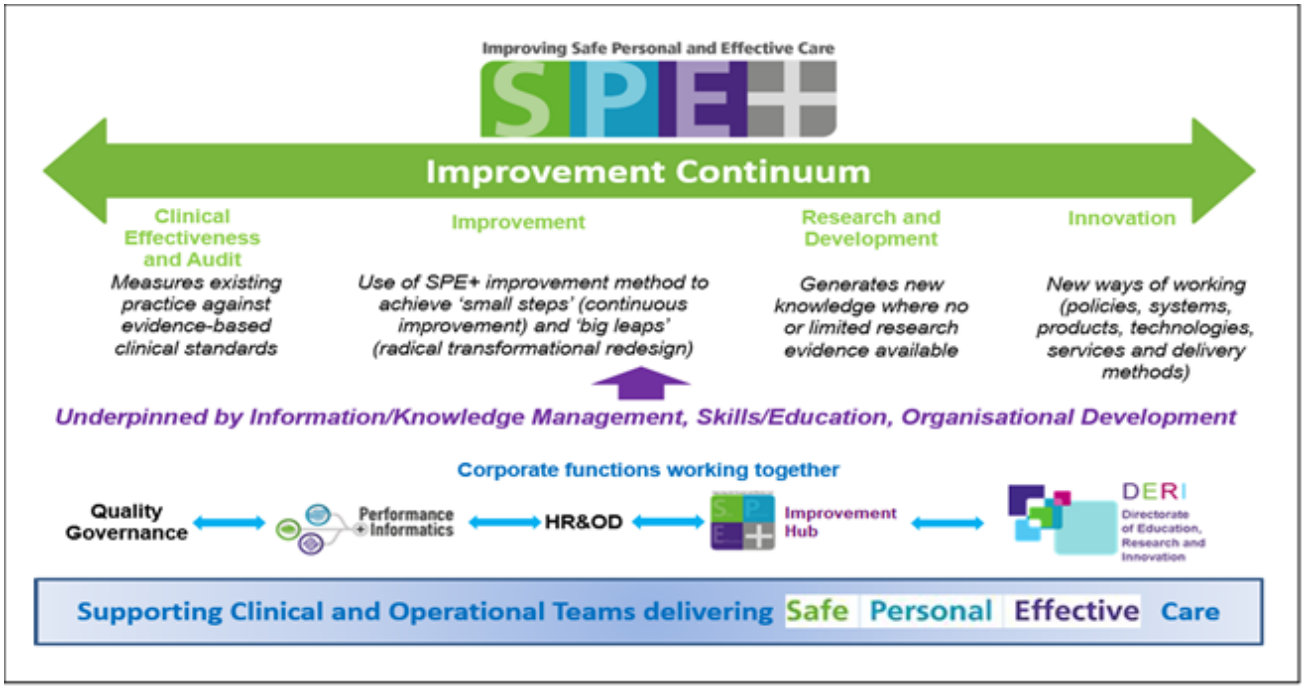
1.4 Our Approach to Quality Improvement

At East Lancashire Hospitals NHS Trust, delivering the highest quality healthcare to our local communities is at the heart of everything we do. We have fantastic teams delivering safe effective care and every day we hear stories about how they go above and beyond. Quality is embedded in our culture, and we are committed to continually improving and, in so doing, achieving our organisational vision 'to be widely recognised for providing Safe, Personal and Effective care.

The Trust has developed a robust approach to continuous learning and improvement. 'Improving Safe, Personal and Effective Care' (SPE+) is our Improvement Practice of understanding, designing, testing, and implementing changes that lead to improvement across the Trust. We work with our partners across Pennine Lancashire to provide better care and outcomes for our patients, staff, and communities and to develop and embed a culture of continuous improvement, learning and innovation.

To ensure that we are delivering Safe, Personal and Effective care we have a robust process for the identification and agreement of key improvement priorities. The Trust has an agreed set of key delivery and improvement programmes. Our improvement priorities are directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation and wider system, and in line with national requirements.

The ELHT Trust strategy has been refreshed for 2022/23. The SPE+ Improvement Practice is underpinning to support the delivery of improved outcomes and ELHT being recognised as a learning and improvement organisation. There is a Trustwide approach which spans our Improvement Continuum and any idea for improvement will have the appropriate support. We are in the process of developing a comprehensive Improvement Network, across the organisation and wider system to bring together colleagues involved in improvement (Clinical Audit & Effectiveness, Improvement, Research & Development, Transformation, and Innovation) to support shared learning and spread and celebration of success. This is depicted below:



SPE+ Improvement Practice Components:
The SPE+ Improvement Practice element of the Improvement Continuum is comprised or 3 key elements which are encapsulated into an Improvement Practice Development Plan.

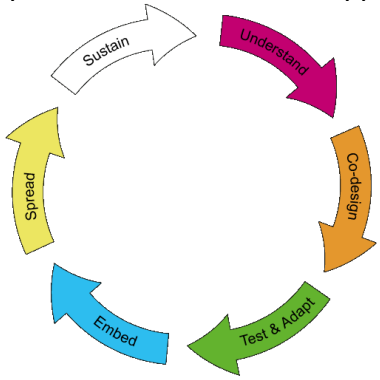
Practice Development Plan and Commitments 2022/25:

Practice Component:	Aim:	Objectives:
Practice Co – production System	To improve outcomes against identified Trust and wider system improvement priorities using an evidence-based and consistent improvement method and tools (SPE+ Improvement Practice).	**1.** Embedding the SPE+ method of improvement across ELHT and Pennine Lancashire PBP **2.** Working with partners across Lancashire and South Cumbria to develop a consistent system-level method of improvement **3.** Ensuring a robust approach to the identification of Improvement priorities **4.** Utilising the SPE+ Improvement Practice to support improved outcomes against agreed improvement priorities **5.** Ensuring robust systems for measurement for improvement
Practice Training System	To develop skills and confidence of staff across the Trust and wider system to apply the SPE+ Improvement Practice to secure the best possible outcomes	**1.** Developing capacity and capability of staff through a robust Improvement Practice training offer

		2. To support staff on their improvement journey through high quality Improvement Coaching **3.** To create a SPE+ Improvement Network to support staff in sharing best practice
Practice Management System	To embed improvement in all that we do as part of our management system	**1.** To develop a robust approach to strategy development and deployment that routinely identifies and supports opportunities for improvement **2.** To support the development of a learning culture where all staff strive for continuous improvement and innovation **3.** To celebrate success and share learning

Improvement Practice:

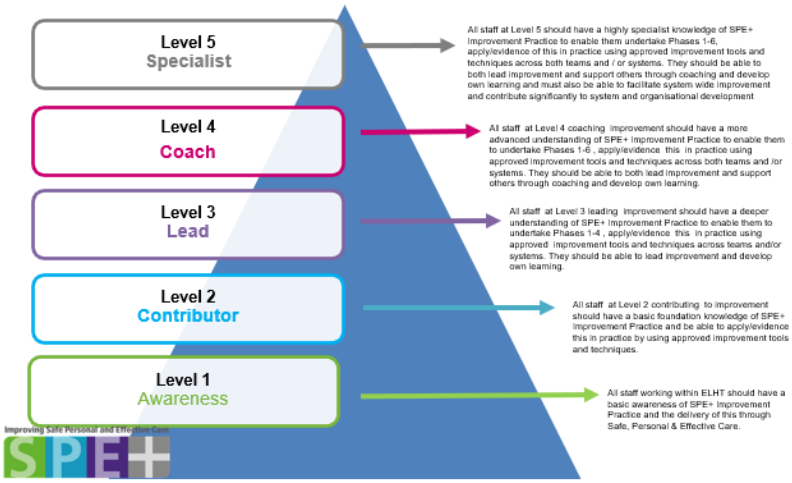
We deliver a 6-phase approach to improvement which brings together the improvement principles of the Institute for Healthcare Improvement (IHI) Model for Improvement and Lean. We measure improvements by Delivery, Quality, Cost and People. The 6 phases of SPE+ are: Understand, Co-Design, Test and Adapt, Embed, Spread and Sustain. This approach is summarised below:



The development of our Improvement Practice has been supported through our involvement in the national NHS Improvement and NHS England Vital Signs Programme. Although this programme has now formally ceased, we continue to develop our Improvement Practice by continually reviewing national and internal best practice and through the development of local, regional, and national Improvement Networks.

Beyond the Improvement Practice methodology and improvement priority workstreams is the fundamental principle of building improvement into our management system so that it becomes a part of everything we do, bringing together planning, improvement and quality contract and assurance and creating a culture of improvement and learning across the organisation.

SPE+ Improvement Practice Training Framework: To support staff in the development of skills and confidence in the application of the SPE+ Improvement Practice we have developed a comprehensive training offer which is summarised in our SPE+ Improvement Practice Training Framework. This is summarised below:



The Improvement Hub Team supports the organisation by coaching and facilitating on defined improvement programmes and projects linked to Trust and Divisional priorities. All Foundation doctors (FY 1&2's), Medical students (SSC 3&4's) and Trainee Advanced Clinical Practitioners contribute to and lead quality improvement projects.

A staff development programme in 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. Support for projects is agreed within Divisions, approved through Divisional Clinical Effectiveness Committee and reported through to Clinical Effectiveness Committee.

Other Key Enablers (Electronic Patient Record)

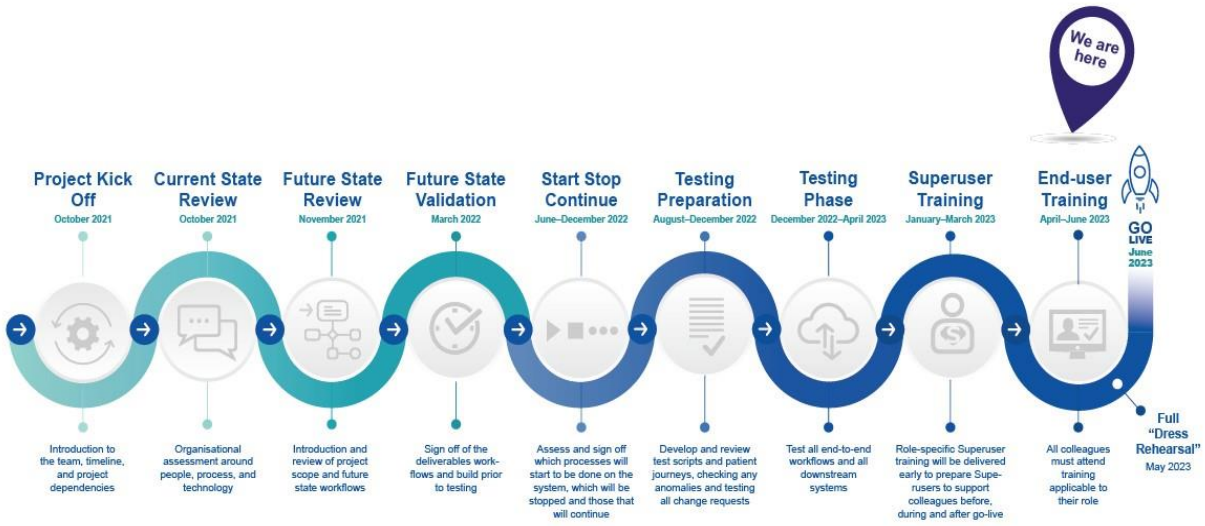
Over the 12months, the Trust has continued to implement one of the biggest programmes on the horizon: an electronic patient record (EPR). The Electronic Patient Record (EPR) will launch in June 2023 and have an impact on staff and patients right across the Trust.

Whilst it might sound simple, it has the potential to completely transform the way we work, with vast benefits for both colleagues and patients and their families. In East Lancashire Hospitals NHS Trust the programme will be known as 'eLancs' and is designed to improve patient care across the health and social care system in the area by replacing paper-based notes and records with a new suite of digital tools and technologies. The programme is patient focused, clinically led, and digitally enabled.

These will be introduced over the coming months across hospital services and community care in Blackburn with Darwen, Burnley, Pendle, Hyndburn, the Ribble Valley, and Rossendale, but substantial changes are scheduled in June 2023 when a new electronic patient record system will go live in hospital settings. This will:

- Provide clinicians with more information at their fingertips to make better, more effective decisions
- They will have automatic access to decision support tools, meaning their decisions will be made based on the best available information
- They will be able to take information from many sources.
- It makes us more efficient and create a smoother care journey for our patients
- It will enhance communication across clinicians and teams, reduce duplication and reduce some of the data collection burdens from people by capturing some things automatically.

Paper records will be replaced by digital records and there will be new ways of working introduced to take advantage of this digital approach. It will make several administrative tasks easier to manage as information will flow around the organisation more easily.



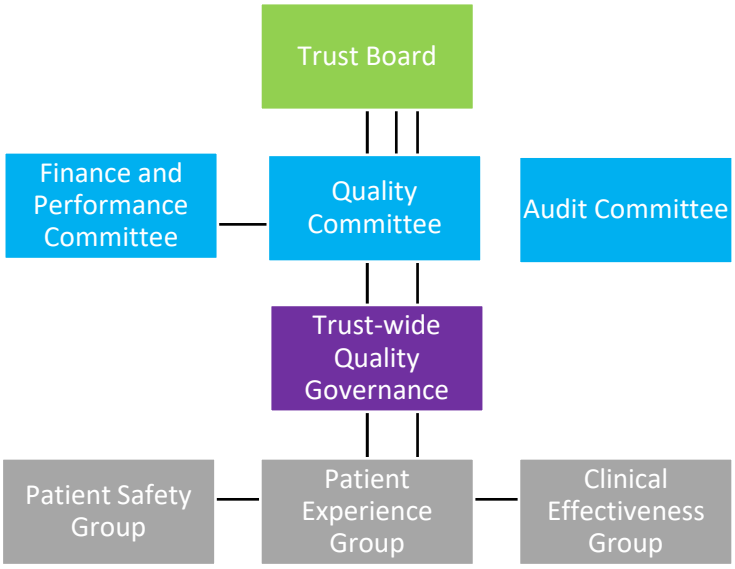
Each division has a governance route (e.g. Divisional Clinical Effectiveness Groups and/or Programme Board) for assurance that plans are in place for reviewing and discussing their Improvements projects, alignment of projects to their priority areas and monitoring the impact of projects. Each division reports their Improvement activity through to Clinical Effectiveness Group (CEG). Projects are agreed by a senior divisional/clinical lead through this forum and are then added to the central Trust Improvement Project Register via the Improvement Hub triage process.

Each division is responsible to provide updates on project implementation for all the projects within their division.

Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to board'.

Monitoring & Assurance:

Quality Governance is the combination of structures and processes both at and below Trust Board level to ensure and assure the quality of our services, together with systems to monitor and assure the Trust Board of Directors. These are listed below.



Board of Directors

The Board of Directors has responsibility for the services that we deliver and is accountable for operational performance as well as the implementation of Strategy and policy. A quality dashboard is reported monthly to the Board of Directors as part of the Integrated Performance Report (IPR). Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators.

Finance and Performance Committee

The Finance and Performance Committee provide assurance about the delivery of the financial and operational plans approved by the Board for the current year and for the longer-term future, develop forward plans for subsequent fiscal years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

Quality Committee

The Quality Committee provides assurance to the Trust Board of Directors in respect of clinical quality and patient safety, effectiveness and experience through robust reporting and performance monitoring.

Audit Committee

The Audit Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance and risk management together. The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

Trust Wide Quality Governance (TWQG)

The progress of each priority is reported on a quarterly basis to the Trust-wide Quality Governance Group which reports monthly into the Quality Committee. Operational implementation of the commitments will be monitored routinely through the Patient Safety, Patient Experience and Clinical Effectiveness Groups which report monthly to TWQG. Divisional representation and Heads of Corporate services are standing members on the TWQG.

Clinical Divisions Quality meetings

There are five Clinical Divisions within the Trust, who report into the Executive Directors and provide assurance on Strategy and risk management performance. Each Division holds a monthly Quality / Performance meeting to receive assurance or escalation from the various Directorates. Similarly, the Directorate meetings are attended by and receive escalation from their respective teams. These meetings are supported by allocated Quality and Safety teams who work closely with the respective Senior Leadership Teams.

Patient Safety Group

Established as a sub-Group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient safety across all spheres of Trust activity and that improvement of patient safety is at the heart of the work of the Trust. Chaired by the Assistant Directors of Patient Safety and Effectiveness, it is the Trust wide operational focus for accountability for patient safety for quality governance within corporate and the Divisions.

It brings together the business of the corporate clinical leaders within the Trust, who with senior members of the Divisional teams supported by members of the Quality and Safety Unit, have day to day responsibility for patient safety driving improvement initiatives in this area.

Patient Experience Group

Established as a sub-Group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient experience across all spheres of Trust activity and that improvement of patient experience is at the heart of the work of the Trust. Chaired by the Assistant Director of Patient Experience, it is the Trust wide operational focus for accountability for patient experience for quality governance within corporate and the Divisions.

This group combines an overview focus on complaints management with feedback from patients and their carers/families. This group monitors the Friends and Family Test results, Annual Patient Survey feedback themes and links with key partners such as Healthwatch to maintain direct links with community groups.

Clinical Effectiveness Group

Established as a formal Sub-Group of the Quality Committee this is the engine room for ensuring that there are appropriate arrangements to monitor, assure and improve clinical effectiveness across the range of the Trust's services. Chaired by the Deputy Medical Director, it is the Trust-wide operational focus for assurance and accountability for clinical effectiveness and improvement for the Divisions. It brings together the business of clinical leaders and senior members of the divisional teams, supported by the corporate clinical effectiveness functions, with a day-to-day responsibility for clinical effectiveness and quality improvement.

Lessons Learnt Group

A Lessons Learnt Group has been established as a subgroup to the Trust Wide Quality Governance meeting. This new group is responsible for providing assurance that there is effective monitoring and oversight of lessons learnt from patient safety events across all spheres of Trust activity and that improvement of patient safety is at the heart of the work of the Trust. Chaired by the Assistant Directors of Patient Safety and Effectiveness, it is the Trust wide operational focus for accountability for learning lessons from patient safety events and investigations for quality governance within corporate and the Divisions.

Quality Improvements Triage

Established as a formal Group reporting to the Clinical Effectiveness Committee it is the engine room for ensuring that the Division(s) have plans in place for the monitoring of the impact of the quality improvement project, and if necessary to ensure that impacts on other divisions are recognised.

Chaired by the Deputy Medical Director (Transformation) it brings together divisional teams and the Quality Improvement team supported by other members of the Quality and Safety Unit, who have day to day responsibility for clinical effectiveness and quality improvement.

Its purpose is to examine the detail of quality improvement projects signed off by Directorate and Divisional Teams, ensuring that plans have details of the change idea, aims and measures as well as details of the support required.

Partnership Working

During 2022-23 there has been a significant change to commissioning arrangements with the replacement of Clinical Commissioning Groups with the new Lancashire and South Cumbria Integrated Care Board. There has also been a change in the place-based partnership arrangements with Pennine Lancashire being replaced with the Lancashire Place with an East Lancashire locality and Blackburn with Darwen.

The Trust continues to build on its relationships and communication as part of these new commissioning arrangements. Regular Quality Review meetings are held with quality leads from all organisations. The focus of these meetings is around clinical effectiveness, risk and safety, quality improvement and the patient, family and carer experience.

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 Divisional Serious Incident Reporting Groups (SIRG) and presented at a monthly Trust Patient Safety Incident Requiring Investigation (PSIRI) Panel. Quality and Safety reports are submitted 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
- Patient Safety Incident Report

The quality scorecard continues 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 2022-23.
- 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.
- 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 2022-23 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 invite you to provide us with feedback about this report, or about our services.

If you wish to take up this opportunity, please contact:

Associate Director of Quality and Safety
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

The CQC completed a system wide inspection of the Urgent and Emergency Care (UEC) service line during April 2022. All acute services in the system were visited. An unannounced inspection of the Trust's Emergency Department took place on the 12th/13th May 2022 and this contributed to the wider system review. This was followed by a 'well led' focused phone interview between the senior Emergency Department (ED) team and the CQC on the 23rd of May 2022.

The inspection focused on the safe and well led domains, both of which were rated as good and that there would be no change in the Trust's overall rating.

Additionally, the CQC inspected Maternity services over the 2nd and 3rd November 2022. This inspection visited Lancashire Women's and New-born Centre in Burnley and Blackburn and Rossendale Birthing Centres which were all confirmed as Good, in both the Safe and Well-led domain. The CQC acknowledged elements of outstanding practices across all three sites.

The last comprehensive Care Quality Commission (CQC) inspection took place from 28th August to 27th September 2018. The CQC visited the Trust to conduct a series of inspections concluding with a 'Well-Led' review. Following their review, the report was published on 12th February 2019 and the Trust was rated as being Good overall, with areas of outstanding.

The CQC scores for each of the combined Trust, main hospital sites and overall are as follows:

Ratings for a Combined Trust	
Acute	Good
Community end of Life	Outstanding
Community health services for adults	Good
Mental Health for children and young people	Outstanding

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

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

The CQC also awarded the use of Resources rating based on an assessment carried out by NHS Improvement.

The CQC combined rating for Quality and Use of Resources summarises the performance of our Trust, taking into account the quality of services as well as the Trust's productivity and sustainability. This rating combines the 5 Trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of resources rating.

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

All areas for improvement continue to be monitored through the appropriate assurance committee structure and the Trust and CQC have regular engagement meetings.

1.7 Our Chief Executive's Statement on Quality

I am proud to present our quality account for 2022/23. The report explains how we performed against our key quality priorities last year and sets out our priorities for the year 2023/24.

We also provide an overview of other key performance indicators including the perspectives of patients, public and ELHT colleagues. It's clear within the Trust that our patients' care and safety and the health and wellbeing of our colleagues are inextricably linked. How we make sure colleagues are physically protected and psychologically supported is critical to the quality of our performance in all areas of the organisation. We are focused on getting this right so we can provide the best care possible to all our patients and for all colleagues to feel they are supported, included and listened to.

The last couple of years have been exceptionally challenging for the wider NHS and this is also true at ELHT. I am aware the Trust has felt, at times, extremely pressured, particularly in our urgent and emergency care pathways. I am grateful for the care, compassion and kindness shown by all colleagues during the most difficult of days, weeks and months.

As well as improving as a healthcare provider and as a place to work, our relationships across the wider health and care system in Lancashire and South Cumbria has continued to strengthen. July 2022 was a key milestone in this respect, with colleagues in the Lancashire and South Cumbria Integrated Care System (ICS) joining colleagues in Clinical Commissioning Groups (CCGs) to become the Lancashire and South Cumbria Integrated Care Board (ICB).

Together we started a long and complex journey to transform services for everyone and there has been lots of progress on this throughout 2022 with collaboration and learning across organisational boundaries for the benefit of patients and their families.

Creating a system where access to health care is both high quality and more equitable is the central aim in the transformation of services however the financial ask of the NHS to deliver efficiencies is never very far from our minds and this is also one of the drivers for making changes and working across teams and services in the wider geographical area. We need to work together in an integrated way to support people's needs in the very best way we can.

I continue to be astounded by the resilience and commitment our colleagues and volunteers show every day and it is not lost on me that everything we have achieved in the last year is as a direct result of their efforts. Our dedication to providing safe, personal and effective quality care across East Lancashire remains strong and I am proud to take this opportunity to send a thank you to every member of the ELHT Family. Thank you for all that you continue to do for our patients, our services and our Trust.

This report describes in detail the work and the impact our improvements have had on patient care. It sets out information that serves as assurance to the Board on the quality of our services and maps out how we are performing against core quality indicators and national targets.

To the best of my knowledge, the information in this this report gives an accurate account of quality at the Trust.

I hope this report will be read widely by colleagues, volunteers, patients, the public and our partners. It has been prepared by our clinical teams and the people who are closest to the service being reported on. The next 12 months will no doubt be extremely challenging, as we continue our focus on reducing our waiting lists for elective treatment and procedures, improving our colleagues' welfare and delivering on our financial expectations.

Whilst considerable progress has been made in these areas, much more will be needed for quite some time to come. However, in doing so, we have a great opportunity to improve the health and wellbeing of the people within our locality and across Lancashire and South Cumbria as a whole.

Martin Hodgson

Chief Executive

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

Quality underpins the vision of East Lancashire Hospitals NHS Trust (ELHT) which is to be "widely recognised for providing safe, personal and effective care." This has been demonstrated in the Trust's continued progress and being rated 'Good with areas of outstanding' by the Care Quality Commission (CQC).

The Trust is committed to the continuous improvement of the quality of care given to local people and, in so doing, achieving our organisational aim 'to be widely recognised for providing safe, personal and effective care'. All Executive Directors have responsibility for Quality Governance across their particular spheres of activity and the Executive Medical Director is the delegated lead for Quality on the Board overall.

Quality monitoring occurs through our Clinical Governance structure, reporting to the Board via the Quality Committee. The Quality Committee is informed by the Trust Wide Quality Governance Meeting (TWQG), Patient Safety Incidents Requiring Investigation Panel (PSIRI), Clinical Effectiveness Group (CEG), Patient Safety Group (PSG), Patient Experience Group (PEG), Health and Safety Committee (H&SC), Lessons Learnt Group (LLG), Internal Safeguarding Board and Infection Prevention and Control Sub-Committee. Divisional Directors or their agreed deputies attend and report at these committees. Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board'.

The ELHT vision aligns directly with the principles of the NHS National Patient Safety Strategy - NPSS (2019). The National Patient Safety Strategy (NHS England 2019) focuses on three key aims.

1. **Improve our understanding of safety by drawing insight from multiple sources of patient safety information**
2. **People have the skills and opportunities to improve patient safety, throughout the entire system**
3. **Improvement programmes enable effective and sustainable change in the most important areas.**

Our Quality Strategy is based on the exact same three aims, with an explicit link to our Quality Improvement programme.

Our commitment to providing high quality care for the people of East Lancashire has seen the embedding of our Public Participation Panel (PPP) as a monthly meeting directly supported by our Chief Nurse. The PPP are actively engaged in the development and review of services, providing a patient/carer perspective to our quality improvement plans.

The system continues to develop across Lancashire and South Cumbria, in line with the national move towards increased integration and we continue to support a system wide approach to quality. As active system partners we continue to support the delivery and improvement of quality at a system level as we continue to plan to develop healthcare services across the region.

Safe Care

The organisations response to safety is being influenced by the new National Patient Safety Incident Response Framework (PSIRF) which replaced the National Serious Incident Framework (SIF).

In November 2019 the Trust was nominated as an Early Adopter of the Patient Safety Incident Response Framework (PSIRF), representing the NHS North-West region. The PSIRF model is described within the National Patient Safety Strategy (NPSS) and has underpinned changes to all aspects of Quality Governance and strengthens links to Improvement.

The priorities below will form the focus of the Patient Safety Incident Response Plan (PSIRP). This plan requires a full incident investigation of the next 5 reported incidents in each category. Thematic review of the learning from each case will then inform an organisational improvement plan, utilising the SPE+_ improvement approach, for each of the 5 areas.

1. **Treatment problem/issue, Diagnosis failure/problem & Radiology -** 104-day cancer breaches
2. **Vulnerable Adults** - Nutrition (Nil by Mouth)
3. **Communication with patients and families** – DNACPR (Do not attempt cardiopulmonary resuscitation), TEP (Treatment Escalation Plans), EOL (End of Life Care)
4. **Falls** - Fractured Neck of Femur
5. **Emergency Department** -Transfers & patient flow, Inappropriate Handovers, NEWS2 (National Early Warning Score Observations), Delays in treatment & Concern around care given

Routine investigation of incidents resulting in harm will be conducted using a portfolio of tools, including round tables, clinical reviews, timeline analysis. These will be coordinated within the divisions and reported/monitored at the Patient Safety Group.

Clinical Effectiveness

There is a continued evolution to the approach of ensuring clinical directorates are delivering effective, evidence-based care in a reliable manner. The Clinical Effectiveness Team's function is to support clinical teams in providing assurance against standards to ensure the organisation is delivering best practice according to national guidance. To ensure that directorates are delivering best practice and are aware of the standards expected of them each directorate has a 'portfolio' of activity against which they monitor their performance.

This portfolio includes:

a. National audits as mandated by the national contract
b. Other national audits included in the NHS England Quality Accounts list
c. Regional and local audits as determined by commissioners or regional bodies
d. Local quality audits (e.g. compliance with local care bundles)
e. Relevant national guidance (e.g. NICE)
f. Relevant National Confidential Enquiry (NCE) recommendations
g. Getting It Right First Time (GIRFT) data

Nationally there is a drive to collect continuous data to support real-time reporting on performance, supported by quality improvement activities delivered by audit providers. This has meant a

continued focus on data completeness and data quality delivery within set deadlines to support ongoing learning and assurance from outcomes.

Systems are also being developed in-house to support real-time data collection for local quality audits. To support this process there are Specialty Clinical Effectiveness leads supported by a Divisional Clinical Effectiveness Lead and a Quality and Safety Lead. They are responsible for developing the divisional portfolio of evidence and ensuring this includes all key priorities as well as ensuring alignment with other quality & safety intelligence i.e. patient safety and experience. This process is supported corporately by the Clinical Effectiveness Team.

Improvement (SPE+)

The Improvement Hub Team supports the organisation by coaching and facilitating on defined improvement programmes, projects linked to Trust and Divisional priorities and educational requirements for our staff in training groups (Foundation Year 1&2, Trainee Advanced Clinical Practitioners, Medical Students, and Preceptorships).

Using the 6 Phases of SPE+, Improvement is facilitated through 'small steps' (continuous improvement) and 'big leaps' (radical transformational redesign).

The Improvement Hub Team facilitate and support the delivery of the agreed Trust Improvement Priorities and Programmes of work, which cover 3 of the 11 Key Delivery and Improvement Programmes underway across the Trust:

- **Quality Strategy** improvement priorities
- **People Plan** improvement priorities
- **Urgent and Emergency Care Improvement**
- **Elective care improvement (elective and outpatients)**

The Quality Strategy improvement / PSIRP priorities for 2022/23 are defined within the current Quality Strategy (2022/25) and have been directly informed by the implementation of the PSIRF (Patient Safety Incident Response Framework), thus providing us with an opportunity to streamline and prioritise future improvement activity. These cover:

PSIRP Priority:	Scope / Aim:
Treatment problem / issue	Reducing 104day Cancer Breaches
Vulnerable Adults – Nil by Mouth	To reduce the number of nutrition and hydration incidents resulting in harm (moderate or above) due to preventable lapses in care, across all inpatient areas at ELHT by *10% by 31st March 2024
Communication with patients and families - DNACPR	To reduce the number of incidents related to poor DNACPR communication resulting in harm (moderate and above) due to preventable lapses in care, across all inpatient areas at ELHT by *10% by 31st October 2023
Falls – Fractured Neck Of Femurs & Post Falls Checklist	To reduce the number of inpatient falls resulting in harm (moderate and above) due to preventable lapses in care, across all inpatient areas at ELHT by 10% by October 2023
Emergency Department – Handover and Transfers	To reduce the number of inappropriate handovers and transfers resulting in harm (reduction in overall number of incidents) due to preventable lapses in care, across all inpatient areas at ELHT by *10% by August 2023

The PSIRP plan requires a full incident investigation of the next 5 reported incidents in each category/priority. For each of the 5 priorities a thematic review of the learning from each case will be undertaken and then inform an organisational improvement plan, utilising the SPE+ improvement approach.

The PSIRP priorities have superseded the existing Harms Reduction Programmes. To provide assurance, a joint review has been undertaken by the Governance and Improvement Hub Quality Programme Leads for each of the existing Trust-wide Harms Reduction Programmes and a closure report will be completed and presented at the relevant committees in early 2023.

Our Quality improvement programme currently comprises a combination of:

- PSIRP Plan priorities
- Directorate and Divisional Quality Improvement Projects
- Quality improvement (QI) projects for Staff in Training Groups
- Other key improvement priorities arising from National Reports/Audit, incidents, and complaints

The improvement priorities supported by the Improvement Hub Team will be reviewed each year to ensure they are aligned to the delivery of the Trust Strategy and key Delivery Programmes.

Monitoring and Improving the Safety Culture

The safety of both patients and staff in healthcare is influenced by the extent to which safety is perceived to be important. The Trusts has a combination of structures and processes both at and below Trust Board level to ensure and assure the quality of our services, together with systems to monitor our safety culture and systems.

The Trust has developed and introduced in 2022 a number of methods of sharing learning across the Trust to support learning and improving the safety culture, which includes:

- Patient Safety Learning events which is a method of sharing learning from incidents to a wide range of staff and giving them the opportunity to look at the identified problems and why they happened, review the actions taken to improve safety and identify any further learning that may be required.
- Patient Safety Alerts are used across the Trust to either raise awareness regarding safety concerns and include safety critical actions for immediate implementation either across the Trust, Divisions or Directorates. These are monitored for assurance against actions at either the Patient Safety Group or Lessons Learnt Group.
- Patient Safety Bulletin is produced quarterly by the Patient Safety Incident Investigation Team to highlight and raise awareness of learning and safety improvements from national and local priorities under the Patient Safety Incident Response Framework (PSIRF).

Mortality Reduction Programme

The Trust monitors mortality statistics, performance and identifies areas for focus or improvement through a monthly Mortality Steering Group, chaired by the Deputy Medical Director (Quality).

The Trust has robust governance arrangements in place to review, report and learn from patient deaths through the analysis of various data sets, including:

- Mortality benchmarking – HSMR, SMR, SHMI, Crude Mortality
- Learning disability deaths, Reviews & Learning

- Medical Examiner Service Activity and Learning
- Deaths related to incidents & Learning
- Adult SJR Mortality Reviews & Learning
- Perinatal, Neonatal & Child Deaths

The Trust continues to use the Structured Judgement Review (SJR) methodology via an electronic review process that is part of our patient safety governance software system. The review process is in line with the most recent NHS England guidance: Learning from Deaths and includes an overall score. On average, the Trust has completed between 200-250 reviews each year since the system was embedded in 2018.

All deaths of patients with a recognised Learning Disability (LD) or Autism are also subject to SJR's in addition to review by our learning disability reviewers. Following this information is submitted to the regional LeDeR team for an external review of care to be completed. Such deaths are either highlighted by the input of the LD team during their stay or highlighted by the Medical Examiner Service and submitted for review.

Maternal deaths are reviewed using a primary mortality review, and then may be referred to the Coroner or Healthcare Safety Investigation Board (HSIB) for further investigation.

All stillbirths and late miscarriages after 22 weeks gestation are reviewed through the perinatal mortality review process (PMRT). This involves a preliminary review, a primary review and a secondary review at the neonatal mortality meeting. All deaths are then further reviewed at Multi-Disciplinary perinatal mortality meetings.

In addition, any stillbirth of a baby over 37 weeks gestation that occurs during the intrapartum period (during labour) is referred to the Healthcare Safety Investigation Board (HSIB) for external review.

All Neonatal Deaths are discussed with the Medical Examiner team and if any care or service delivery issues are identified these are referred to the coroner for further investigation.

Child Deaths are all subject to the Sudden Unexpected Death in Childhood process (SUDC) and co-ordinated through the Trust Safeguarding Team, where appropriate. Any unexpected child death would also be discussed with the Coroner.

Medical Examiners

The Trust continues to review all hospital deaths and has recently appointed additional Medical Examiners and Medical Examiner Officers to roll out the medical examiner service to cover community deaths.

Medical Examiner Officers utilise medical records and accounts to create a complete case for the Medical Examiner, and by performing appropriately delegated tasks they allow the medical examiners to focus on case scrutiny. Proportionate scrutiny will be undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death.

Data from the Medical Examiner Service has shown that in nearly 20% of cases recently bereaved families had passed positive comments back to the teams looking after their loved one at the end of their life.

The Trust retains the aspiration to be within expected according to all markers of mortality, and uses the data, closely scrutinised and triangulated to investigate key areas of learning and improvement.

Personal Care

Our continued aim is to strengthen what we know is important in terms of the care and experience given to our patients, their relatives, and our staff. Whilst we know quantitative data gives us a particular insight, we won't simply stop there, as we seek to develop our understanding of patients', and relatives, overall interaction with the Trust. Collection of qualitative and quantitative data allows the Trust to gauge expectations and perceptions, which we aim to translate into meaningful actions to enhance the care and experience we provide.

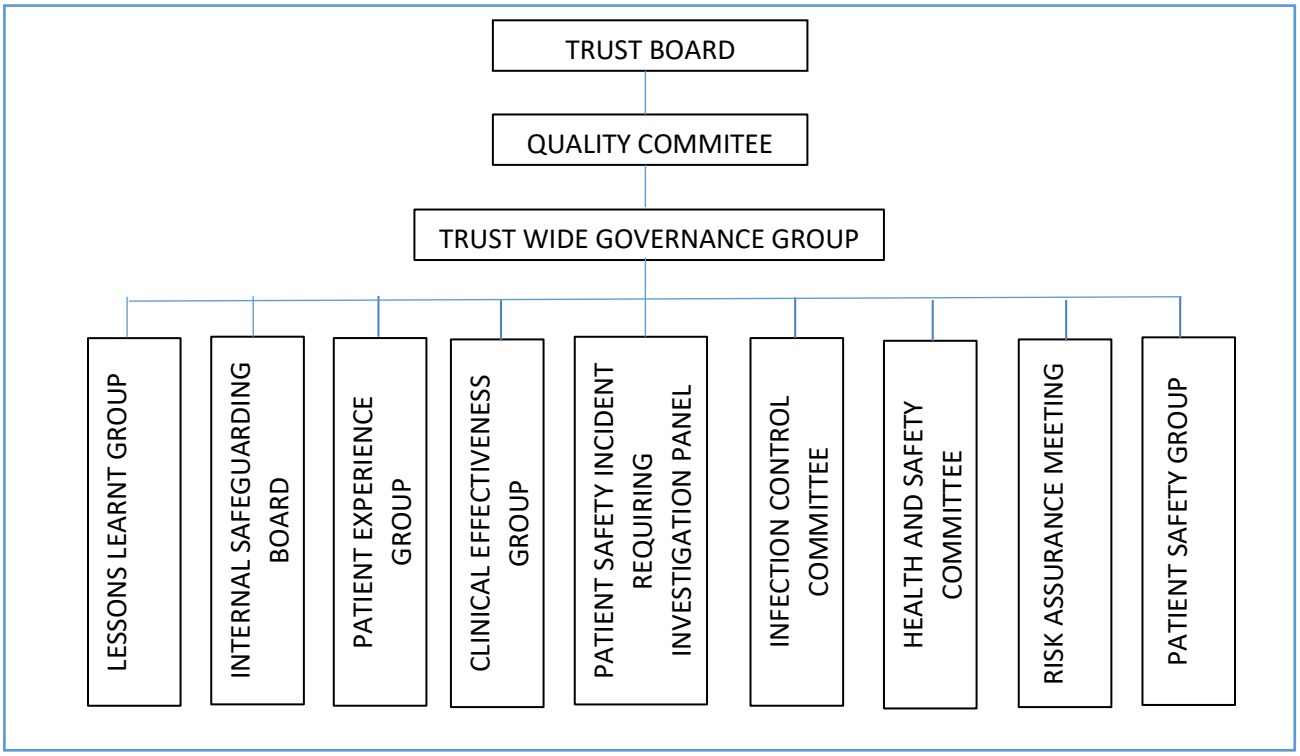
We actively encourage feedback in a variety of ways across the organisation including:

1. Friends and Family Test and local patient survey results remain a rich source of, relative, real-time patient and care feedback. From floor to Board can quickly obtain a snapshot of perceptions of care, with a Trust wide overview reported at the Patient Experience Group
2. Patient, Carer, and staff stories remain a crucial qualitative source of information, that influences our quality improvement work. These stories regularly feature at Trust Board and divisional meetings.
3. Complaints, concerns and soft intelligence are actively encouraged, and provide a smoke alarm to the organisation as to where we need to focus our attention. We support staff to provide the most appropriate and proportionate response to any matter.
4. National Surveys including the annual Adult In-Patient Survey, and national surveys of the Emergency Department, Maternity and the Children and Young People's Survey
5. The Trust continues to regularly meet with patient representative organisations such as Healthwatch - two local organisations (Healthwatch Lancashire and Healthwatch Blackburn with Darwen). Carers Service, N-Compass, VoiceAbility and Advocacy Focus. These organisations provide a critical friend role to the Trust, and we share best practice and regional and national initiatives in respect of patient experience.
6. Development of our Patient, Carer and Family Experience Strategy 2022-25.
7. The Trust's Public Participation Panel is well-established and actively involved in numerous projects and governance meetings. Whilst the Children and Young People's Forum is developing it approach to ensure we have a diversity of opinion as to how our services are delivered.

Governance Arrangements for Quality

Improving quality continues to be 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 Governance 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.

During 2022-23 the East Lancashire Hospitals NHS Trust continued to provide and / or subcontracted 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 continues to use its integrated quality, safety and performance scorecard to facilitate this and has begun using a Quality Dashboard to support triangulation. Reports to the Trust Board, the Quality Committee, Trust-wide Quality Governance Group and Senior Leaders Group 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 2022-23; have been managed by way of these reporting functions.

The income generated by the NHS Services reviewed in 2022-23 represents 98% of the total income generated by the East Lancashire Hospitals NHS Trust for 2022-23. (2021-22 98%).

2.3 Priorities for Quality Improvement 2022/23

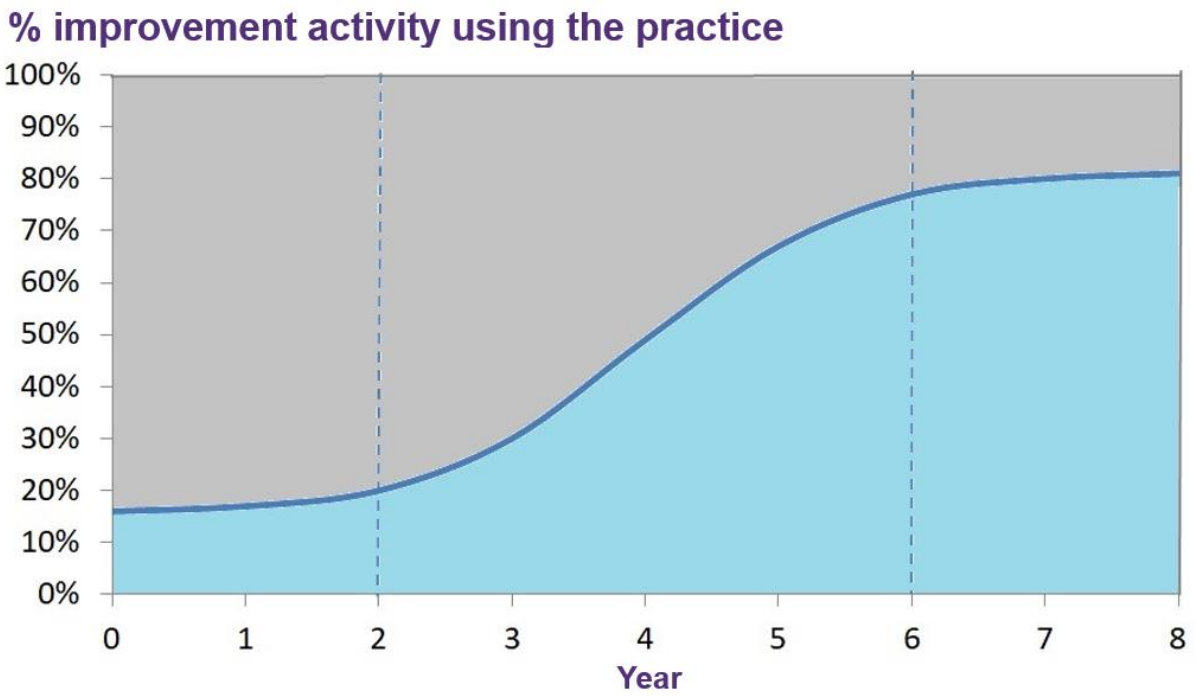
The Trust co-ordinates a comprehensive rolling programme of Quality Improvement and Harms Reduction initiatives and the publication of the Quality Account give us the opportunity to highlight some of the initiatives which we will specifically focus on during the coming year(s).

The Trust has identified a number of key delivery and improvement programmes to support achievement of Trust goals. The Improvement Hub team will be deployed each year to directly support delivery of a sub-set of these priorities through application of the SPE+ method. This will be agreed through the annual planning process. The Improvement Hub team will also support development of skills for improvement through training for others to apply the improvement method. Over time the improvement practice will be used increasingly to support delivery of Trust Goals.

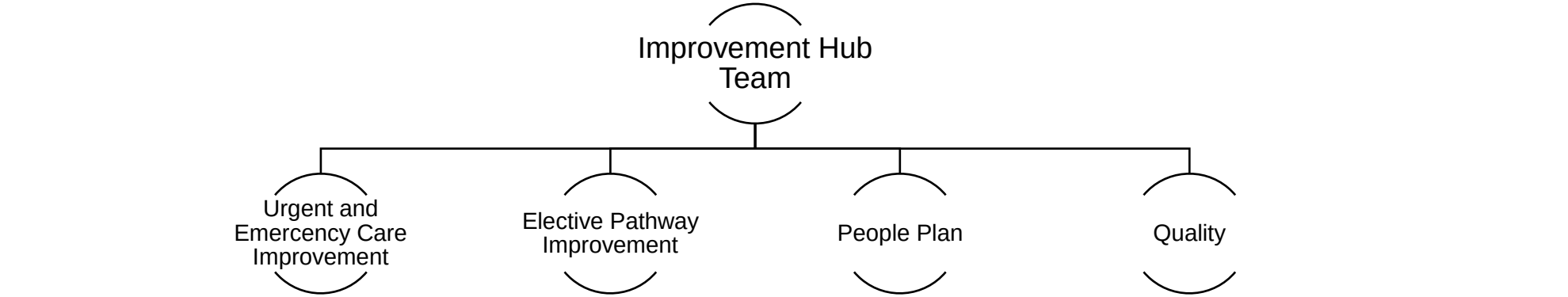
2022-23 Trust Goals and Key Delivery and Improvement Programmes

Key Delivery Programmes	Deliver Safe, high quality care	Secure COVID Recovery and Resilience	Compass-ionate and Inclusive Culture	Improve health and tackle inequalities in our community	Healthy, diverse and highly motivated people	Drive sustain-ability
Urgent and emergency care improvement	●	●				
Elective pathway improvement	●	●				
People Plan priorities		●	●		●	●
Quality and safety improvement priorities	●			●		
Electronic Patient Record	●				●	●
Care closer to home/place-based partnerships	●	●		●		
Provider Collaborative	●			●		●
Tackling health and care inequalities			●	●		●
R&D, Education and Innovation	●				●	
Waste Reduction Programme	●					●
Sustainability						●

SPE+ Approach and Improvement Hub Team support



Improvement Hub Team Priorities 2022/23



Emergency Care Improvement Plan

- 6s in Emergency Department (ED)
- Discharge PTL
- ED Board round
- Discharge Care Bundle
- Time to Triage
- Same Day Emergency Care

Increased focus on supporting improvements across our **Elective and Outpatient pathways**

- **Elective Improvement Plan**
- **Outpatient Improvement Plan**
- Chronic Pain PIFU (Patient Initiated Follow Up)
- Diabetes end to end
- Fracture Clinic for EPR (Electronic Patient Record) readiness

People Strategy

- Leadership & OD (Organisational Development
- PCB Nurse Bank / Agency Improvement Event
- PCB Grow Occupational Health services
- Improvement Practice Training offer
- Staff in training QI Projects
- Daily Quality Management

Quality Strategy

- Handover of Harms Reduction Programme to BAU
- PSIRP 5 x Quality priorities – see section 2.1
- End of Life Care
- Nutrition and Hydration
- Histopathology
- Adhoc coaching for Divisional QI Projects (371 on the Central Improvement Register)

L&SC System Model for Improvement - launch and testing / Pennine Lancashire Priorities – Frailty (with Respiratory)

Electronic Patient Record – Facilitation of Stop, Start, Continue process and selected change management/preparation activities

Waste Reduction Programme (WRP) – WRP Training (Level 2), WRP website/ideas register, selected WRP projects

Our overall Improvement Programme for 2023/24 will continue to comprise of a combination of:

Delivery Programme	Trust Goal(s)	Improvement initiatives/programmes
Quality	• Deliver safe, high quality care • Improve health and tackle inequalities in our community	• PSIRP Plan - 1 x Breakthrough Series Collaborative
Non-Elective	• Deliver safe, high quality care • Secure COVID recovery and resilience	• Emergency Care Improvement Plan – Inflow / Emergency Department: Ambulance Handovers
Elective	• Deliver safe, high quality care • Secure COVID recovery and resilience	• Elective Improvement Plan – Outpatient Clinic Bookings (Clinic Utilisation)
People	• Secure COVID recovery and resilience • Compassionate and inclusive culture • Healthy, Diverse and highly motivated people • Drive sustainability	• Hire to Retire / Agency reduction • Improvement Practice Training Offer – Launch of Level 1: Awareness and development and launch of Level 4: Coach • Continue to deliver Levels 2: Contributor and 3 Lead • Directorate and Divisional Quality Improvement Projects • Quality improvement (QI) projects for Staff in Training Groups • Everyday Improvement – Forum & SharePoint Site
Other		
Partnership Working	• Improve health and tackle inequalities in our community • Drive sustainability	• Lancashire and South Cumbria (LSC) System Model for Improvement launch and testing – Engineering for Better Care: Frailty
Electronic Patient Record implementation (EPR)	• Deliver safe, high quality care • Healthy, Diverse and highly motivated people • Drive sustainability	• Project Management support • Operational Readiness support • *Go Live* – Superusers & Floor Walkers • Clinical & Procedural Documents support • Baseline and post *Go Live* value objectives support
Waste Reduction Programme (WRP)	• Deliver safe, high quality care • Drive sustainability	• WRP Training (Level 2 Improvement Practice: Contributor) • Waste Reduction projects (various)

Other improvement priorities as required.

Electronic Patient Record (e-PR) Implementation

The culmination of several years of work at East Lancashire Hospitals NHS Trust towards a digital system leads to the implementation of an Electronic Patient Record (ePR) across the multi-site hospital Trust.

The Cerner Millennium ePR provides clinicians with more information at their fingertips to make better, more effective decisions. They'll have automatic access to decision support tools, meaning their decisions will be made based on the best available information and information will be taken from many sources. It makes staff more efficient and creates a smoother care journey for our patients.

It will enhance communication across clinicians and teams, reduce duplication and reduce some of the data collection burdens from people by capturing some things automatically.

Paper records are being replaced by digital records and there will be new ways of working introduced to take advantage of this digital approach. It will make several administrative tasks easier to manage as information will flow around the organisation more easily.

The launch of the ePR in June 2023 is the major step forward in our eLancs ambitions towards digital hospitals.

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 2022-23 56 national clinical audits and 11 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 51 (91%) 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 2022-23 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
Acute Upper Gastrointestinal Bleeding (AUGIB)	NHSBT	Intermittent	No	NA
Adult Asthma Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	BCIR	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Consultant Sign off (Care in Emergency Departments)	RCEM	Intermittent	Yes	100%

Elective Surgery (National PROMs Programme)	NHS Digital	Continuous	Yes	100%
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Infection Prevention and Control (Care in Emergency Departments)	RCEM	Intermittent	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC)	IBD Registry	Continuous	No	NA
Learning Disability Benchmarking Audit Year 5	NHS Benchmarking	Intermittent	Yes	100%
Learning Disability and Autism Programme (LeDeR)	NHS England	Continuous	Yes	100%
Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	BAUS	Intermittent	Yes	100%
Mental Health Self Harm (Care in Emergency Departments)	RCEM	Intermittent	Yes	Ongoing
Myocardial Ischaemia National Audit Project (MINAP) - National Cardiac Audit Programme (NCAP)	NICOR	Continuous	Yes	100%
National Adult Diabetes Audit – Core (NDA)	NHS Digital	Continuous	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	RCS	Continuous	Yes	100%
National Audit of Cardiac Rehabilitation	University of York	Continuous	Yes	100%
National Audit of Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
National Audit of Care at the End of Life (NACEL)	NHS benchmarking	Intermittent	Yes	100%
National Audit of Dementia: Care in General Hospitals	RCPsych	Continuous	Yes	100%
National Audit of Inpatient Falls (FFFAP)	RCP	Intermittent	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) - National Cardiac Audit Programme (NCAP)	RCP	Continuous	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	RCPCH	Intermittent	Yes	100%
National Bowel Cancer Audit (NBOCA)	NHS Digital	Continuous	Yes	100%
National Audit of Metastatic Breast Cancer	CEU - RCS	Intermittent	Yes	100%
National Audit of Primary Breast Cancer	CEU - RCS	Intermittent	Yes	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Child Mortality Database	University of Bristol	Continuous	Yes	100%
National Comparative Audit of Blood Transfusion – 2022 Audit of Blood Sample, Collection & Labelling	NHSBT	Intermittent	Yes	100%
National Diabetes Foot Care Audit –Adults (NDA)	NHS Digital	Continuous	Yes	100%
National Diabetes Inpatient Safety Audit (NDISA)	NHS Digital	Continuous	No	NA
National Early Inflammatory Arthritis Audit (NEIAA)	BSR	Continuous	Yes	100%
National Emergency Laparotomy Audit (NELA) Year 9	RCA	Continuous	Yes	100%
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Hip Fracture Database (FFFAP)	RCP	Continuous	Yes	100%
National Invasive Cervical Cancer Audit	RCP	Continuous	Yes	Ongoing
National Joint Registry (NJR)	HQIP	Continuous	Yes	100%
National Lung Cancer Audit (NLCA)	RCP	Continuous	Yes	100%
National Maternity and Perinatal Audit (NMPA)	RCOG	Continuous	Yes	100%
National Neonatal Audit Programme (NNAP)- Neonatal Intensive and Special Care	RCPCH	Continuous	Yes	100%
National Ophthalmology Database (NOD)	RCOphth	Continuous	No	NA
National Paediatric Diabetes Audit (NPDA)	RCPCH	Continuous	Yes	100%
National Pregnancy in Diabetes Audit - Adults (NDA)	NHS Digital	Continuous	Yes	100%
National Prostate Cancer Audit (NPCA)	RCS	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	92%
Paediatric Asthma Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Pain in Children (Care in Emergency Departments)	RCEM	Intermittent	Yes	100%
Perioperative Quality Improvement Programme	RCA	Continuous	No	NA
Pulmonary Rehabilitation Organisational and Clinical Audit	RCP	Continuous	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	SHOT	Continuous	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAMBA	Intermittent	Yes	100%
Tobacco Dependency Audit- Maternity Services	BTS	Intermittent	No	NA
Trauma Audit & Research Network (TARN)	TARN	Continuous	Yes	92%*
UK Parkinson's Audit	Parkinson's UK	Intermittent	Yes	100%

*Provisional up to Q3 based on predicted HES expected denominator per quarter

Key to Audit Coordinator abbreviations	
BAUS	British Association of Urological Surgeons
BCIR	Breast and Cosmetic Implant Registry

Key to Audit Coordinator abbreviations	
BSR	British Society for Rheumatology
BTS	British Thoracic Society
CEU	Clinical Effectiveness Unit
FFFAP	Falls and Fragility Fractures Audit Programme
HQIP	Health Quality Improvement Partnership
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care Audit & Research Centre
MINAP	Myocardial Infarction National Audit Project
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
NBOCAP	National Bowel Cancer Audit Project
NDA	National Diabetes Audit
NHSBT	NHS Blood and Transplant
NICOR	National Institute for Cardiovascular Outcomes Research
NPDA	National Paediatric Diabetes Audit
RCA	Royal College of Anaesthetists
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
RCPsych	Royal College of Psychiatrists
RCS	Royal College of Surgeons
PROMs	Patient Recorded Outcome Measures
SAMBA	Society for Acute Medicine's Benchmarking Audit
TARN	Trauma Audit Research Network

National Confidential Enquiries (NCE's)

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2022 -23	Sample Submission
Medical and Surgical Clinical Outcome Review Programme: Epilepsy	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Endometriosis	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme: End of Life Care	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme Transition from child to adult health services	NCEPOD	Intermittent	Yes	Ongoing	87.5%
Medical and Surgical Clinical Outcome Review Programme Testicular Torsion	NCEPOD	Intermittent	Yes	Ongoing	100%
Medical and Surgical Clinical Outcome Review Programme: Crohn's Disease	NCEPOD	Intermittent	Yes	Ongoing	100%
Medical and Surgical Clinical Outcome Review Programme: Community Acquired Pneumonia	NCEPOD	Intermittent	Yes	Ongoing	86%
Maternal, Newborn and Infant Clinical Outcome Review	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%

Programme: Perinatal Mortality Surveillance					
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality and serious morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	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
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries – United Kingdom
NPEU	National Perinatal Epidemiology Unit

The results of 78 national clinical audit reports and 5 National Confidential Enquiry reports were received and reviewed by the Trust in 2022-23. Following the review of National Clinical Audit reports, East Lancashire Hospitals NHS Trust intends to continue to implement the following actions to improve the quality of healthcare provided:

- National Audit reports will continue to be presented at specialty/ multi-specialty effectiveness meetings or other appropriate forums where lessons learnt, subsequent recommendations and action will be agreed so that practice and quality of care can be improved
- A list of all National Audit Reports received is collated and shared with the Medical Director, Divisional / Directorate Clinical Effectiveness Leads, and is monitored via Divisional and Trust Clinical Effectiveness Groups to provide assurance that these reports are being reviewed and lessons learnt, and any subsequent recommendations and action captured
- The Medical Director / Designated Deputy may request clinical leads to present finding at Clinical Leaders Forum or Quality Committee for further assurance
- National audit activity which highlights the need for improvement will have associated improvement plans developed and monitored at an appropriate forum for assurance
- The Clinical Audit Annual Report will include a summary on the participation in national audit activity along with learning, assurance or subsequent actions for improvement

194 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2022-23. 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 to support improvement
- 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 Clinical Effectiveness Lead
- All specialty effectiveness meeting minutes and action matrices will be shared for discussion at Divisional Clinical Effectiveness meetings or appropriate management forums. Outcomes will be included in divisional reporting to the Trust Clinical Effectiveness Group

All local clinical audit activity will also be included in annual reporting as a record of all activity and lessons learned as a result of audit to provide assurance and support improvement in quality and patient care.

2.4.2 Research and Development

The number of patients receiving relevant health services provided or subcontracted by ELHT in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee is 4,268 recruited participants across 70 studies.

2.4.3 National Tariff Payment System and CQUIN

A proportion of East Lancashire Hospitals NHS Trusts income in 2022-23 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 relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2022-23 and for the following 12- month period is available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

Unlike in previous years, providers are required to report their performance against all indicators to the relevant national bodies where they deliver the relevant services. The CQUIN financial incentive will only be earnable on the five most important indicators for each contract, as agreed by commissioners. Specialist Commissioning (Spec Comm) will also hold a separate financial incentive for each of the relevant indicators. For 2022- 2023 there were 17 CQUIN schemes (inclusive of the five financially incentivised schemes and specialist service schemes, the following Table sets out brief details of each of these.

ELHT CQUIN Programme Summary

Commissioned by	Scheme (*= incentivised)	Indicators
National	Staff Flu Vaccinations*	Achieving 90% uptake of flu vaccinations by frontline healthcare workers (HCWs) between 1 September 2022 and 28 February 2023, include non-clinical staff who have contact with patient.
National	Appropriate antibiotic prescribing for UTI in adults aged 16+*	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment. 1. Documented diagnosis of specific UTI based on clinical signs and symptoms 2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all catheter associated UTI (CAUTI) 3. Empirical antibiotic regimen prescribed following NICE/local guidelines 4. Urine sample sent to microbiology as per NICE requirement five. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.
National	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having the following are all recorded in clinical notes at time of admission to the critical care unit: 1. NEWS2 score; and, 2. The time and date of escalation (T0) 3. The time and date of response by appropriate clinician (T1)
National	Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways
National	Treatment of community acquired pneumonia in line with BTS care bundle*	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle. Total number of admissions of patients aged 18+, admitted from the usual place of residence with a primary diagnosis of pneumonia: 1. Perform a chest x-ray within 4 hours of hospital arrival time. 2. Pneumonia severity score (CURB65) calculated and documented in the medical notes during the ED and/or acute medical clerking. 3. Receive antibiotics within 4 hours of hospital arrival time. Antibiotic prescription is concordant with severity score and in line with local guideline
National	Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24. Total patients who had pre-operative assessment, prior to an elective inpatient admission, with a specified primary procedure: 1. Haemoglobin (Hb) measured at pre-op assessment, or reviewed and recorded if test results were already available 2. If anaemia present, have serum ferritin level tested 3. If diagnosed with iron-deficiency anaemia offered appropriate iron treatment (oral and/or IV iron); or refer to back to primary care for treatment where an existing local pathway is in place.

National	Timely communication of changes to medicines to community pharmacists via the discharge medicines service*	Achieving 1.5% of acute Trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message. The number of patients, where a referral was made within 48 hours following a patient discharge via secure electronic message which included: 1. Patient's demographic details (including their hospital medical record number) 2. The medicines being used by the patient at discharge (including prescribed, over-the-counter and specialist medicines) 3. Any changes to medicines (including medicines started or stopped, or dosage changes) and documented reason for the change 4. Contact details for the referring clinician or hospital department 5. Hospital's Organisation Data Service (ODS) code or Trust name.
National	Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending. Admissions where, within 24 hours of surgery ending, the patient was supported to drink, eat and mobilise by the following actions being taken: • Documented order and provision of the patient with free fluids • Documented order and provision of food, which may include oral soft nutrition or any other food • Documented order and provision of assistance to support an awake patient to mobilise from bed to chair
National	Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis
National	Outcome measurement across specified mental health services*	Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice.
National	Malnutrition screening in the community	Achieving 70% of community hospital inpatients and community nursing contacts having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks. Patients where the following actions were taken within 24 hrs of admission/at the first face-to-face community nursing contact (or by 1 June 2022 for those admitted/where the first face-to-face contact is prior to 1 April 2022) and then repeated at least every 30 days of the patient spell: 1. A malnutrition risk screening using a validated tool, such as The Malnutrition Universal Screening Tool (MUST) that measures all the items below, with each documented in the management care plan: • Body mass index (BMI) • Percentage unintentional weight loss • The time duration over which weight loss has occurred • The likelihood of future impaired nutrient intake.

		2. All people who are identified as malnourished or at risk of malnutrition have a management care plan that aims to meet their complete nutritional requirements. 3. There is evidence of all actions or goals within the management care plan being acted upon
National	Assessment, diagnosis and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines. The number where the following audit criteria for diagnosis and treatment are met within 28 days of referral to service or, for a patient already receiving care from that service, within 28 days of a non-healing leg wound being identified and recorded: • Documentation of a full leg wound assessment that meets the minimum requirements described in Lower Limb Assessment Essential Criteria. • Patients with a leg wound with an adequate arterial supply (ABPI > 0.8-1.3) and where no other condition that contra-indicates compression therapy is suspected, treated with a minimum of 40mmHg compression therapy. • Patients diagnosed with a leg ulcer documented as having been referred (or a request being made for referral) to vascular services for assessment for surgical interventions.
National	Assessment and documentation of pressure ulcer risk	Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. Where the following actions were taken within 24 hours of admission (or by 1 June 2022 for those admitted prior to 1st April 2022) and then repeated at least every 30 days of the patient spell: 1. A pressure ulcer risk assessment (within 6hrs) using a validated scale, such as Waterlow, Purpose T, or Braden, that assesses all of: i. Mobility; ii. Skin; iii. Nutritional status; iv. Continence; v. Sensory perception. 2. Has an individualised care plan9 which includes all of: i. Risk and skin assessment outcomes; ii. Recommendations about pressure relief at specific at-risk sites; iii. Mobility and need to reposition the patient; iv. Comorbidities; v. Patient preference. 3. Actions to manage the risks identified by the pressure ulcer risk assessment are documented by clinical staff.
NHS Spec Comm	Achievement of revascularisation standards for lower limb Ischaemia	Achieving 35% of patients that have a diagnosis of chronic limb threatening ischaemia (CLTI) that undergo revascularisation (improve blood supply to prevent leg amputation) either open, endovascular or combined within 5 days of a non-elective admission to vascular provider units.
NHS Spec Comm	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	The level of patient satisfaction with shared decision-making conversations – as measured by patient scores on internationally validated patient questionnaires – at key decision points in specified pathways that are priority areas for recovery around managing/reducing waiting lists, unplanned admissions and keeping vulnerable people out of hospital.10 SDMQ9 is the recommended questionnaire to be used. Alternatively, CollaboRATE can be used.

NHS Spec Comm	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	Co-ordination of Operational Delivery Networks to work towards Hepatitis C elimination by delivering an out of hospital-based HCV Programme, liaising with stakeholders such as prisons, probation services, community pharmacies, drug and alcohol services, GPs and patient groups to identify, test and engage people living with HCV. • In support of the NHSE/I public commitment to achieve hepatitis C elimination ahead of the WHO target of 2030 and be the first country in the world to do so. • The wider cost savings and benefits of eliminating Hepatitis C include fewer people requiring liver transplants, and reductions in the numbers of people experiencing liver cirrhosis due to HCV. • Supports the NHS Long Term Plan in reducing health inequalities as many of the groups most affected by HCV are not in regular contact with healthcare services and experience significant health inequalities. The proportion of patients treated, relative to the 2022/23 run rate
NHS Spec Comm	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines	The proportion of patients on admitted pathways for: cardiac surgery; cardiothoracic surgery; neurosurgery; AAA surgery; and within cardiology: TAVI and complex cardiac devices; who receive a priority categorisation - according to the Federation of Surgical Specialty Associations (FSSA) clinical guide to surgical prioritisation or equivalent14 - that is entered into the waiting list minimum dataset (WLMDS) alongside a decision to admit date and a proposed procedure code15

2.4.4 Care Quality Commission Compliance

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

The Trust is now registered with the CQC as a provider of Acute, Community and Primary Care services, following the transfer of PWE Primary Care services to our provision.

An application for the provision of care to patients who are subject to the Mental Health Act has been submitted to the CQC, in support of the wider system. We await authorisation from the CQC.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2022-23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 22 to Feb 23 (most recent figures):

- Admitted Patient Care 152,265
- Outpatient Care 635,005
- Accident & Emergency Care 191,914

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

Performance for Apr 22 to Feb 23 (most recent figures):

- Admitted Patient Care 99.90%
- Outpatient Care 100%
- Accident and Emergency Care 99%

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

Performance for Apr 22 to Feb 23 (most recent figures):

- Admitted Care 100%
- Outpatient Care 100%
- Accident and Emergency Care 99.6%

East Lancashire Hospitals NHS Trust will be taking the following actions to improve data quality:

- Continue to use the Second User Service (SUS) data quality tools and other benchmarking tools to identify areas of improvement
- Support data quality improvement within the meeting structures
- Continue to embed data quality ownership across the Trust

2.4.6 Information Quality and Records Management

The Trust aims to deliver a high standard of excellence in Information Governance by ensuring information is collated, stored, used and disposed of securely, efficiently and effectively and that all of our processes adhere to legal requirements. This includes completion of Data Protection Impact Assessments, annual Information Governance training for all staff, contract reviews and a comprehensive information asset management programme. The Trust has a suite of Information Governance policies to ensure patient, staff and organisational information is managed and processed accordingly.

The Data Security and Protection Toolkit sets out standards for maintaining high levels of security and confidentiality of information. Our Information Governance Assessment report for 2022-23 is ongoing with the final submission due at the end of June 2023. The Data Security and Protection framework and workplan is overseen by the Information Governance Steering Group which is chaired by the Trusts SIRO. The Information Governance Steering Group reports into the Trust's Audit Committee.

2.4.7 Clinical Coding Audit

The following external clinical coding audit is required to be carried out on 2022-23 data (but at the time of publication of the Quality Account had not yet been completed):

Data Security and Protection Toolkit Audit 2022-23 (200 episodes) - currently in discussions with the Lancashire Coding Collaborative / other potential parties about when this can be scheduled in, due to not having an auditor on-site and having no member of staff currently in an audit role.

The department no longer has a qualified Accredited Clinical Coding Auditor. Some audits have been carried out by senior members of the coding team and external auditors, but the programme has been limited due to staffing issues.

The Senior Clinical Coder is currently covering the role until March 2024 to minimise risk within the team, whilst a review of the structure and requirements of the Clinical Coding Team takes place.

- Band 2 Performance Audits (100 episodes per coder x 4 audits)
- Band 4 Performance Audits - Informal Performance Management (100 episodes per coder x 2 audits)

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.

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 2022-23, 2519 enquiries were received from a variety of sources (3402 in 2021/22). The team reports key performance indicators to Executive and Divisional leads to closely monitor concerns raised and to ensure a timely response is provided. Within the 2519 enquiries, 344 were logged as formal complaints during this period (389 in previous year). 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 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. This training includes local resolution, complaints policy, staff responsibilities and response writing. Regular reports now include more detail of these.

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 2022-2023, 11 complaints were referred to the Ombudsman, 1 is currently under investigation by the Ombudsman, 5 are being reviewed for possible investigation, 1 is awaiting casenotes etc being sent to Ombudsman, 3 are closed (2 were not agreed for investigation and 1 was not upheld), 1 has further local resolution ongoing, as recommended by Ombudsman.

2.6 Duty of Candour

The Duty of Candour (DOC) requirement (Health and Social Care Act 2008 Regulations 2014: Regulation 20), was established as a statutory duty for provider organisations in 2015 and is a requirement for registration with the Care Quality Commission (CQC).

The Trust has a Being Open and Honest Policy to ensure an apology is given to all patients, families and carers where the Trust has caused moderate harm or above to a patient. The Trust has a Standard Operating Procedure for tracking and monitoring the delivery of Duty of Candour and a report is published twice weekly and made available to Divisional Quality and Safety Leads, to support clinical teams to deliver the regulation requirements in a timely manner. 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. The Trust has an e-learning package for Duty of Candour which is available to all staff on the Trusts learning hub to access.

In 2022/23 the Trust reported no breaches of Duty of Candour in line with the required Health and Social Care Act 2008 Regulations 2014: Regulation 20.

2.7 NHS Staff Survey Results

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

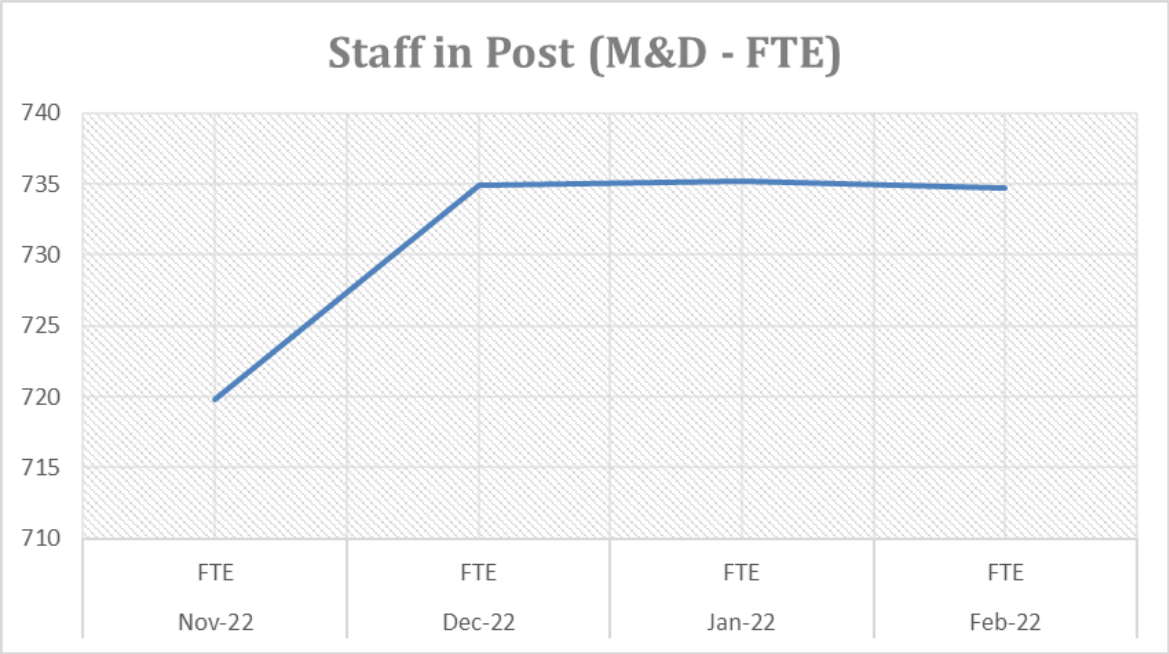
Indicator	Question	% Result
KF21 (Q15)	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	63.2.3%
KF26 (Q14c)	In the past 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	15.5%

For Q15, ELHT has seen an improvement on the previous year's percentage (62.0%). ELHT is better than the national average of 55.6%.

For Q14c, ELHT has seen a slight decline on the previous year's percentage (14.1%). ELHT is better than the national average of 20.0%.

2.8 Medical and Dental Staffing

Whilst Medical and Dental gaps continue to be a challenge, especially in our unscheduled care areas since the introduction of the 1:3 weekend rule, the Trust continue to proactively monitor and innovate to manage the recruitment and retention of Medical and Dental (M&D) staff. The Trusts figures show a significant increase in M&D WTE establishment, but due to increased footfall and acuity of patients, this has not translated into a saving on contingent workforce. Please see the growth in M&D Establishment:



The monitoring of M&D gaps is done through the Trusts Workforce Efficiencies Group in which each Division on a monthly basis, presents its M&D vacancies as well as agency usage. The purpose of this is to triangulate with our support services to ensure proactive recruitment, rotas are fit for purpose, agency exit plans etc.

Since forming the group in 2021, we have seen an introduction of schemes such as the GPF2+, several rota redesigns, signing up to the regional DiT bank, focused recruitment drives and the introduction of the Trusts Rota Continuity policy for any rota escalation. The Trust has also agreed a new contract for Locally Employed Doctors in the last 12 months which gives Trust doctors the same opportunities as those in training, with 15 days study leave a highlight of that.

In the next 12 months, we will continue to innovate and monitor the Trust M&D rota gaps. We are developing a regional CESR programme, providing pathways for oversees workers to progress into SAS posts, a task and finish group has been set up to look at the whole multi-disciplinary clinical workforce. Looking at a more competency-based resource as opposed to a role based. There is also a sickness project which has been audited by MIAA and has been sanctioned by our Improvement Team to help report and manage M&D sickness.

Overall, the Trust continue to proactively manage M&D gaps in an inclusive and innovative way.

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

3.1 Achievements against Trust Quality Priorities

The table below gives an overview of progress against the quality improvement priorities outlined in Section 2.3:

*For the purpose of this update, any Projects recorded as Sustain, will be underlined, and shaded in a light grey.

Please note that where data and metrics have been provided sample size will vary

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Non-Elective	**2595: SAECU Utilisation**	To increase the capacity for same day emergency surgical patients on SAECU by 21% by December 2022	• Understanding of current utilisation • Set up a clinic code and utilisation report • Relaunch and promotion of the STAR model • Relaunch of the FRIDAY Clinic • Created Standard Work for booking patients into SAECU to challenge appropriateness of booking to ensure that the patient is receiving care in the right place, first time • 58% decrease in the number of patients booked in as 'Other' (as part of a PDSA) • 50% increase in utilisation (as part of a PDSA)
	2594: Time to Triage	To ensure75% of patients are triage within 15 minutes of handover from NWAS by January 2023	• NWAS handover times have improved by 7% within 15 minutes (23%) and 12% for 30 minutes (79) • Median time to triage has dropped from 33 mins (baseline) to 21 mins for January 2023 • 13% increase in the quality for the triage (Baseline = 74%, Current = 87%, Target = 90%) • 20% reduction in Overprocessing of CRP & Coagulation Blood requests • 42% increase in staff morale when working in Triage

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Non-Elective	**2594: Time to Triage**		(Baseline = 5%, Current = 47%, Target 80%)
	2606: ED Board Round App	To provide assurance and evidence that a ward round has taken place by moving the paper based nursing safety huddle process to an electronic process, where notes can be recorded and stored	• Tested and implemented Use learning for EPR
	2465: In-reach Acute Physician	To reduce the waiting time for patients to be seen by an Acute Medicine Physician, after referral from the ED team by January 2022	• 59% increase of patients seen within the recommended timeframes, post intervention over a two month period • Time to be seen by a Medical Consultant reduced significantly by 9.08hrs, post intervention over a two month period • Improvements to patient care and improved flow (e.g. reduced time waiting for investigations/discussions with other specialities. Providing life-saving medical input to patient care at an earlier stage in their journey throughout the system) • Patients to be clerked by a junior doctor also improved. This may be due to patients already being reviewed by medical consultants in ED, which allows pressure to be uplifted from the junior doctor clerking team. This consequently allows junior doctor trainees to perform safer under less pressure dealing with other severely unwell patients on the AMU • Junior doctors have benefitted greatly by being able to discuss cases in depth with senior medical physicians. This has created a great opportunity for teaching • Medical SpRs feel better supported within the ED as other medical senior physicians

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Non-Elective	**2465: In-reach Acute Physician**		• are reviewing patients that require acute medical attention - sharing the workload and providing prompt senior support • Attended SAM (Society of Acute Medicine) Conference • Nominated for HSJ Award
	2538: Ward Processes		• Presented at the NHSi Focus on Discharge Planning National Conference • Ward Processes continue to be further adapted and adopted more widely across the Trust
	2383: Transfers to Community	To have all transfers to community wards to be completed by no later than 2pm each day	• Increase in the number of transfers undertaken to community wards before 2pm • Further understanding around transfers escalated post 2pm • Visual management developed and in place – Intermediate Care List (to identify patients who are suitable and/or require rehabilitation) • Discharge Matron post introduced
	2681: Daily Discharge Delays within Community and Intermediate Care (CIC)	To have 80% of discharge beds available in IMC (Community Wards) by 12pm by 31st March 2023	• Baseline was established this was between 16-35% • Main themes identified from the snapshot audits – Transport, TTO's and Communication • 2 x PDSA's undertaken – key learning established • 16/16 patients were discharged & 15/16 patients had their TTO's ready the day before discharge • Updated existing Log to identify delays
	2619: Point Of Care Testing (POCT) in the Emergency Department	To ensure 100% of patients in ED who have a COVID-19 swab taken have their result available on ePTS within 1hour by January 2023	• 95% of tests were accurately packaged and labelled (November 2022 data) • Average time for test to be completed and uploaded onto ePTS was 25 minutes (November 2022 data)

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Non-Elective	**2619: Point Of Care Testing (POCT) in the Emergency Department**		• Follow up observations and value stream analysis post ED 6S event • ED and POCT project group established • Time stamps introduced and to be added to test labels • Communication Newsletter developed and circulated • New equipment introduced
	2382: Discharge PTL	100% of relevant wards in MEC to follow one agreed standard process for data capture within the electronic DPTL by 30th September 2022	• 100% of wards within the MEC Division now using one agreed standard process for data capture • Future State Mapping Event supported and facilitated • Development of Standard Work • Introduction of Bi-weekly newsletter • Spreading learning to SAS and CIC Divisions • Pilot undertaken on wards D1, D3, C6 & C8 for PFFs / Clinical staff to update the DPTL during MDT Board Rounds
	Discharge Checklist Care Bundle	Wouldn't it be great if we had 80% compliance with the use of the Discharge Care Bundle across all Medicine and Emergency Care wards by 31st March 2023	• New Aim established as part of the Trust Improving Flow Weeks (November 2022 – March 2023) • PDSA undertaken: Any patients being discharged within 48hrs to have the discharge care bundle discussed on post ward round board round. This PSDA saw a 77% increase from the Baseline (total 87%) • Implementing learning from pilot wards – where the document needs to be anchored and where conversations are already happening • Positive impact on the utilisation Discharge Lounge – supporting earlier discharges

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Non-Elective	**Discharge Checklist Care Bundle**	For the Discharge Care Bundle to be consistently and reliably applied during each patient's inpatient journey, across all Intermediate Care wards (7 in total)	• Coaching and education with the wider MDT • Really good engagement with initial concept of the document – service users' daughter strongly influenced the design/content and continues to have a great interest in its continued progress • Monthly audits across the 7 IMC wards showed positive improvement in compliance • 4/7 x IMC ward piloted bringing the document into the daily board round – this is an established process, undertaken as business as usual. Introduced a Discharge Care Bundle File as part of the daily board rounds – supported continuous discussion around discharge. Have seen a significant improvement not only to compliance but embedding and sustainability on these 4/7 IMC wards • Really good positive feedback from MDT members • 4/7 wards have consistently been achieving 100% compliance (November 2022) • Ward Managers championing ongoing work and offering peer support and guidance as required
	2571: Avoiding hospital acquired deconditioning (Get Up, Get Dressed, Get Moving)	For 80% of all patients identified as meeting the Get up, Get Moving, Get Home criteria, on OPU (MEC division) are out of bed by noon (either independently or assisted by a member of the MDT) by 31st May 2022	• Established Improvement Coaching Board on ward C9 • Survey – Staff perception and patient awareness around importance of getting out of bed • Increase of 11.3% of patients who meet the Get Up, Get Moving, Get Home Criteria were out of bed by noon (total of 78%) • 18.2% of patient facing staff have completed the Frailty Training Tier 1 •

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	• Achievements:
Non-Elective	**2571: Avoiding hospital acquired deconditioning (Get Up, Get Dressed, Get Moving)**		• Increase of 22.5% of ward staff feel very confident in transferring patients out of bed (total of 54.5%) • Attended ELHT Trust Improvement Report Out
	Enhanced Care Risk Assessment Tool	To increase accuracy in the completion of the enhanced care tool by 20% on all Community & Intermediate Care wards by September 2022	• Training Package developed and delivery in progress • Adaption of existing SBAR - Enhanced Care Score further broken-down into categories – this has increased staff confidence & empowerment and safety of patient transfers
	2156: Safer Transfer of Patients – ED	85% of patients with a decision to admit to an SDEC Pathway, will be transferred within 1hour of the bed turning green by the 31st of May 2023	• Quick wins identified • Visual Management implemented around whether ED patient notes have been tracked on PAS • Safer Transfer Patient Matrix added to ED Nursing document
	NWAS National Collaborative – Ambulance Handovers	By 31st March 2023 we will have a 50% reduction in all >30 minute Ambulance Handovers	• Since the start of the collaborative we have seen a 40% reduction in the number of >30 minute handovers • Held 4 x Workshops within the Organisation to support the development of improvement, skills & education and to maintain focus on the work
Elective / Outpatient	**2636: Endocrine Adult Outpatients**	To reduce the endocrinology holding list for past to current month to 310 by 31st March 2023	• Seen a 50% reduction in the number of patients on a holding list (Baseline = 593, Current = 311, Target = 310) • Removal of duplicate patient entries on the holding list • Coding of uncoded patients • Reallocation of patients, for those with consultants that have left the Trust • Standard operating procedure created for patient initiated follow ups to reduce variation in practice

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Elective / Outpatient	**2723: Initial Management of Patients with Lower Limb Wounds with or without Lymphorrhoea (Wet Legs)**	The aim of the pathway is to support community disciplines with the initial management of patients with lower limb wounds with or without Lymphorrhoea (wet legs)	• Supported and facilitated bespoke improvement workshops • Redesigned the pathway to empower staff to make decisions around the right patient care first time • Removed duplication • Introduced a competency framework for training and education
	2611: Rheumatology Improvement A3	To transfer 5% of outpatient attendances to PIFU pathways in Rheumatology by March 2023	**PIFU – Patient Initiated Follow-Up** • Staff Webinar delivered on how to use PIFU and opportunity for Q&A's • Development of a PIFU SOP • Training & Engagement Session delivered on identifying clinical suitability for PIFU • Patient Information Leaflet created **NAL – Nursing Advice Line** • Further development of the Nursing Advise Line to now include PIFU patient calls • A bespoke clinic has now been added to PAS • An Automatic Text Service is now in place • Good staff feedback received **Bloods referral processes** • GP Event held with referrers to further understand demand management pathways
	2610: Chronic Pain Improvement A3	To ensure 10% of Chronic Pain follow up appointments are on the PIFU pathway by the end of March 2023	• Significant reduction of patients on the holding list • 5.4% increase in PIFU uptake between April 2022 and January 2023 – above the National Target • Downward trend in the number of DNAs since November 2022 • Developed PIFU pathway for the Pain Management Service • Developed points that needed to be included in the PIFU letter to the patient

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Elective / Outpatient	**2610: Chronic Pain Improvement A3**		• Informed all clinicians within the service about the process and what needed to be done • Positive feedback from patients • Improvement in administrative management of holding lists • Improvement in Clinician waiting lists and clinics • Attended ELHT Trust Improvement Report Out
People	**2620: PCB Nurse Bank & Agency Event**	• Reduce agency usage and increase bank usage • Reduce/eradicate off framework • Consistent and/or collaborative approach • Shared understanding of the problem • Hit price cap 80% of the time • 10% reduction in agency spend	• Bespoke 3day Bank & Agency Event – Lancashire & South Cumbria Collaborative • Staff engagement – creation of welcome packs • Matron of Professional Standards – point of contact for staff, visible person • 6 week roster lockdown – giving banks staff a good time to view and choose their shifts • Access to book own shifts • Wage stream App – real time view of wages and able to see earning from shifts • HCA recruitment events • Check, challenge and coach forum • Access to occupational health, wellbeing and training
	Improving Flow Weeks	• To support a Bed Occupancy of 92% or under • Support patients having the right place of care at the right time • To build Capability and Capacity within the Trust using the SPE+ Methodology To introduce the KATA Coaching Concept, Coaching Board and Coaching Questions	• 22 Bitesize education modules were delivered over 17 sessions, to 57 Members of staff covering the SPE+ methodology, Kata coaching concept, Everyday Improvement, Improvement Cell & the psychology of change • The Kata Coaching Concept was introduced, and we delivered 10 Bitesize Kata and Everyday Improvement sessions, supporting the Embed, Spread and Sustain phases • Over 75 coaching cycles were completed

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
People	**SPE+ Improvement Practice Training Activity**		• 19 x Level 2 Improvement Practice Training Sessions: Contributor = 364 • 10 x Level 3 Improvement Practice Training Sessions: Contributor = 236 • 2 x 2day Kata Improvement Coaching Session (Cohorts 1 & 2) = 41 Kata Coachees • 12 x Bespoke Level 2 Improvement Practice Training & Workshop Events delivered (including those recorded within individual programmes of work) Total numbers trained may also include Bespoke Improvement Practice Training / Workshops & Staff in Training / External Colleagues
	SPE+ Improvement Practice Level 2 and Level 3 Feedback		**Level 2 Improvement Practice Training Session: Contributor** • 100% Strongly Agree or Agree that they know what support is available to them when undertaking improvement • 98% Strongly Agree or Agree that the session met all of the Learning Outcomes • 98% Strongly Agree or Agree that they know how to register their improvement idea/project and who to contact • 90% Strongly Agree or Agree that they would recommend this training session to colleagues • 90% Strongly Agree or Agree that they know what further improvement development & training is available to me • 90% Rate their overall experience of this training session as Excellent or Very Good **Level 3 Improvement Practice Training Session: Lead** • 100% Strongly Agree or Agree that they know what support is available to them when undertaking improvement

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
People	**SPE+ Improvement Practice Level 2 and Level 3 Feedback**		• 99% Strongly Agree or Agree that they would recommend this training session to colleagues • 99% Strongly Agree or Agree that they know what further improvement development & training is available to me • 96% Strongly Agree or Agree that the session met all of the Learning Outcomes • 96% Strongly Agree or Agree that they know how to register their improvement idea/project and who to contact • 91% Rate their overall experience of this training session as Excellent or Very Good
	Staff in Training: The Improvement Hub team, work in conjunction with the Department of Education, Research and Innovation (DERI) and UCLAN to support a range of trainees and newly qualified staff to develop their improvement skills and undertake improvement projects – '*Our Improvers of the Future'*		• 4 x Level 2 Improvement Practice: Contributor, as part of the Preceptorship Programme for newly qualified nurses = 144 • 9 x Trainees have commenced the Advanced Clinical Practitioners - Level 3
	Staff in Training: The Improvement Hub team, work in conjunction with the Department of Education, Research and Innovation (DERI) and UCLAN to support a range of trainees and newly qualified staff to develop their improvement skills and undertake improvement projects – '*Our Improvers of the Future'*		• Improvement Practice: Lead to be delivered • Approximately 73 x FY2 Junior Doctors and 31 x Junior Clinical Fellows took part in an Introduction to Level 3 Improvement Practice Training: Lead • 90 x SSC4 UCLan Medical Students (2022/23 Cohort) trained in Level 3 Improvement Practice: Lead and supported to undertake a Quality Improvement Project, as part of their SSC4 (Student Selected Component)

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Quality	**Harms Reduction Programme / Patient Safety Incident Response Framework**	To undertake a full review of the existing Trust-wide Harms Reduction Programmes (HRP) and produce a Closure Report. Transition from existing Trust-wide Harms Reduction Programmes to Patient Safety Incident Response Framework (PSIRF)	• Supported the full review and revision of the Quality Strategy for 2022/25 • Launched the revised Quality Strategy for 2022/25 • Undertaken a full review of the existing x16 Trust-wide Harms Reduction Programmes (HRP) / Other Quality Priorities with Project Leads and Teams • Produced a HRP Closure Report • Identified the scope and/or aim for 5/5 PSIRP priorities • Began to undertake a current state analysis on 4/5 PSIRP priorities as part of the Understand Phase of Improvement • Developed Driver Diagrams on 4/5 PSIRP priorities, as part of the Co-design Phase of Improvement
	Falls Prevention		Ongoing delivery of the Falls Prevention Improvement Programme
	Medication Errors		Ongoing delivery of the Medication Errors Improvement Programme
	MatNeoSIP / CNST		Ongoing delivery of the MatNeoSIP / CNST Improvement Programme
	Infection Prevention & Control		Ongoing delivery of the Infection Prevention & Control Improvement Programme
	SAFER Surgery		Ongoing delivery of the SAFER Surgery Improvement Programme

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Quality	**Deteriorating Patient**		To improve the recognition and response to the Deteriorating Patient
	End of Life Care (EOLC)		Ongoing delivery of the End of Life Care Improvement Programme
	Nutrition and Hydration		Ongoing delivery of the Nutrition and Hydration Improvement Programme
	2439: Histopathology processing and reporting turnaround times	To reduce the processing and reporting turnaround times for histology specimens by 25% by 31st December 2023 (% reduction in days equates to: 2WR 5 days; Urgent 5 days; Routine 10 days; Average 7.5 days)	• Daily huddle now embedded • Increasing compliance with staff appraisals being completed • Histopathology Improvement Forum piloted. Good feedback and felt to be a useful addition • Continuing to undertake Trust Education Roadshows at Directorate Meetings across the Trust • Review of the Frozen Section specimen - equipment moved and dedicated bench to process frozen section specimens now in place • Labelling of Endoscopy specimen bags - Test of change underway to put a sticker on the bags to help with the check-in of the specimens • Urgent specimen list introduced as part of the huddle and sits next to the huddle board. Aids escalation of specific specimens • New check in process in specimen reception. Change implemented with support of a flow chart • Plans to convert the send away list which shows the specimens that have been sent to other hospitals to an electronic system to reduce the number of errors

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Quality	**2439: Histopathology processing and reporting turnaround times**	To reduce the processing and reporting turnaround times for histology specimens by 25% by 31st December 2023 (% reduction in days equates to: 2WR 5 days; Urgent 5 days; Routine 10 days; Average 7.5 days)	• Change made to use Tpath re the process related to notifications of when a specimen requires to be disposed off • Focus on the specimens coming into the department and work supporting reduction in errors and improving the flow of the process • Numerous areas of the department clean and tidied using the 6S approach • White laboratory coats - Standardising where coats should be hung and kept. Ensuring a stock of spare coats are kept in a specific place • Introduced Visual Management into the Department - including educational posters; instructions of how to undertake a process; visuals regarding work areas and expectations • Occupational Health review of chairs completed - new set of chairs ordered and now in place • Reduction in the backlog of specimens awaiting processing - prior to Christmas 2022, this reduced to 0. Staff absence had reduced leading to this improvement • Reduction in number of cases requiring escalation by Cancer Services for reporting
	2386: Error reporting in the Pharmacy Dispensary at ELHT	To reduce the number of IR1s related to dispensing of medicine at ELHT by 25% by 30th June 2022 To increase the number of Share To Learn reported by 25% (~24), by 31st March 2022	• Share to Learn process now part of the induction for new starters • Continuing to develop the reporting system

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Quality	**2425: Parkinson's Medication – get it on time**	To improve the number of instances that Parkinson medication is given on time by 60%, across ELHT, by the end of March 2023	• Collaborative working with colleagues from the Royal Preston Hospital • e-Learning package developed and piloted at ELHT
	2638: Enhancing the care for Bariatric Patients	To review pathways , equipment and training for our Bariatric patients, with a view to developing policy and a care plan and assurance reports	• Scope of project defined & Task & Finish Group established • Great attendance and engagement from key stakeholders • Patient representative involvement • Patients Stories/Experience & Staff Surveys underway to assess current Governance and Training & Education
	2547: Hands First (National Quality Improvement Collaborative	To improve clinical outcomes regarding hand trauma by reducing variation in management and reducing time to surgery	• Project Lead presented at the RCS Hands First National event. Feedback received was excellent • 4 x PDSA's undertaken: 1. Introduction of a proforma for hand injuries presenting to ED 2. Allocation of Hand Therapist in Fracture Clinic 3. Introduction of Hands First UCC proforma triage 4. Pilot of HT Team screening call Impact on the National Outcome measure seen slight improvement • Invited to Royal College of Surgeons as part of the National Collaborative • Won an award for *'Best Application of PDSA's'* out of 26 Trusts that were part of the collaborative
Waste Reduction Programme (WRP)	**2540: Waste Reduction Programme**	There will be a platform available for ELHT staff to share any ideas / suggestions to reduce waste (cost, time etc.) in their area (either systems or processes) to help ELHT become Leaner	• Relaunch of WRP Scheme • WRP SharePoint Site developed • TIMWOODS incorporated as part of the SPE+ Improvement Practice Training • Collaborative working between the Improvement Hub and the Benefits Realisation Team to join up the dots between QI

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Waste Reduction Programme (WRP)	**2540: Waste Reduction Programme**		• Projects registered and Divisional central schemes • 10 x WRP Ideas submitted
	2441: Salary Overpayments at ELHT	To reduce the salary overpayments to ELHT staff by 50% by the end of March 2023	• 2 x workshops held in August & September 2022 to establish metrics, identify waste, gather experiences and assumptions and generate ideas for future testing • 33% reduction in the number of overpayments by month (Baseline = 380, Current = 253, Target = 170) • 46% reduction in error types due to late termination • 47% reduction in total overpayments by month = £321.687.18 (Target = 50%) • 55% of staff surveyed feel more training needs to be provided before being able to make assignment changed. • 73% feel there is adequate support available if they need help / support. • 71% feel they have sufficient admin time and resources to ensure timely assignment changes. • Creation of the ESR Helpdesk, expanding each month and will soon cover whole Trust - well received by managers and well used. Assists managers in completing actions and provide regular reminders to complete termination forms and assignment changes • Redesign of ESR Assignment change portal - making it as straightforward as possible to find forms/links • Overpayments added to FAB agenda re WRP- improved Divisional input • Input from HR/Finance colleagues supporting around overpayments

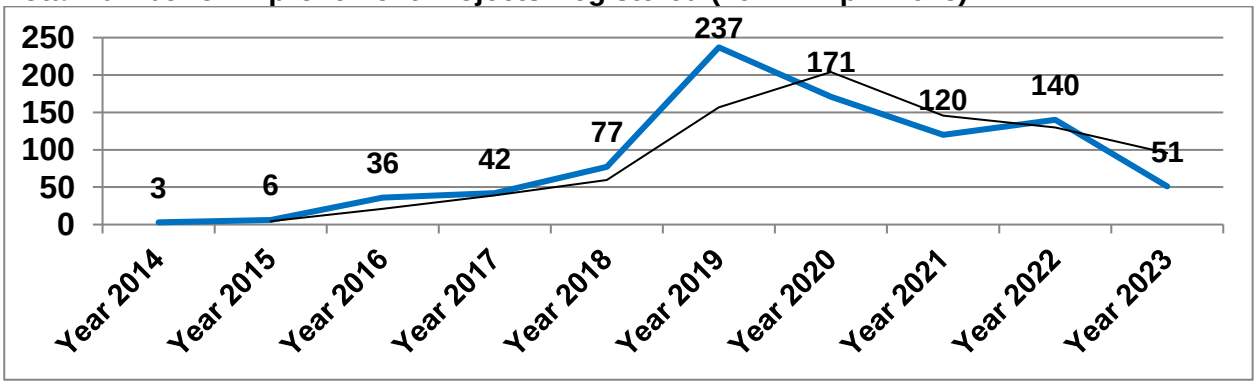
Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	• Achievements:
Waste Reduction Programme (WRP)	**2441: Salary Overpayments at ELHT**		• Ongoing HR & Finance support around overpayments • MIAA undertaken – recommendations received
	2562: Assign Outpatient Letter to the most appropriate form of postal delivery	Reduction in sending letters by taxi or internal transport by 50% by December 2022	• 3 x workshops supported and facilitated with the Endoscopy, Post room and Transportation teams/services to understand the current processes, barriers and opportunities for improvement • Co-design and development of a Postal Services SOP • Development of an educational poster to increase awareness • Snapshot Audits across RBH & BGH currently underway – early analysis has highlighted a reduction in the use of taxis to deliver an Outpatient Appointment Letter
	2607: ED 6S Workplace Organisation and Flow Improvement Event	Empower staff in ED to create and sustain a safe, well-organised workplace and productive environment, which contributes to reliable delivery of SPE care, by 31/03/23	• Bespoke 3day 6S Event – Emergency Department • Release of 168hrs a week of clinical time back to patient care. • Reduce waste of expired products by managing stock levels by minimum 50% in year 1 and by 20% per year • Inventory Reduction by 20% £15k • Inventory Identification to add to balance sheet, initial addition of £78k • 1.38% in the staff attrition rate (Baseline = 5.64%, Current = 4.26%, Target = 10%) • 62% increase of staff morale when working in zonal areas • 69% of actions on the equipment project tracker completed • Ingenica implementation has been shortlisted in the HSJ Digital awards

Key Delivery Programme:	Improvement Project Title and Phase of Improvement:	Goal / Aim:	Achievements:
Electronic Patient Record (EPR)	**Electronic Patient Record (EPR)**		• Supported and facilitated over 17 x Stop, Start, Continue sessions across workflows, Directorates and Divisions • Supported the identification and review of ELHT Clinical Care Bundles • Supported the review of procedural documents for EPR, using the SPE+ improvement methodology and A3 Thinking
Partnership Working	**L&SC System for Improvement – Engineering Better Care (EBC)**	To develop a system-wide model for improvement to tackle L&SC-wide improvement opportunities	• Initial focus identified: Frailty and Respiratory • First workshop completed • Pennine Lancashire Team convened – ELHT a key partner in EBC Programme • Great engagement to date • ELHT are the lead organisation in the ICS on the subgroup: Identification and Assessment of Frailty • Bespoke 3day Frailty Event • Goal of the Frailty sub-group: Improving the implementation of the Clinical Frailty Score (CFS) within ELHT and East • Plans to pilot with GP Practices within scope to identify patients with a CFS and intervention plans

Improvement Hub Activity

There are currently **542** Improvement Projects registered as 'live' – 'live' projects are classified as those in one of the SPE+ 6 phases of improvement registered from 2018 to April 2023.

Total number of Improvement Projects Registered (2014 – April 2023)

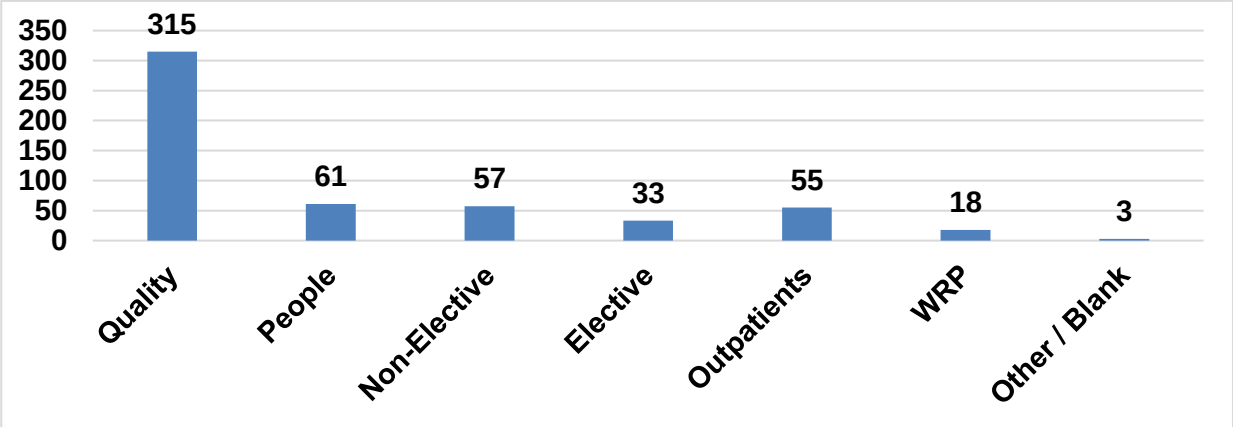


The significant increase of registered projects in 2019 shows the impact of the implementation of the improvement registration and triage processes. The decreases in years 2020 and 2021 reflect the impact of the Covid-19 pandemic and the response for some improvement activity to be stood-down and refocused. It may also reflect, the further work and focus undertaken to 'prescribe' existing registered improvement projects to promote continuous improvement and establishing links to other key strategies, initiatives, and programmes of work Trust-wide.

Total number and % of Improvement Projects Registered per Phase (2018 – April 2023)

Understand	Co-design	Test and Adapt	Embed	Spread	Sustain
228	44	106	45	19	100
42%	8%	20%	8%	4%	18%

Total number and % of Improvement Projects Registered per Improvement Pillar (2018 – April 2023)



3.2 Harms Reduction Programmes

ELHT's Harm Reduction Programmes encompass a number of different improvement initiatives designed to improve patient care and reduce harm. Each element of this programme has its own steering group, are supported by the Quality Improvement Team, and updates are reported through to the Trust-Wide Quality Governance (TWQG) monthly.

Following on from the Quality Workshops held in July 2021, over the last 12-18months the local PSIRF priorities have superseded the existing Harms Reduction Programmes (HRP). In order to provide assurance, a joint review has been undertaken by the Improvement Hub and Governance Quality Programme Leads for each of the existing Trust-Wide Harms Reduction Programmes.

A Closure Report will capture the review of each of the Harms Reduction Programmes/Other Quality Priorities and will be presented at the relevant committees in early 2023 for final agreement.

The tables below provide an overview of the aims and key achievements of each individual project since the last Quality Accounts was published:

Falls Reduction

Aim: To reduce the number of inpatient falls resulting in harm (moderate and above) due to preventable lapses in care, across all inpatient areas at ELHT by 10% by October 2023.
Key Achievements / Updates
• Good representation and attendance across all divisions at the monthly Falls Strategy Group • Falls Change Package embedded across all inpatient ward areas • Launch of Patientrack - Lying and Standing BP included as part of this eObs system • Post Falls Checklist introduced for all falls moderate and above in all clinical areas / across all sites • Falls Checklist now added to Datix (internal incident reporting system) • New Dementia Lead Nurse commenced in post • Get up, get moving campaign commenced on Older Persons Unit (OPU) • Introduction of Falls Prevention e-Learning module • Introduced Falls Training for Junior Doctors • Falls Prevention included as part of the Safer Handling e-Learning module • Included as part of the Enhanced Care Planning e-Learning module • Enhanced Care – Cohort Bay Tagging signage distributed & Enhanced Care cohort bed signs distributed to the wards • Post Falls Medical Checklist prevalence audit commenced • Falls Lead Consultant identified • Falls Awareness Week: 19th- 25th September 2022 • New aim has been agreed for 2022/23 - To reduce the number of inpatient falls resulting in harm (moderate and above) due to preventable lapses in care, across all inpatient areas at ELHT by 10% by October 2023. • Low rise beds arrived at Trust and are now available on Community Hospital sites (PCH & CCH) • Enhanced Care Yellow Bay Tagging Badges arrived

Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**7**

Medication Errors

Aim: Reduction of Medicines Omissions especially for critical medicines and Reduction in dosing errors with Insulins
Key Achievements / Updates
• Over the last 12-18months Gentamicin has become the priority for this HRP • Medicines Focus Bulletins were developed and circulated for: Exogenous steroids, adrenal insufficiency and adrenal crisis – who is at risk and how should they be managed safely? Gentamicin Prescribing, Monitoring and Dosing and Making Anticoagulation safer • 5 Minutes Facts educational documents have continued to be developed and circulated for: Controlled Drugs, Medicines Security, Risk of severe and fatal Burns with emollients, Insulin and Paracetamol • Medicines Safety and Optimisation Committee SharePoint page launched • Launch of the new Adult Drug Prescription and Administration Chart • Medicines Memos were developed and circulated for: Expiry dates for Oral Liquid Medicines and Dalteparin for prophylaxis of venous thromboembolism • New BD pumps with guardrails software • Second check requirement for insulin administration added to Agency Nurse Induction Checklist

• Baseline assessment tool for Controlled drugs: safe use and management (NICE medicines practice guideline NG46) - 94% of the recommendations have been met in the baseline assessment • Baseline assessment tool for medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (NICE medicines practice guideline NG5). 76% of the recommendations are met with 11% as partially meeting recommendation • Patient Safety Week - Insulin Safety, Gentamicin Safety & Critical Meds – Get it on time • Gentamicin training courses are now on the Learning Hub – 296 staff trained to date • Get It on Time: Parkinson's Disease Society Toolkit and Working Group QI Project registered • Medicines Management Link Champions introduced	
Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**57**

Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) / CNST

Aim: To reduce the national rate of preterm births from 8% to 6% and reduce the rate of stillbirths, neonatal deaths and brain injuries occurring during or soon after birth by 50% by 2025	
Key Achievements / Updates	
• Digital Midwife Role funded and implemented to support data quality to inform improvements • Care Bundle approach of delayed cord clamping for 1 min, PEEP less invasive ventilation for all babies and thermoregulation implemented • Benefits of delayed cord clamping, simulations of pre-term birth training • Spread – Feasibility testing for use of Lifestart trolley for twin deliveries for thermoregulation • Breastfeeding - BAPM- Preterm Maternal Breast Milk Toolkit implementation (2020) and evaluated and presented to region (2021) • Electronic Patient Record (Badgernet) for Maternity Services was implemented, enhancing data recording and data quality • Audit of early breastfeeding and expressing in NICU mothers completed • Human factors training undertaken • Regional re-launch of the programme with new driver diagram highlighting focus on Optimisation and Deterioration: smoking cessation focus moved to Prevention Programme and culture focus moved to Perinatal Culture & Leadership Programme • Audit of Delivery Room Cuddles to assess impact on colostrum and early breastmilk • Digital Nurse Role for Neonatology introduced • Regional team drop-in to ELHT with promotional posters, mugs etc to engage teams and ensure the optimisation measures are a key focus • To support the collaborative working between Maternity and Neonatology the Family Care Divisional management structure is moving to ensure maternity and neonatology attend the same forums and have the same directorate manager enhancing the ability for joint working across programmes such as Mat Neo SIP.	
Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**60**

Infection Prevention & Control

Aim: To reduce the number of Healthcare-associated infections (HCAIs – MRSA, C.Diff & E.coli) by reducing variation and obtaining assurance of IPC practice by 2025.
Key Achievements / Updates
• No progress made on 'Prompt to Protect' due to IPC Team resource, Covid-19 becoming the priority for the IPC Team

• ELHT are no longer participating in the NHSE / NHSI initiative 'Every Action Counts' and NHSI are no longer implementing this initiative • New National Directive for NHSE – see Aim above • The IPC Team attended a bespoke Level 3 Improvement Practice Training Day	
Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**27**

SAFER Surgery

Aim: To improve the safety culture in theatres for all operating lists, through compliance with the '5 steps to safer surgery' – WHO checklist by March 2024	
Key Achievements / Updates	
• Introduction of the Feedback Friday across sites Theatres, Day Case and Elective Centre • A focus group with staff from BGH & RBH will be developed; this will then be rolled out to the Patient Participation Panel to ask for patient input into the concept of 10,000 feet as a safety initiative • CQC identified on their last visit that the new brief boards are good in gaining staff engagement • Theatre Safer Surgery meeting recommenced with a renewed focus to review the Brief and Debriefs. This has been registered with the Improvement Team and work is ongoing • All Briefing boards to include a standardised message, which will act as a prompt at the theatre briefs to remind and empower all staff to raise concerns and engage and focus on patient safety within the professional environment: If you have any concerns, please call 10,000 feet and Call for a silent focus prior to a critical safety step. This message has now also been added to the electronic brief/debrief form • Theatre SharePoint Site developed and launched • Joint Patient Safety Event – Quality Governance & Theatres • Culture Workshop – Team Leaders & Band 6's • Electronic Brief & Debrief Form launched • Review of online 5 Steps to SAFER Surgery syllabus • Competency Pack updated – new starters now meet with Practice Educator (PEF) to go through induction checklist	
Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**29**

Deteriorating Patient

Aim: To improve the recognition and response to the Deteriorating Patient Due to the size and complexity of the Trust-wide project, 7 key workstreams each with individual aims, have been identified.	
Key Workstreams – Cardiac Arrests, Sepsis, Acute Kidney Injury (AKI), Early Warning Score (NEWS2), Fluid Balance, Safer Transfers and Fluid Stewardship	
Key Achievements / Updates	
Cardiac Arrests • QI Project commenced to *Improve the compliance and reliability of checking the kit and equipment on the Resuscitation Trolleys* • QI Project commenced to *Improve compliance with structured debrief post cardiac arrest to 80% in the next 3 months* • Resuscitation Policy Revised Sepsis • All Suspicion of Sepsis Care Bundles continue to be revised and updated, as per National Guidance and the Trust Management of procedural documents policy (October 2021) • ELHT / key stakeholders for sepsis agree to implement the new guidance from the Academy of Medical Royal Colleges - Initial antimicrobial treatment antimicrobial of sepsis	

- Trust Sepsis focus as part of the WHO Patient Safety Week for World Sepsis Day - 13th September 2022

AKI (Acute Kidney Injury)

- New QI project is underway in collaboration with IHSS with regards to the management of AKI in the community to identify this who can be managed at home to prevent admission to secondary care – links now fully established
- Recent data shows that new referrals to the Acute Care Team have reduced significantly
- E-learning package is now complete and will be available to all staff
- Introduction of Healthcare Assistants (HCA's) reviewing AKI 1 and 2 patients

NEWS2 / Clinical e-Observations

- QI Project commenced to *Reduce the number of incidents related to failure in escalation of deteriorating patients and reduce variation in practice by introducing an in-reach service into ED*
- Integrated a standard response to escalation and treatment for patient plans and transfers at BGH
- Launch of Patientrack (e-Obs system) across all ELHT Hospital Sites and areas (excluding Maternity)
- Clinical Observations Task and Finish Improvement Group commenced

Fluid Balance

- Revision of Fluid Balance Chart – All Adults (aged over 16years) in-patient areas including the Emergency Department and Critical Care at ELHT must be placed on a Fluid Balance Chart
- New e-Learning Package developed – awaiting go live date
- Quarterly Deteriorating Patient Link Nurse Meetings restarted

Safer Transfers

- Spot-check Audit of Correct minimum Clinical Personnel required undertaking transfer and Patient Decision Matrix present undertaken – Achieved above original SMART Aim = 90% compliance reached
- QI Project commenced in the Emergency Department to *Reduce the median time patient wait from bed turning green to arriving on AMU A&B by 33% (within 60 Mins) by May 2023*
- As a Trust we are now talking more about safer transfers
- Staff are feeling more supported and feel that they are supported in practice
- Has become embedded into daily practice / business as usual (BAU)

Fluid Stewardship

- Fluid Stewardship Group commenced
- Maintelyte approved for use and rolled out in ELHT
- Fluid Stewardship YouTube videos created and uploaded
- ELHT Fluid Stewardship Article published in Hospital Pharmacy Europe
- Drug Prescription Chart revised in order to help educate and spot check audits
- Funding agreed for Blippit Meds – Fluid Stewardship for Health Trusts
- Revised audit tools / adapted quality
- FY1 and FY2 Training and Education Sessions introduced
- Fluid Stewardship Posters designed and distributed to the wards

Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**36**

Nutrition and Hydration

Aim: 1. To reduce the number of serious incidents relating to nutrition assessment, oral nutrition and hydration on wards C2 and C4 to zero by December 2021. 2. To reduce the number of nutrition and hydration incidents resulting in harm (moderate or above) due to preventable lapses in care, across all inpatient areas at ELHT by 10% by 31st March 2024	
Key Achievements / Updates	
• Visual management system agreed • NJ bedside placement by nutrition nurses, negating the need for endoscopy, reducing length of stay and need for parenteral nutrition • NJ placement enabled faecal transplant for patients with persistent C diff • QI project on C2 and C4, recommendations now in place which include dedicated nutrition team (business case) and Nutrition Excellence Award Self-Assessment • Mealtime delivery SOP created, roll out planned as part of Nutrition Excellence Award • Real time ordering system procured and awaiting implementation • Roles and responsibilities document created • Commenced creation of a nutrition and hydration page on share point to improve access to information • Learning from QI project influencing the creation of solutions in Cerner • Introduction of smaller menu options, roll out of food for fingers across Trust and improved menu choices for children • Focussed training to wards breaching Speech and Language Therapy (SaLT) recommendations has resulted in a reduction of incidents • SSC4 Medical Student projects completed to further understand why nutrition is not a consistent part of medical care planning • Nutritional Support Team Business Case approved, and recruitment process commenced	
Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**30**

End of Life Care

Aim: To improve the quality of care of inpatients at ELHT in the last days of their life, to at least the National Average (NACEL) by 2023 (2024 report. Due to the size and complexity of the Trust-wide project, 5 key priorities have been identified.
Key Achievements / Updates
• EoLC and Bereavement Team now provide a 7/7day service • Advanced Communication skills, Sage & Thyme and Breaking Bad News training now regularly available for staff to attend • The Bereavement Support Line is no longer advertised or in use. The Teams have adapted access to bereavement support for families and friends and this is more responsive • The collection of qualitative feedback from those that have lost a loved one via the Bereavement Survey has sustained since being reintroduced back in March 2021 and has now spread to Community Services • The Reflections in Practice – End of Life Care (Community Nursing) QI Project has been put on-hold due to staffing issues – there are plans to trial again once these issues are resolved • This Improvement Programme was shortlisted as a finalist for a HSJ Award 2022 • ELHT has developed its own CARE Model, and this is now embedded

• Trustwide visibility • Adhoc Education Workshops held in Bereavement Care, Tissue Donation and Verification of Death • Part of the Nurse and Midwife Bereavement Network across Lancashire and South Cumbria • Resource boxes now available on the wards – memories, signs, property bags, tissue donation, parking vouchers • A Community version of the IPOC is currently being piloted • Patients who are in the last days and hours of life are no longer being moved from side-rooms • The EoLC Operational and Strategy Group now receive Divisional Assurance Reports • The Team now has bereavement admin support which enables a bereavement card to be sent to families and a follow-up phone-call after 3weeks • Improving Recognition of the dying patient has a well-established project group, aiming to increase the number of patients recognised as dying before the last 24 hours of their life to at least current national average (65%) by 30th April 2024	
Total number of Improvement Projects Registered linked to HRP (2018 – February 2023)	**14**

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 and Social Care 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 November 2022 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Latest published rolling 12 months to Nov-22
East Lancashire NHS Trust SHMI Value	1.069
East Lancashire NHS Trust % of deaths with palliative care coding	30
East Lancashire NHS Trust SHMI banding	2 (as expected)
National SHMI	1.00
Best performing Trust SHMI	0.717
Worst performing Trust SHMI	1.222
Trust with highest % of deaths with palliative care coding	66
Trust with lowest % of deaths with palliative care coding	13

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

The trust is as expected for the SHMI mortality indicator. The HSMR mortality indicator is above expected, and the trust palliative care rate is below that expected. The elevated HSMR is due to the lower than expected levels of palliative care coding.

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

- Introducing an Electronic Patient record which will improve the quality of coded data to make the coded diagnosis and comorbidities as accurate as possible.
- Funding a 7 day specialist palliative care service.
- Reviewing the coding of the end of life care and bereavement team to more accurately reflect the interventions which have been delivered.
- Reviewing alerting groups and where appropriate undertaking quality improvement in these areas.
- Focusing on end-of-life care both within the trust but also across the wider system.

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	30%
National percentage of deaths with palliative care coding	40%
Trust with highest percentage of deaths with palliative care coding	66%
Trust with lowest percentage of deaths with palliative care coding	13%

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

The Trust has a lower-than-average score for specialist palliative care coding. This is reflected in part by differences in coding palliative care input in some areas of the Trust such as critical care.

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

- Relaunched our Trust wide end of life care strategy group.
- Input into ICP wide end of life care discussions to improve quality of advance care planning discussions.
- Prioritising quality improvement in delivery of end-of-life care across the Trust.

3.3.3 Patient Recorded Outcome Measures (PROMs)

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

The two procedures are:

- Hip Replacement
- Knee Replacement

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 both of the 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 Hip Replacement Surgery

Hip Replacement Surgery	2017-18	2018-19	2019-20*	2020-21*	2021-22**
ELHT	90.7%	92.9%	93.8%	No Data	No Data
National Average	89.7%	89.8%	90.1%	No Data	No Data

3.3.3.2 Knee Replacement Surgery

Knee Replacement Surgery	2017-18	2018-19	2019-20*	2020-21*	2021-22**
ELHT	83.9%	83.4%	88.3%	No Data	No Data
National Average	82.2%	82.2%	83.2%	No Data	No Data

**PROMs outcome data covering April 2020 to March 2021 published by NHS Digital Hospital, currently shows no returns from ELHT during this period for both Pre & Post op questionnaires – ELHT records show that only 5 pre-op questionnaires were completed for this period due to the COVID Pandemic.*

*** NHS Digital have added the following statement to their PROMs web page: 'In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.'*

'We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known.'

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 via the post; completion is prompted during their telephone pre-operative assessment.

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.

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

On attendance at Ward 15 patients will be asked to confirm completion of the questionnaire at pre-op, if not a questionnaire will be provided for completion.

3.3.4 Readmissions within 28 Days of Discharge

The following table sets out the Trust's performance during 2022-23 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 April 23:

All ages	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23 (Apr - Sep)
Readmission Rate	8.33%	8.20%	8.61%	9.07%	9.73%	9.57%	8.96%
Age Band	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23 (Apr - Sep)
0-15	13.12%	11.74%	12.52%	12.02%	11.43%	13.09%	13.82%
16+	7.28%	7.45%	7.81%	8.53%	9.46%	8.91%	7.98%

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

The overall ELHT 28-day readmission rate produced by Dr. Foster is 8.96% which is below the Dr. Foster risk adjusted expected rate of 9.11%. Compared to local acute hospitals, the Trust is just above the national rate of 8.54%.

- For the 0-15 age group, the rate is 13.82% which is higher than the expected rate of 10.71% and the national rate of 9.52%.
- For the 16+ age group the rate is 7.98% which is below the expected rate of 8.79% and better than the national rate of 8.41% reflecting good performance and **Safe**, **Personal** and **Effective** care in terms of discharge planning.

East Lancashire Hospitals NHS Trust has taken the following actions to improve the ratio for the under 0-15 age group and so the quality of its services by:

The readmission and admission rates for ELHT are skewed by the fact that our assessment units (including assessment and ambulatory care) is coded as an 'inpatient admission'. Many of our pathways readmit children into the assessment unit, which is clinically appropriate and efficient, but this skews data. This has also been impacted by the success of SDEC NWAS model which direct admits to assessment unit, a proportion of these children would have gone to the emergency department and been discharged.

Key actions taken to manage readmission rate in the 0-15 year age band:

- 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 is also available as a mobile phone App. Videos circulated across third sector for sharing with difficult to engage families
- Hot clinics and emergency clinic slots have been set up and are working very successfully, for urgent paediatric consultant input – as an alternative to admission or readmission. Slots are accessed directly from GPs.
- 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.
- The Community Children's Nursing (CCN) service has been extended so that GPs can refer directly to the CCN rather than hospital for care and the hours have been extended to 22:00 to support out of hours GP referrals.
- 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.
- Consultant presence in COAU extended until 10pm Monday- Friday – to support more senior decision making.
- Extended Community Children's Nursing service to a longer day / 7-day service (was previously Mon-Fri 8am-6pm service).
- Discharge process tightened so that all discharges are reviewed at consultant level.
- Establishment of 'Patient Trigger Reviews' so that parents can contact the department directly for an outpatient consultation after admission/last appointment. This allows parents control on required further help and advice and offers a more suitable alternative to readmission - this has been established.
- Allergy specialist nurse recruited February 2020 and extended to a second nurse July 2021 so that children and families with severe allergies can be managed safely at home and avoid admission and readmission for acute episodes. Also, the development of Allergy MDT with Consultant Paediatricians to manage allergy patients in a more seamless way.
- Introduced direct ED referrals to our Children's Community Nursing Service to support admission avoidance.
- Increased our nurse led clinics for respiratory, community nurses, epilepsy and allergy.
- Children's Hub development– which is a multi-disciplinary community hub is on-going – which has shown initial reduction in admissions and need for secondary care interventions. There are plans to extend hub working in 2023/23.
- Implementation of primary care pathways to support General Practitioners in the management of common childhood illnesses using RCPCH guidance
- Developing an asthma severity score and associated pathway using QI methodology which is an ICS led pathway.
- Developing an allergy pathway using QI methodology.
- Developing same day emergency care model and 111 booked appointments in Paediatrics in next 12 months.
- Launched a virtual ward within Paediatrics to support children post discharge.
- Development of CNP services to offer nursing support for CYP with ADHD and ASD to empower families and carers with the tools to manage children with neurodevelopmental conditions

- Diversification of child development centres offering therapeutic interventions and empower parents with strategies to support children with neurodevelopmental and neurodisability conditions
- Developmental of CYP website to signpost families to self-help and access to specialist nursing services for support and guidance including signposting to third sector and the Blackburn with Darwen/East Lancashire Local Officer
- Introduction of palliative care nurse to support care at home for CUP with life limiting conditions
- A third epilepsy nurse specialist started in June 2022, to support care in community and support children on discharge from hospital, particularly focusing on newly diagnosed patients so that hospital admissions and readmissions are minimised.
- Development of a new Assistant/Advance Practitioner for self-management of key chronic conditions where children and parents can get advice and support and directly contact the specialist team for advice.
- Participation by ELHT paediatrics in the NHSE SDEC task and finish group in diabetes services and includes guidance on managing acute episodes, sick day rules etc. for parents to avoid admissions and re-admissions.

Key further actions within the Directorate in the next 12 months to support further reductions in readmission rate:

- 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. Consider rollout into Blackburn with Darwen.
- A review of the high intensity users of acute services alongside CCG to develop a targeted approach

East Lancashire Hospitals NHS Trust has taken the following actions to improve the ratio for the under 16+ age group and so the quality of its services by:

- Work continues across Pennine Lancs to ensure that we move to an equitable service offer across all pathways working with our partners. Key services to avoid unnecessary admission and focus on hospital avoidance are our Intermediate Tier Community teams such as Intermediate Care Allocation Team and Intensive Home Support Service.
- Our Integrated Discharge Service also now deliver a Care Allocation Service which works closely with care homes to ensure that we secure the best placements for patients and provide ongoing support and liaison to prevent readmissions.

3.3.5 Responsiveness to Personal Needs of Patients

The Trust actively seeks out and encourages feedback from patients, carers and relatives on how its services perform, utilising a variety of methods including patient satisfaction surveys. We also believe that involving and co-producing service developments with patients and the public will help us to continually improve the care, experience and services we provide.

The Trust participates in the national programme of patient satisfaction surveys. The Care Quality Commission uses the results from the surveys in the regulation and monitoring and inspection of Trusts in England. Results are shared with the Clinical Divisions and action plans are developed to address any issues identified.

The Adult Inpatient Survey sampled 1250 consecutively discharged inpatients, working back from the last day of November 2021. There were 408 responses received giving a final response rate of 34%. This is a decrease on the response rate of 39% in the 2020 survey.

Table 1 below details the top 5 scoring questions for the Trust in 2021. Some questions changed in the 2021 survey so a comparison with 2020 may not be available.

Question	Score	
	2020	2021
During your time in hospital did you get enough to drink?	95.4%	95.7%
Were you given enough privacy when being examined or treated?	95.5%	94.7%
To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	n/a	90.6%
How clean was the hospital room or ward that you were in?	92.1%	90.6%
Overall, did you feel you were treated with respect and dignity while you were in hospital?	92.7%	90.3%

Table 1 – ELHT top 5 scoring questions

Table 2 below details the bottom 5 scoring questions for the Trust in 2021 and a comparison with the 2020 score if available.

Question	Score	
	2020	2021
During your hospital stay, were you ever asked to give your views on the quality of your care?	16.4%	14.8%
Thinking about any medicine you were to take home, were you given any of the following	46.8%	43.2%
Were you ever prevented from sleeping at night by any of these? None of these	47.7%	45.7%
Were you able to get hospital food outside of set meal times?	n/a	56.1%
How long do you feel you had to wait to get a bed on a ward after you arrived at hospital?	70.3%	59.3%

Table 2 –ELHT bottom 5 scoring questions

In comparison to other Trusts who took part in the survey, ELHT has performed about the same. Overall, there has been a decline in opinions since the 2020 survey across Trusts who took part. In particular, there are continuing challenges around the number of patients attending Emergency Departments and requiring admission.

IQVIA (who carry out the survey) have recommended areas the Trust may want to consider strengthening. The survey details have been shared with all Divisions for integration into their existing service improvement plans, where identified as required. The Trust's Quality Strategy and Patient Experience Framework 2023-25 will monitor the progress of this work.

3.3.6 Recommendation from Staff as a Provider of Care

The data made available to the East Lancashire Hospitals NHS Trust by the National Staff Survey Coordination 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.

- 64% of staff said – if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation.
- 78% of staff said – care of patients/services users is the organisations top priority.

The Trust scored 7.0 for the overall staff engagement score on the 2022 national staff survey which is significantly above the national average of 6.8 for Combined Acute and Community Trusts in 2022.

3.3.7 Friends and Family Test Results (Inpatients and Emergency Department)

The Friends and Family Test (FFT) is a means to capture 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.

Patients are invited to respond to a question, in the context of each service, 'Overall, how was your experience of our service?', by choosing one of six options ranging from very good to very poor. Patients can give feedback at any time during their episode of care, which is used by staff to influence improvement.

Patients can answer the FFT question via completion of an FFT card, online via the Trust's website or QR code. FFT feedback is also collected from patients via SMS texting across Accident & Emergency, Outpatient attenders, maternity, and community services.

The following table sets out the percentage positive rating for the period April 2022 to March 2023 for inpatients and emergency care and also how these results compare with other Trusts nationally.

	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Inpatient positive % rating												
ELHT	96	96	96	96	94	94	96	95	97	95	96	97
Nat Ave	94	94	94	94	94	94	94	94	94	95	94	Not yet available
A&E positive % rating												
ELHT	66	65	69	66	68	75	68	70	63	78	78	73
Nat Ave	75	75	74	75	77	76	74	75	73	83	80	Not yet available

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

The Trust values the feedback from our patients and ensure it influences how we develop and deliver our services; therefore, staff are supported to collect information from patients.

Over 25,000 inpatients and emergency care attenders have provided feedback during April 2022 – March 2023. The Trust has received consistently high scores from inpatients, with an average of 96% of inpatients rating their overall experience as either very good or good.

The Trust recognises the ongoing increased activity within the Emergency Department and Urgent Care Centres has impacted on the positive response rate across Emergency Care. The feedback received has informed improvements to patient safety and experience in that area.

The Patient Experience Team will continue to advise and support colleagues in the collection and analysis of their FFT, to influence service improvements.

3.3.8 Venous Thromboembolism (VTE) Assessments

		1st April 2022- 31stMarch 2023				
	VTE RISK Assessments 22-23	Q1	Q2	Q3	Q4	Total
ELHT	Number of VTE-risk assessed Admissions	32,405	32,344	32,690	34,091	131,530
	Total Admissions	32930 **98.3%**	32977- **98.5%**	33046- **98.5%**	34550- **98.6%**	133,503 **98.47%**
National	Number of VTE-risk assessed Admissions Total Admissions Percentage of admitted patients risk-assessed for VTE	National figures are not available because the submission was suspended due to the Covid-19 pandemic and yet to resume https://www.england.nhs.uk/?s=VTE				
	Best Performing Trust Worst performing Trust	National figures are not available because the submission was suspended due to the Covid-19 pandemic and yet to resume https://www.england.nhs.uk/?s=VTE				

The above data is ready for submission to NHS UNIFY system from Trust whenever the data submission portal is re-opened and requested by NHSEI as the data submission was suspended by NHSEI in view of the Covid 19 pandemic since 01/04/2022 and yet to resume.

The annual data over the four quarters compared with the national average and the best and worst performing Trusts is not available as a result in the absence of National data publication comparators that is normally available and was available until 31/03/2020.

The VTE risk assessment annual figure in 2019/2020 was 98.3% and in 2020/21 this dropped slightly to 97.90%. The VTE risk assessment figures for this reporting year 2021/22 is 98.45% which was an improvement from last year by 0.55%. During last year of 2022/2023 remained same as compared to the previous year. The Trust VTE committee monitors the Divisional and Directorate VTE risk assessment figures and Trust figures with action plans as part of the VTE Harms reduction program.

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 utilising the national VTE risk assessment tool on admission. The current risk assessment system is an online system called Alcadion on Hospidea system.
- Trust VTE performance has consistently improved from just above 95% in 2012, to 97% since July 2013, above 97.5% since July 2014 and above 98.3% since July 2016 until April 2020. There was a drop in the VTE risk assessment figures noted by 0.40 % overall during the pandemic times in 2020/21 and this has now resumed Trust trajectory at 98.45% last year and it has been maintained for the year of 2022/2023.Trust VTE risk assessment figures continue to be significantly above National average of above 95% at 98.47% this year.

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

- VTE committee terms of reference updated to quarterly frequency and to reflect the governance reporting arrangements currently in place.
- Further change envisaged with the documentation of VTE risk assessment from current Alcadion hospidea system to Cerner EPR system from November 2022. Educational events and training plans in place for the launch and roll out focused on VTE through the Divisional governance leads and matrons. This is yet another transition for medical and nursing professionals to get familiar with and supported with again since extramed electronic risk assessment implementation 2 years ago. Educational and awareness raising campaigns and ward based support resources as appropriate as part of the QI interventions to sustainably improve safety and quality are planned to be in place effectively to support this transition.
- One of the key changes in Cerner system is that the time of admission for clock start is calculated from the time of decision to admit made in Emergency department (ED) rather than the current clock start time which is the actual time of admission into the inpatient wards/beds from ED as captured on Cerner. This issue was extensively discussed via the medical directors' forum and consensus agreed by medical director to approve Cerner recommendation for clock start as "decision to admit time rather than actual admission time to inpatient ward bed". Impact of this change will only be known after the transition and will be closely monitored through the VTE committee and Patient Safety Group.

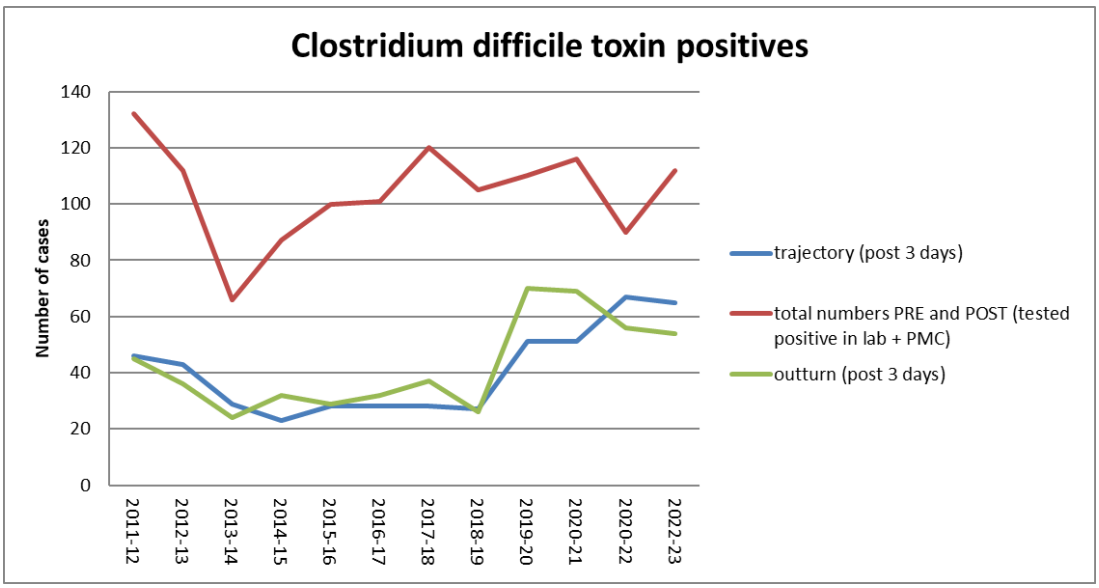
- Automated report generation is an expectation from the Cerner system and this has been requested to cover NICE quality standards and guideline standards related to VTE risk assessment and final reporting methodology and outcomes awaited from Trust Cerner team. Currently the data for organisational reporting is captured from Hospidea and linked to the Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS) and this linkage will continue even after transition to Cerner system for Organisational reporting purposes.
- A Trust wide re-audit on VTE risk assessment has been agreed in principle and proforma and data collection tool approved through VTE committee to commence as a Trust wide Quality improvement project as prospective re audit in June 2022 and resultant action plans based on findings will be implemented Trust wide to benefit patients and lessons learnt shared cross organisationally.
- Monitoring of VTE risk assessment and management of Hospital acquired VTE through formal quarterly reporting by all divisions through the Trust VTE committee which functions as a sub-committee of the Trust Patient safety group formerly called Patient Safety and Experience Group (PSEG) continues.

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.

The Trust reported 65 clostridium difficile positives 44 HOHA & 21 COHA the trajectory for 2022/23 was 54.

Clostridium difficile toxin positive results from April 2022 – March 2023:



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 of HOHA & COHA are reviewed the themes, lapses and areas for learning are discussed at the C. difficile multidisciplinary ICB meeting and shared divisionally.

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 and glove usage improving antimicrobial prescribing and recommencement of antimicrobial quarterly audits, 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 published Patient Safety Incident Reports by organisation bi-annually showing comparative data with other large acute Trusts, in April 2020 this changed to annual national reporting. 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 the latest NRLS organisational data workbook and sets out the Trust's performance over the last ten reporting periods. The table also compares the Trust's performance against similar large acute organisations in the cluster data.

Patient safety incidents per 1000 bed days	**April 2016 to Sept 2016**	**Oct 2016 to Mar 2017**	**April 2017 to Sept 2017**	**Oct 2017 to Mar 2018**	**April 2018 to Sept 2018**	**Oct 2018 to Mar 2019**	**April 2019 to Sept 2019**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**	**Apr 2021 to Mar 22**
ELHT number reported	7010	7122	7032	7401	6426	6398	8128	8269	11142	12887
ELHT reporting rate	44.9	44.8	45.5	46.4	42.0	40.9	52.0	53.2	44.0	43.1
Cluster average number	4995	5122	5226	5449	5583	5841	6276	6502	12502	14368
Cluster average reporting rate	40.7	41.1	43	43	44.5	46	50	51	58	57.5
Minimum value for cluster	1485	1301	1133	1311	566	1278	1392	1271	3169	3441
Maximum value for cluster	13485	14506	15228	19897	23692	22048	21685	22340	37572	49603
Patient safety incidents resulting in severe harm	**April 2016 to Sept 2016**	**Oct 2016 to March 2017**	**April 2017 to Sept 2017**	**Oct 2017 to March 2018**	**April 2018 to Sept 2018**	**Oct 2018 to March 2019**	**April 2019 to Sept 2019**	**Oct 2019 to Mar 20**	**Apr 2020 to Mar 21**	**Apr 2021 to Mar 22**
ELHT number reported	13	8	14	9	6	9	5	6	19	20
ELHT % of incidents	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Cluster average number	13.4	13.8	13	13.5	13.5	14	15	14.5	31	37.4
Cluster average reporting rate	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3	0.3
Minimum value for cluster	0	0	0	0	0	0	0	0	4	2
Maximum value for cluster	75	67	92	78	74	62	76	91	137	157
Total incidents across cluster	1826	1872	1821	1810	1771	1780	1896	1870	3,817	4603
Cluster % of incidents	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.3

Patient safety incidents resulting in death	April 2016 to Sept 2016	Oct 2016 to March 2017	April 2017 to Sept 2017	Oct 2017 to March 2018	April 2018 to Sept 2018	Oct 2018 to March 2019	April 2019 to Sept 2019	Oct 2019 to Mar 20	Apr 2020 to Mar 21	Apr 2021 to Mar 22
ELHT number reported	6	8	2	2	1	6	4	6	17	8
ELHT % of incidents	0.1	0.1	0	0	0	0.1	0	0.1	0.2	0.1
Cluster average number	5	5.5	5	5.3	5.1	5.2	4.8	5	24	20.4
Cluster average reporting rate	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Minimum value for cluster	0	0	0	0	0	0	0	0	0	1
Maximum value for cluster	36	31	29	24	22	23	24	22	146	81
Total incidents across cluster	690	751	661	712	706	678	628	666	3011	2513
Cluster % of incidents	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	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 in the last reporting period has increased from the previous 3 years. Staff are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared. The Trust does however consistently report higher numbers of incidents compared with similar Trusts in the cluster, which demonstrates an open and honest culture within the Trust, this has reduced in the most recent reporting period, however these figures will be affected by the COVID pandemic starting within the reporting period.

Patient Safety Incident Requiring Investigation (PSIRI) Panel has focused on the identification of lessons learned and actions taken following review of patient safety incident investigations to ensure services are improved and harm is reduced.

The Trust has a comprehensive harms reduction programme supported by Quality Improvement Team and Quality and Safety Unit which provides assurance of the reduction in harms to the Trusts Quality Committee.

The Trust has been reporting and managing incidents under the new Patient Safety Incident Response Framework (PSIRF) since 1st December 2021. As such the Trust has made several changes to reflect the approach to Patient Safety Incidents as set out by the framework:

- Recruitment of a new Patient Safety Incident Investigation (PSII) team, which investigate incidents that meet National or Local priorities defined in the PSIRF and the Trust Patient Safety Incident Response Plan.
- Development of incident investigation tools for incidents that do not meet the criteria to be investigated by the PSII team.
- New Terms of Reference for incident review groups at both Divisional and Trust level reflecting the new approach.
- Development of the Datix system to allow the effective management of incidents under the new framework.
- Introduction of assurance processes to ensure there is consistent culture of learning and improvement in line with PSIRF and the response to patient safety incidents.

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 2022/23 the Trust has reported 2 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Retained foreign object (guidewire)	1
Wrong site surgery (Nerve Block)	1

The retained foreign object (guidewire) has been fully investigated and in this case, the Trust found important learning that has been shared with staff across the organisation, with our commissioners and the patient. Detailed action plan for the incident has been developed, updated and assurance on the completion and embedding of learning has been overseen by Patient Safety Group and Lessons Learned Group.

The Wrong site surgery (Nerve Block) at the time of producing this Quality Account was under investigation.

Learning from Never Event Incidents

On two occasions within 2022-23 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 from the retained foreign object (guidewire) and processed a Trust Patient Safety Alert which highlighted learning and actions to be taken across the Trust. These include:

- Ensuring all areas where invasive procedures are undertaken have LocSSIPs proformas in place relevant to the procedure
- Teams to ensure that the LocSSIP is used as a real-time checklist, monitored by an assistant with knowledge of the procedure and not as a retrospective document
- Education and training to be provided to all staff during local induction on the use of and the reasons why LocSSIPs are in place and used

The Trust has developed a schedule of audits devised for all LocSSIPs compliance which is reported at the Clinical Effectiveness Group.

3.3.12 Learning from Deaths

Throughout 2022-23 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 assigns a score to particular elements of care and an overall score for a patient's care. A score of 1 or 2 identifies a concern that care was poor and a secondary review process (base 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 round table discussion is held with the clinical team involved and where the SJR concerns are validated a full patient safety investigation of the case is undertaken and presented to the Trust's Patient Safety Incident Requiring Investigation (PSIRI) Panel.

The identification of cases to be reviewed follows the processes identified within 'Learning from Deaths' and in line with National Guidance.

Not every death is subjected an SJR; the primary reasons for triggering an SJR are listed in the Trusts 'Learning from Deaths' Policy. The triggers for SJR are reviewed and amended in line with alerting groups.

As part of the review of SJRs specific thematic analysis has taken place around sepsis management.

Breakdown of deaths in 2022-23 and number of completed SJR's for this time period.

	Completed	2022-2023	
Total number of inpatient deaths 2022/23	**Q1**	506	
	Q2	564	
	Q3	667	
	Q4	598	
Total		**2,335**	
Number of Stage 1 & 2 SJR's completed 2022/23 (May contain deaths from current and prior years)		**SJR 1**	**SJR 2**
	Q1	44	4
	Q2	46	7
	Q3	42	13
	Q4	48	7
Total		**180**	**31**

The learning points from SJR reviews are collated into areas of good practice and areas for improvement which are tied into the Trust improvement priorities. Whilst end of life care remains a significant area of improvement, there has been notable evidence of good practice likely to be a result of the introduction of the end of life care and bereavement team and their support to ward based teams.

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 and 3.2 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 2023-24.

Paediatric Mortality

At East Lancashire Hospitals NHS Trust, all Paediatric deaths including out of hospital deaths are reviewed through a mortality process. In 2019 a strengthened review process more akin to the structured judgement review process used in adults was implemented. All paediatric

deaths are subject to a multidisciplinary primary review with a paediatric consultant and senior nurse reviewing the case in a structured way. Following this all deaths are reviewed at the paediatric mortality group consisting of consultant's senior nurses and doctors in training. Actions for improvements are noted and implementation is monitored through this group. Going forwards this process will also align with the newly implemented child death review meetings.

The table below demonstrates the number of cases reviewed by the process.

		In Hospital	At Home	Another Trust	Out of Area
Total number of Paediatric Deaths by Location and quarter the Death occurred 2022/23	**Q1**	1	2	1	1
	Q2	2	1	0	1
	Q3	3	3	1	3
	Q4	0	0	0	0
Total		**6**	**6**	**7**	**4**
Number of Stage 1 & 2 PMR's completed during by quarter 2022/23 And the number which required an RCA (May contain deaths from current and prior years)	**Completed**	**PMR 1**	**PMR 2**		
	Q1	6	0		
	Q2	6	6		
	Q3	9	3		
	Q4	1	9		
Total		**22**	**18**		

In summary areas of good practice noted through this process are:

- Paediatricians and Children's Community Teams for Children and Young People with life limiting conditions.
- When advance care planning is done well it has an incredibly empowering impact on the families whose voice can be clearly heard in the process
- Resuscitations started by North-West Ambulance Service and continued in the Emergency Department with general paediatric input are extremely systematic and processes for bereavement support and escalation to the Child Death Overview Panel robustly followed

Key issues for which actions have been generated relate to the following:

- End of Life Care and Advance Care Planning should be started at earliest opportunity. This would prevent escalation of care to tertiary centres when the ceiling of care has been reached.
- Discussion of what the ceiling of care is and being clearly documented to prevent invasive interventions should be completed early in the patient journey when it is clear that further escalation would not have a positive outcome

- Advance Care Planning should be considered and evidenced even before End Of Life Care in order to ensure child and families wishes are captured and to prevent feeling of panic when difficult conversations need to take place
- Primary care management of acutely unwell child needs to be supported to empower GP's and ensure children get the most appropriate and timely review.
- Childhood suicide has been more prevalent nationally and local trends although low are evident in the reviews.
- As part of the review of child mortality it has become evident that there is a gap in service with the need for a Bereavement/Palliative care nurse based locally to empower families and promote Advanced Care Planning. This discussion is currently taking place with commissioners and has been incorporated as part of the community specialist nursing review.

Learning Disability Mortality Reviews (LeDeR)

The NHS Long Term Plan made a commitment to continue learning from deaths (LeDeR) and to improve the health and wellbeing of people with a learning disability and autism.

The LeDeR programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and autism and to reduce health inequalities. By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

ELHT contribute to this process by notifying NHS England of all the deaths of people with a learning disability or autism. Following the notification of death a structured judgement review is completed and recommendation and actions for learning are shared within the organisation at the Lessons learnt groups and with the LeDeR programme. Thematic cause of death is also reported annually to NHS England's national standards.

This year there have been 32 deaths reported to LeDeR

Breakdown of Learning Disability deaths in 2022-23 and number of completed LeDeR's for this time period by financial quarter:

		2022/23
Total number of Learning Disability deaths 2022/23	**Q1**	8
	Q2	4
	Q3	6
	Q4	2
Total		20

		2022/2023
Number of LeDeR's completed 2022/23 (May contain deaths from current and prior years)	**Q1**	14
	Q2	7
	Q3	5
	Q4	6
Total		32

3.3.13 Seven Day Service Meeting the Clinical standards

The Trust continues to deliver services in line with the national 7-day standards.

The Trust continues to deliver services in line with the national 7-day standards.

- Consultant job plans enable the review or delegated review of patients by a consultant within 14 hours of acute admission in all specialities 7 days a week.
- Consultant led Board rounds and ward rounds take place on all inpatient units 7 days per week. This enables prioritisation of patient reviews based on severity of need, and delegation of review or need for the review for each patient.
- All diagnostic services for acute admissions are available for patients 7 days a week either within ELHT or in an arrangement with a regional provider
- NEWS2, or maternity and paediatric equivalents are used across the Trust to measure patient illness and risk of deterioration, so that assessments can be escalated if the patient deteriorates or is at risk of deterioration 7 days a week, and 24 hours a day. Sepsis Bundles and e-Observations for these cohort patients are also in place. The Trust has a 24-hour graded response by a dedicated team who have responsibility for managing and treating acutely unwell and deteriorating patients.
- Patient flow facilitators and discharge coordination team works over 7 days per week to ensure timely progress of the patient's care including discharge in collaboration with system partners
- Multidisciplinary team members including pharmacists, therapists and advanced and specialist practitioners work across the 7 days of the week where this is required in acute care.
- Shift handovers occur throughout every day of the week in all specialities to ensure continuity of care.
- The In-patient Therapy Services for Acute Inpatient Stroke has increased to 7 days, 8-4pm in April 2023. This is on the back of the ISNDN / stroke specification.

Our electronic patient record which will be implemented in June 2023 will enable us to measure and audit against the timed standards in a comprehensive and efficient manner.

3.3.14 Staff can speak up (Freedom to speak up)

ELHT is committed to ensuring the highest standards of service and the highest ethical standards in delivering this service. The Freedom to Speak up (Whistleblowing) policy (HR20) is in place to support and assist staff in raising concerns without fear of discrimination or reprisal. ELHT will deal with all disclosures consistently, fairly and confidentially. Anyone who works (or has worked) in for East Lancashire Hospitals NHS Trust can raise concerns

under this policy. This includes agency workers, bank staff, temporary workers, students, volunteers and governors.

Anyone raising a concern under this policy is not at risk of losing their job or suffering any form of reprisal as a result. ELHT will not tolerate the harassment or victimisation of anyone raising a concern. Nor will the Trust tolerate any attempt to bully staff into not raising any such concern. Any such behavior is a breach of ELHT values as an organisation and, if upheld following investigation, could result in disciplinary action.

Staff can raise concerns in a variety of ways and advice is given that in the first instance to raise the concerns with their line manager (or lead clinician or tutor) if staff member feels able to do so, however if this is not an option or this step does not resolve matters, the other options are:

- Though the Staff Guardian - identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with direct access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.
- If a concern remains then they can be brought to the attention of our Executive Director or Non-Executive Director with responsibility for whistleblowing or one of the external bodies as listed in the Trust Policy.

Feedback to the person who raised the concern is critical. The sense that nothing happens is a major deterrent to speaking up. There are situations where this is not straightforward due to the need to respect the privacy of others involved in the case. However, there is almost always some feedback that can be given, and the presumption should be that this is provided unless there are overwhelming reasons for not doing so. Feedback is given to those who speak up in a variety of ways, mainly face to face, letter or via email.

ELHT are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with the model published in Sir Robert Francis's CQ (2015) Freedom to Speak up: an independent report into creating an open and honest reporting culture in the NHS.

The Trust board is provided with regular information in a full board report about all concerns raised by our staff and what actions are being taken to address any problems.

3.3.15 NHS England National Improvement Standards for Learning Disability

An audit against the national improvement standards for learning disability is completed each year, the results of which are submitted to NHS England. The results of the standards are published by NHS England who make suggested actions that should be taken by the Trust to support the development of services provided by ELHT ensure safe personal effective care for people who have a learning disability and autism.

This year's report includes the actions from the improvement standard recommendations and includes the recommendations from LeDeR report 2021.

The following actions have been prioritised for the coming year 2023-24:

- Development of accessible information to inform patients and carers about health-related rights, including DNACPR.
- A review of cancer pathways to ensure they are accessible for people with a learning disability

- Establishing that electronic patient record systems can record reasonable adjustments
- To establish frequency of readmission rates to hospital and delays in waiting times for admission
- Make amendments to ELHT policy in relation to ‘was not brought’ rather than did not attend.
- The implementation of the Oliver McGowan training in learning and disability and autism as mandated in the Health Care Act 2022
- Business case for the increase in nursing resource for people with a learning disability accessing services provided by ELHT due to significant increase in referral numbers during 2022.

3.4 Other Quality Achievements

3.4.1 There's no place like home – New Pennine Lancashire Intensive Home Support Service to support more Patients at Home

The Trust Intensive Home Support Service (IHSS) joined forces with the Lancashire and South Cumbria NHS Foundation Trust IHSS on Monday, 3 October 2022, to enable even more patients to access treatment from home. The new Pennine Lancashire IHSS will help to further reduce avoidable hospital admissions by supporting patients across East Lancashire and Blackburn with Darwen to stay well at home by offering a full assessment service, treatments and medical reviews, all from their usual place of residence.

The service, which has been running separately across both Trusts for a number of years, is offered to patients aged 18+ through a referral from a health professional and helps to avoid hospital admissions, easing pressure on both Emergency Departments and ambulance callouts. The service also works within the hospital, with members of the team identifying patients who could be discharged, and their treatment continued at home. Those patients that have already been looked after by the service can self-refer back in – thus ensuring they can have quick access to an expert service that they are familiar with.

Through the new joint approach, patients across the area will now experience equal health provisions and targeted support by having more choice about where they access their care, with the benefit of avoiding disruption through unnecessary hospital visits.

3.4.2 Making Waves!

Patients receiving critical care in East Lancashire can now benefit from a new hydro-therapy service to support their rehabilitation. It is aimed at patients who have been on the critical care unit for an extended period of time and the first therapy session took place at Royal Blackburn Teaching Hospital in August to support a patient with motor neurone disease.
Critical Care Therapy Team Leader, states: "Hydro-therapy benefits the patient by creating a sense of weightlessness and the warm water provides joint and muscular pain relief. We are also able to utilise various muscle strengthening and joint range of movement techniques in the water and it is a relaxing calming environment to lift mood and help critical illness wellbeing".

This type of therapy is only offered by a couple of NHS Trusts and sessions can be adapted to include patients with tracheostomy, and other complexities.

3.4.3 The Trust Research and Development recruit patients to Harmonie Study

Our Research and Development team have recently become the first unit to recruit patients in the HARMONIE Research Study in the Greater Manchester Network.

The study involves working with families and infants across East Lancashire, to help develop and advance Respiratory Syncytial Virus Infection (RSV) protection in babies. RSV is a common seasonal virus that infects nearly all babies by their second birthday. Most of the time it causes a mild illness, like a cold. However, for some babies, it leads to more severe lung problems such as bronchiolitis and pneumonia. RSV infection is unpredictable and is a leading cause of hospitalisations in babies.

Most hospitalisations due to RSV occur in otherwise healthy babies, and it is difficult to know which babies will develop severe disease requiring medical care. For this reason, research is needed to protect babies from respiratory infections in the future. The HARMONIE

Research Study will be looking at how strongly babies can be protected from serious illness due to RSV infection by giving them a single antibody.

3.4.4 Hospital without Walls – online brain injury and stroke support scheme receives additional funding

An online brain injury support scheme to help brain injury and stroke survivors has been boosted with additional funding, enabling people across Lancashire and South Cumbria to continue accessing therapy and support from home. The Lancashire and South Cumbria regional NeuroRehabilitation OnLine (NROL) programme, which is hosted by East Lancashire Hospitals NHS Trust (ELHT) and the University of Central Lancashire (UCLan) uses online video sessions to provide specialist group neurorehabilitation to brain injury and stroke survivors.

The scheme was created in winter 2020/21 because patients were limited in accessing face to face NHS treatment due to COVID restrictions and now over 2,000 patients have been able to access the sessions from the comfort of their own home thanks to funding from the charity SameYou. The additional £169k secured from NHS England's Stroke Quality Improvement Rehabilitation (SQuIRe) catalyst funding process will enable this vital resource to continue for a further 12 months.

The sessions are a great example of how ELHT is developing a hospital without walls, with care being provided in a place and at a time convenient to patients rather than within the traditional confines of a hospital building. The county-wide scheme which began in ELHT involves physiotherapists, occupational therapists, psychologists, speech and language therapists and assistant practitioners from ELHT, Lancashire and South Cumbria NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and Blackpool Teaching Hospitals NHS Trust, after it was rolled out across Lancashire and South Cumbria thanks to new funding earlier this year.

3.4.5 'Virtual wards' prevent thousands of hospital admissions in East Lancashire and help to free-up much-needed beds.

A community-based service launched by the Trust is giving patients the opportunity to be treated at home instead of being admitted to hospital. Hospital at Home uses an Intensive Home Support Service (IHSS) to initially assess patients from their own home. Depending on the condition of the patient, they will be treated, given the necessary equipment and

monitored and supported from home - their 'virtual ward' - instead of being admitted into hospital.

This way not only is the patient more comfortable staying in their own surroundings, no stress or worry is incurred over having to leave their home and, most importantly, this service frees up hospital beds for those who need them most. A practical and resourceful way to help manage demand and pressure on hospital services, patients benefit from accessing a multidisciplinary team of healthcare professionals that also have access to social care support in their own homes.

Hospital at Home has already proven a success by attracting more than 2,000 patient referrals in its first months of working. After an initial assessment by the IHSS, only 10% needed to be admitted to hospital. The community teams at ELHT work non-stop to support patients in their own homes, and the 'virtual ward' was introduced during the COVID-19 pandemic to initially provide support and consultations remotely. However, the service proved so successful winning a national Health Service Journal Award, that ELHT continued to develop the concept to support other areas of the organisation to assist patient flow and ultimately improve patient experience.

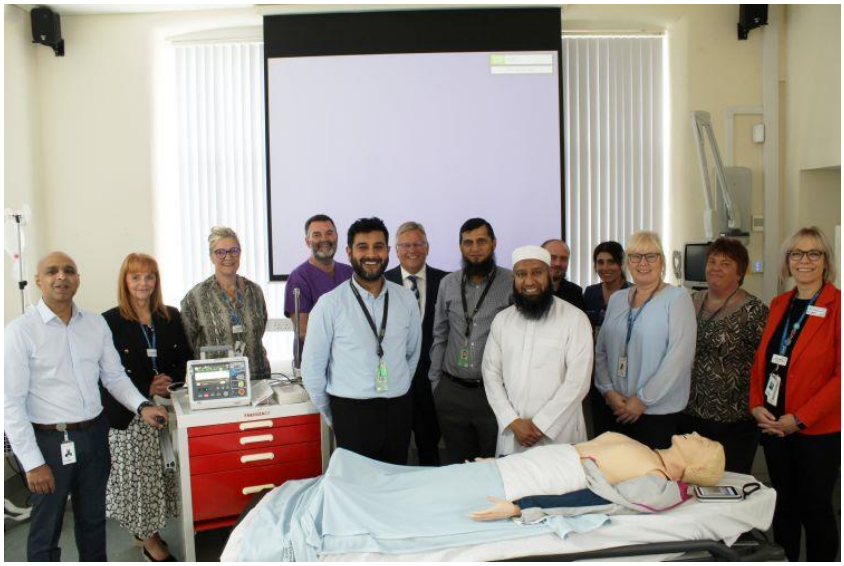
3.4.6 COVID vaccination centres in East Lancashire officially close

Employees of the Trust have been thanked for their hard work as the mass vaccination hubs at Barbara Castle Way, Blackburn and Charter Walk Shopping Centre, Burnley officially closed in December 2022. The two centres were the last remaining vaccination centres out of the seven mass sites established across the Lancashire and South Cumbria region during the pandemic.

The sites administered over 4.3 million vaccines across Lancashire and South Cumbria including first, second and booster doses with 86% of high-risk and eligible people taking up the offer of their vaccine. The team also administered up to 28,500 vaccines to people in their own homes or via pop-up clinics.

3.4.7 127 defibrillators donated to hospital charity ELHT&Me

The Foundation, led by local entrepreneurs Zuber and Mohsin Issa, Co-CEO's of EG Group, donated a staggering £350,000 for the equipment on behalf of the Trust's charity ELHT&Me. In July 2022, representatives from the Issa Foundation Trust visited Royal Blackburn Teaching Hospital to see their donation in action and hear how the equipment was making an incredible difference to local people. ELHT Associate Director of Integrated Care and Partnerships, Arif Patel said: "Defibrillators can often mean the difference between life and death. In the event of a cardiac arrest, every second is crucial, and this incredible donation has allowed us to purchase over 120 new state-of-the-art defibrillators, enabling us to significantly reduce the length of time it takes for a patient to receive the life-saving treatment they need. Thank you to the Issa Foundation Trust for supporting our work and to everyone who donated."



3.4.8 Electronic System revolutionises referrals at East Lancashire Hospitals

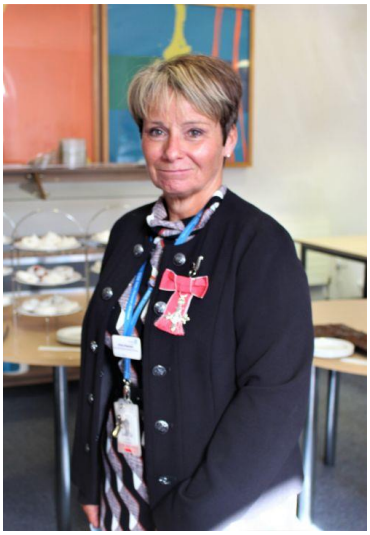
In April 2022 an innovative project led by a team at the Trust was highly commended at the National Digital Library (NDL) Community Awards, a celebration of public sector teams working towards digital transformation. The project used Robotic Process Automation to manage referrals from GP's, which originally required staff to manually retrieve and print referral paperwork before appointments. This was time-consuming for staff, reducing the time they had to spend caring for patients, was an expensive process and wasted paper – approximately 83,000 sheets a month.

In a matter of days, the team was able to implement a new automated system which resolved these issues rapidly, managing an average of 15,000 e-referrals per month. Patient records are then accessible on the clinical portal, allowing clinicians to view the referral letter electronically, rather than relying on a printed copy. They can then be seen well in advance of clinical appointments, enabling for better preparation, prioritising, and patient experience. The successful project was shortlisted for NDL RPA Project of the Year, and won a donation of £250 for a charity chosen by the team, which was ELHT&Me, the Trust's official charity. The charity funds projects and initiatives that improve patient and staff environment and experience.

3.4.9 Chief Nurse receives MBE recognition of her services over more than 40 years

One of the UKs highest ranking NHS nurses has become a Member of the order of the British Empire (MBE) in recognition of her services over more than 40 years.

Christine Douglas (formerly Pearson), who was the Chief Nurse and Executive Director of Nursing at East Lancashire Hospitals NHS Trust from 2014 to 2022, was presented with the honour at a ceremony at Royal Blackburn Teaching Hospitals in May 2022, where she has led the nursing team and been a member of the Trust Board. She was joined by colleagues from the Trust, family and friends at the ceremony and received the award from the Lord-Lieutenant of Lancashire the Rt Hon Lord Shuttleworth. Chris received the MBE in the Queen's New Year's Honour's list in 2021 but was delayed in receiving it as the entire NHS rallied against the Covid pandemic.



She joined the Board of Directors at ELHT in 2014 after gaining extensive experience in both hospital and community settings, where she successfully held a number of senior leadership roles. Chris's passion for ensuring safe, personal and effective care is delivered harm-free and of the highest quality, is something she has carried throughout her career and passed on to many colleagues that she has worked with.

3.4.10 ELHT gains Baby Friendly award

ELHT awarded the prestigious Baby Friendly Award and became the latest UK health care facility to gain recognition from the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative. The Baby Friendly Initiative is a global programme which aims to transform healthcare for babies, their mothers and families as part of a wider global partnership between UNICEF and the World Health Organisation (WHO).

The Trust began working towards the UNICEF Neonatal Baby Friendly Initiative accreditation seven years ago and the journey has been incredibly important for the Trust to ensure it is giving excellent care and support around infant feeding and relationship building to families and involving parents as partners in care.

In the UK, the Baby Friendly Initiative works with public services to better support families with feeding and developing close, loving relationships in order to ensure that all babies get the best possible start in life. The award is given to hospitals after an assessment by a UNICEF UK team has shown that recognised best practice standards are in place.

3.4.11 MacMillan Cancer Information and Support Service recognised with Parliamentary Award nomination

ELHT's Macmillan Cancer Information and Support Service (MCISS) was shortlisted in this year's Parliamentary Awards, for the work they are doing in the community to increase access to cancer services and support. The MCISS has been working hard to encourage more people from Asian communities to access services and support for themselves or a family member with a cancer diagnosis. This has included a programme of outreach work in partnership with a local mosque, other teams in cancer service and Macmillan to raise awareness of signs and symptoms of cancer and highlighting support available.

Over 700 nominations were submitted for the NHS Parliamentary Awards which recognises the massive contribution made by the individuals who work in and alongside the NHS. The annual NHS Parliamentary Awards provide an opportunity for health and care organisations to engage with their local MPs, tell them about the work they do, and build or strengthen ongoing relationships.

3.4.12 ELHT becomes 100th Trust to commit to National Bereavement Care Pathway

East Lancashire Hospitals NHS Trust is delighted to announce it is now the 100th Trust to commit to the National Bereavement Care Pathways (NBCP), which works to provide high quality bereavement care to parents and families who experience pregnancy loss or the death of a baby. As part of the pathway, colleagues will work in partnership with health professionals and others to minimise the risks of stillbirth and to ensure the families of those babies who do die receive the best possible care.

Following the commitment, the Head of Hospital Liaison and Bereavement Care at Sands, a stillbirth and neonatal death charity in the UK, visited Royal Blackburn Teaching Hospital where they were shown round the facilities by Kathryn Sansby, a Specialist Bereavement Midwife at the Trust. Sands have been leading the roll out of the NBCP since 2019 which includes a nine-point plan that helps NHS Trusts improve the quality of care for bereaved families. The Trusts that have implemented the Pathway since its first pilots back in 2017 have seen huge improvements in bereavement care.

3.4.13 ELHT catering team win VFL Hospital Caterer of the Year 2022 and two of our chefs fought off competition to be crowned Regional NHS Chef of the Year

In November 2022, ELHT catering team were announced the winners of the Hospital Caterer of the Year 2022 Awards for Excellence in Vegetarian and Vegan Care Catering in a ceremony held in the Houses of Parliament. This was a new award category introduced to specifically recognise hospital catering teams this year. Also two Chefs from East Lancashire Hospitals NHS Trust have fought off competition to be crowned Regional NHS Chef of the Year.

Kurt Dillon and Dylan Lucas, both Chefs at Royal Blackburn Teaching Hospital, cooked up a storm to bag the top spot, winning both the 'Chef of the Year' accolade and the prize for best plant-based dish on the day. The win comes after Sinto Jose and Sanish Thomas, who are both also Chefs at Royal Blackburn Teaching Hospital, were crowned National NHS Chefs of the Year 2021 by baking legend and Great British Bake Off star Prue Leith, when the competition launched last year.

During the event, each team had 90 minutes to prepare, cook and present three portions of each dish, which had to be suitable for generic NHS patients and costing no more than £5-6 for the three-course meal. The meal also had to reflect Government Buying Standards for Food and Catering Services, the Department of Health and Social Care's Obesity Strategy and nutritionally balanced in accordance with the British Dietetic Association (BDA) guidance. Kurt and Dylan had a recipe for success with their healthy allergen-free dishes with their starter of homemade vegan falafel with lemon and vegan mayonnaise dressing picking up the 'best plant-based dish' prize. The winning dishes also included salmon supreme with duchess potatoes and pea puree, followed by a fresh fruit homemade tart with crème patisserie for dessert.

3.4.14 Outstanding contribution to Equality, Diversity, and Inclusion

Assistant Director of Patient Experience, Barry Williams, is presented with a Royal College of Nursing award to mark his outstanding contribution to the equality, diversity and inclusion agenda. The award forms part of the RCN North West's annual event to recognise and celebrate the outstanding contribution of nursing staff from BAME backgrounds who work in health and social care across the region.

This year's winners work across a range of settings including in hospitals and out in the community, and in clinical and non-clinical areas such as governance, general nursing, mental health and education. They were recognised for a variety of reasons including their commitment to ensure the BAME agenda is heard and acted upon in their organisations and supporting newly recruited nurses from the BAME workforce.

3.4.15 Giving HOPE – ELHT midwives honoured with National Safeguarding Award

Two midwives who have been helping create connection boxes for women who are at risk of being separated from their baby at birth, have been recognised for their work. Louise Slater, a midwife working in drug services and Natalie Woodruff, a Perinatal Mental Health Midwife at East Lancashire Hospitals NHS Trust (ELHT) were awarded a National Safeguarding Star for Outstanding Practice from NHS England last week. They have been instrumental in implementing HOPE boxes at ELHT, which aim to minimise the trauma parents experience when they are separated from their baby at birth due to a court decision.

The boxes help families capture important memories prior to separation and promote ongoing connection between them and their baby post-separation whilst the court proceedings consider longer term plans for the child. Louise and Natalie were presented with their award for outstanding practice by Catherine Randall, Associate Director of Safeguarding for NHS England.

Research published in 2018 undertaken by The Centre for Child and Family Justice Research at Lancaster University has shown that in England there are more than 2500 newborns subject to care proceedings in England each year and this initiative will now help acknowledge that it is not only women who have miscarried that experience a birth trauma, but also women whose babies are taken away from them, too. The boxes are being piloted in a number of NHS Trusts between Summer 2022 and 2023 as part of the 'Giving HOPE' impact project being led by The Centre of Child and Family Justice at Lancaster University through money received from the Economic and Social Research Council and the NHS National Maternity Safeguarding Network.

3.4.16 Celebrating with the Prince's Trust

A celebration event took place in December to showcase a partnership between the Trust and the Prince's Trust. The hospital has been working with the Prince's Trust charity since 2017, offering work experience and skills development to young people through its Get Into Hospital Services programme. Over 100 young people have now completed a work placement, giving them valuable hands-on experience – and a staggering 86% have gone on to secure further paid work with the hospital.

The partnership with the hospital is part of the Prince's Trust's efforts to help young people overcome challenges and achieve their potential. The placements are open to anyone aged 18-30 who is not in education, employment or training and who is interested in a career with the NHS. They are given a four week placement within clinical or non-clinical departments, are assigned a mentor and given support with activity such as CV writing and interview skills.

3.4.17 Doctor draws patient plaudits

A doctor from East Lancashire has been praised by his patients for the exceptional care he provides. Dr Jason Lie, a Consultant Anaesthetist at East Lancashire Hospitals NHS Trust (ELHT), has received a national Certificate of Excellence thanks to five-star feedback from patients on the healthcare review website iWantGreatCare.
One patient described Dr Lie as "pure sunshine" and many of the other 120 patients who left reviews praised his reassurance and the way he put them at ease when they were extremely anxious.

iWantGreatCare is an independent review site which uses feedback from patients to highlight excellent care within healthcare in the UK. It has generated over six million reviews. Certificates of Excellence are awarded to clinicians, clinics or teams who receive consistently outstanding patient feedback throughout the year. This is the fourth time Dr Lie has received the award.

3.4.18 Hospitals charity wins prestigious award

Hospital charity, ELHT&Me, as a winner at the Ribble Valley Business Awards for making a real difference to the lives of patients and colleagues. The Trust's official charity, ELHT&Me, which has funded a wide range of initiatives from state-of-the-art surgical robots to a specialist suite where bereaved parents can prepare to say goodbye to their baby, was named winner in the Not for Profit category. More than 400 businesses and charities were nominated for awards across 18 categories.

3.4.19 Recognition for Intensive Care Baby Unit at Burnley General Teaching Hospital

Support provided to families with babies being cared for at the Neonatal Intensive Care Unit (NICU) at Burnley General Teaching Hospital has been recognised through a regional award. The team, which is part of Lancashire Women's and Newborn Centre, has received Family Integrated Care (FICare) accreditation, which recognises neonatal units that are focused on empowering parents as their baby receives treatment.

In NICU, it is often necessary to separate babies physically from their parents as they are treated, which can have an impact physically, psychologically and emotionally. To help the wellbeing of families and reduce separation anxiety, greater involvement is encouraged, such as coaching parents on how to care for babies, providing advice on how to give medication, take temperatures and day-to-day activities such as feeding and changing their children.
The accreditation helps the team to assure parents that high standards of integrated care are in place for their family at what is often a very difficult and worrying time.

The accreditation was presented by the North West Neonatal Operational Delivery Network (NWODN) following a rigorous assessment. A panel of experts assessed Burnley's NICU, including interviewing colleagues and patients as well as examining standards of practice. The unit passed with flying colours.

3.4.20 District Nurses are Pride of Barnoldswick

The Trust's Pendle East District Nursing team have been named the Pride of Barnoldswick for delivering excellent patient care. The team were recognised for their outstanding service to the local community after being nominated by a member of the public who stated: "The team has gone above and beyond to look after their patients through the pandemic and beyond. True heroes, whose care is second to none."

Working closely with other district nursing teams in East Lancashire, Pendle District Nurses help provide complex clinical care to patients living in their own homes. They also support patients and their families with palliative and end of life care.

Organised by Barnoldswick Town Council, the Pride of Barnoldswick Awards recognise local heroes who are nominated by the public. This includes volunteers, members of the community and local organisations.

3.5 Statements from Stakeholders

3.5.1 Healthwatch Blackburn with Darwen and Healthwatch Lancashire

Introduction:

Healthwatch Blackburn with Darwen and Healthwatch Lancashire are pleased to be able to submit the following considered response to East Lancashire Hospitals NHS Trust's Quality Accounts Report for 2022-23.

Part 1 including Statement on Quality from the Chief Executive:

This section of the Quality Account provides a clear description of the Trust, the range of services and the Trust's commitment to quality improvement practice, including capacity building within the staff team, clear governance structures and partnership working.

The tenor of the whole document is summarised within Part 1 and Statement on Quality, namely the commitment to deliver high quality care and patient safety and to improve and transform services with partners to become a clinically and financially sustainable organisation as well as a learning organisation that is committed to the continuous improvement of care provided, an aspiration we fully support.

Part 2: Quality Improvement:

We are pleased to see the implementation of the Quality Strategy and monitoring structures which encompass the 'floor to the Board'.

There are clear measures being taken to develop a robust quality improvement programme which also improves patient experience. The priorities of the Patient Safety Incident Response Plan are well chosen and we look forward to seeing the improvements made through this work.

We very much appreciate the continuous open working relationship with ourselves as a local Healthwatch as a valuable source of patient feedback. We are very happy to support the ongoing development of the Public Participation Panel and are glad to see that members of the Panel are involved in a number of quality improvement initiatives.

The Governance Arrangements for Quality are commendable, describing the methodology used to ensure that the Trust Board has clear oversight of performance and quality and underpins the principles of accountability and responsibility at all organisational levels**.**

Priorities for Quality Improvement 2022-23

We note the initiatives listed in 2.3 which will receive specific focus during 2022-23 and would agree with the priorities as described.

Mandated Statements

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account we believe the Trust has fulfilled this requirement. The Quality Indicators, results and supporting narrative are clear and well laid out.

We note the very high participation rate in the National Clinical Audits and National Confidential enquiries and the implementation of actions described to improve the quality of healthcare provided and similar rigour continues in respect of the local clinical audits.

Information received by Healthwatch Blackburn with Darwen from service users and their families and carers regarding services provided by East Lancashire Hospitals NHS Trust is consistent with the data, statements and comments contained in the Quality Account.

Part 3 Quality Achievements and Statutory Statements

We would single out the comprehensive key actions taken by the Trust in respect of its Harms Reduction and various Discharge programmes with significant improvements in patient care already being achieved in the year and we are supportive of the future plans to build on this work.

We also note the continued focus on keeping people safe and healthy at home through the work of the IHSS team and the virtual ward programme.

Summary

Overall, this is a fair and well-balanced document which acknowledges areas for improvement and details comprehensive actions being taken to further improve patient treatment, care and safety. We welcome these and as Healthwatch we are committed to supporting the Trust to achieve its aims.

Sarah Johns

Chief Officer
Healthwatch Blackburn with Darwen

Jodie Ellams

Manager
Healthwatch Lancashire

3.5.2 Lancashire and South Cumbria Integrated Care Board (LSCICB)

Lancashire and South Cumbria Integrated Care Board ("LSCICB") welcomes the opportunity to comment on the 2022/23 Quality Account for East Lancashire Hospitals Trust (ELHT).

Throughout 2022/23, the Trust has continuously demonstrated their commitment to providing safe, personal, and effective care for patients they serve with the dedication to work closely with external health and care providers across Pennine Lancashire.

LSCICB is pleased with the progress made against key priorities identified in 2021/2022 and the continuous learning and improvements made by the Trust to ensure quality commitments are achieved.

The Trust continues to proactively look at ways to ascertain patient feedback, through surveys, friends and family tests, patient forums, patient stories presented to the board and complaints. The principles "Getting it right - Being customer focused - Being open and accountable – Acting fairly and proportionately - Putting things right and seeking continuous improvement are principles the Trust works with to ensure patients are receiving safe, effective, and personal care.

The Trust has been successful in reducing the number of inquiries received in 2022/23 (2519) compared to 3402 in 2021/22. Improvements in patient experience include training staff in how to effectively deal with complaints and increasing the availability of virtual appointments which has seen a reduction in cancellations and inappropriate admissions to hospital by promoting end of life community services.

LSCICB is pleased that the Trust has benefitted from being an early adopter of the Patient Safety Incident Response Framework (PSIRF). Investigations have supported the Trust to learn and prioritise future improvement workstreams to better the service offering. Since 2021/22 the Trust has recruited a Patient Safety Incident Investigation (PSII) Team to investigate incidents that meet the national and local priorities defined in PSIRF and the Trust patient safety incident response plan. They have developed tools for incidents that do not meet the criteria to be investigated and introduced robust assurance systems to provide improvements and effective management of incidents.

LSCICB acknowledges the various methods the Trust has undertaken, to share learning to improve patient safety culture and to raise awareness of safety improvements from national and local priorities under PSIRF.

LSCICB continues to attend the Trust's Mortality Steering Group which provides robust reviews of mortality statistics and performance. The Trust continues to use the Structured Judgement Review (SJR) process, completing between 200-250 reviews each year since 2018. The recent recruitment of additional Medical Examiners and Medical Examiner Officers has provided more capacity to review community deaths. Data from the Medical Examiner Service reported positive comments about the end-of-life service provided by the Trust to their loved ones. Learning Disability Mortality Reviews (LeDeR) are being routinely subject to SJRs as well as being reviewed by learning disability reviewers. Any actions and lessons are monitored through the Mortality Steering Group.

The Trust reports their Summary Hospital Level Mortality Indicator (SHMI) as expected, however, the Hospital Standardised Mortality Ratio (HSMR) is above expected with palliative care flagging as an outlier. LSCICB acknowledges the Trust's improvement actions including funding for a 7-day palliative care service; reviewing the coding for end-of-life bereavement interventions delivered and introducing an electronic patient record to improve the quality of coded data.

During 2022/23 the Trust participated in 100% of national clinical audits and 100% national confidential enquiries which it was eligible to participate in. LSCICB is pleased to note the continued monitoring of compliance, with associated improvement actions and learning to inform improvement programs. LSCICB recognises that over the period of 2022-23, the Trust completed 193 local clinical audits of which the results have contributed to the improvements across the Trust.

The Trust reported high compliance submission to the NHS Digital Secondary Uses Services, this is a repository for healthcare data, enabling analysis to support the delivery of NHS healthcare services. The Trust reported 99.90% of records included a valid NHS Number and 100% had a valid GP Code, for admitted patient care - in the case of outpatient care, 100% of records included a GP Code.

The Trust is introducing a new electronic patient record (Cerner system). Although there have been delays in the implementation of an electronic patient record, LSCICB acknowledges that the electronic patient record system will be in place by the end of June 2023. The

implementation of this system across multiple sites will enable clinicians to have access to the best available information from different sources, to make effective decisions about the patients care and treatment. LSCICB recognises that this will be a big change and the impact will be closely monitored through the patient safety groups and other committees.

During 2022/23 the Trust reported consistently high scores for the inpatients Friends and Family Test, with an average of 96% of inpatients rating their overall experience as either very good or good. Scores have been lower for patients attending Emergency Department and Urgent Care Centres with comments reflecting the busy nature of these units. Work is ongoing to address responses from patients, with the Friends and Family Test reports helping to inform the service developments. Progress to improve response rates and patient satisfaction is discussed at the Patient Experience Group meeting, which is attended by LSCICB.

LSCICB commends the Trust for the improvements seen in the NHS staff surveys. The Trust scored better than the England average, in Q14c which related to career progression regardless of gender, age and ethnic background and Q15 which related to staff experiencing harassment, bullying or abuse at work from other colleagues. The Trust has engaged with staff following publication of the survey results and developed an action plan to address feedback and further improve performance.

Whilst the Trust continues to have local staffing pressures, LSCICB welcomes the Trust's work to recruit overseas and their involvement in developing a regional Certificate of Eligibility for Specialist Registration (CESR) programme, providing pathways for oversees medical professionals. LSCICB would like to thank the Trust for their transparency by providing vacancies, sickness, bank, and agency usage figures regularly through the quality review meetings. Progress against these figures and plans to keep staff safe are monitored and discussed throughout the year.

The Trust reported a number of achievements against their quality improvement priorities including:

- Improvements in ambulance handover times by 7% within 15 minutes and 12% for 30 minutes.
- In January 2023 they reported dropping their triage from 33 mins (baseline) to 21 mins.
- There was seen to be a 20% reduction in overprocessing of C-reactive protein (CRP) and Coagulation Blood requests
- Staff morale in triage has improved with 42% of staff reported having a good morale.
- Junior doctors clerking patients in AMU has improved, because patients are being reviewed by medical consultants in ED.
- Significant investment in training staff to deliver safe, effective, and personal care with the support of the Improvement Hub.

The Trust reported having a significant number of live improvement projects, supporting the Trust to achieve safe, effective, and personal care. The ICB will look again next year to understand the maturity and impact of these projects. LSCICB recognises the progress made by the Trust in training members of staff in improvement methodologies, offering coaching sessions and delivering specific key workshop events.

Readmissions within 28 days of discharge has decreased from the previous year, however, remains above the national average. LSCICB acknowledges actions ELHT has taken to

improve the position, especially for the 0-15 age group. A third Epilepsy Nurse Specialist has been recruited to support care in the community and support children on discharge and ELHT has extended services to support paediatric care, improving family experience of pathways. The Trust reported 2 Never Events in 2022/23. Root cause analysis investigations have been completed and have identified lessons learned and actions. LSCICB has reviewed the action plans and is satisfied that there is a robust governance process in place to ensure patients are kept safe. Local Safety Standards for Invasive Procedures (LocSSIPs) have been put in place, and staff have been provided with education and training. The ICB will continue to review the investigative outcomes of any significant incidents which are reported, particularly reviewing the Trust's application of learning, training, and scrutiny.

LSCICB is appreciative of the Trust's persistent focus on strengthening Community Rehabilitation Services. The work done by the Trust to develop the new Hydro-Therapy Service to support rehabilitation and the online Brain Injury Support Scheme has been recognised. Furthermore, the ICB notes the ongoing collaborative work with Lancashire and South Cumbria NHS Foundation Trust Integrated Home Support Service, to support patients at home to avoid hospital admissions.

The level of commitment to quality throughout 2022/23 has seen ELHT deliver safe, personal, and effective care to each patient using their services. LSCICB will continue to support ELHT's staff, processes, pathways, and strategies to achieve the key priorities identified for 23/24 to make sure that patients and their families are at the centre of everything we do as a collective system.

Yours sincerely

Claire Lewis

Associate Director - Quality Assurance

On behalf of Professor

Sarah O'Brien

Chief Nursing Officer

3.5.3 Lancashire County Council

Although we are unable to comment on this year's Quality Account, we are keen to engage and maintain an ongoing dialogue throughout 2023/24.

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 and Social Care 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:

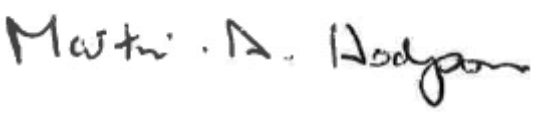
- The Quality Account presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in 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 and Social Care 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: Shazad Sarwar

Chief Executive: Martin Hodgson



Date: 30 June 2023

3.7 GLOSSARY

Term	Explanation
Acute Kidney Injury (AKI)	Acute kidney injury is a sudden episode of kidney failure or kidney damage that happens within a few hours or few days.
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Advancing Quality Alliance	The Advancing Quality Alliance was established to support health and care organisations in the North West to deliver the best health, wellbeing and quality of care for all by being a trusted source of quality improvement expertise for the NHS and wider health and social care systems.
Antimicrobial	An agent that kills microorganisms or inhibits their growth
Board Assurance Framework (BAF)	The BAF is a key framework which supports the Chief Executive in completing the Statement on Internal Control, which forms part of the statutory accounts and annual report, by demonstrating that the Board has been properly informed through assurances about the totality of the risks faced by the Trust.
Care Bundle	A group of interventions which are proven to treat a particular condition
Care Quality Commission (CQC)	The independent regulator for health and social care in England
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary
Clinical Commissioning Group (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 (CSUICB)	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
DNACPR	Do not attempt cardiopulmonary resuscitation – this is a treatment that can be given when you stop breathing (respiratory arrest) or your heart stops beating (cardia arrest)
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
GROW	Gestation related Optimal Weight, used to assess fetal size and growth of baby.
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.
Health Education England (HEE)	Supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.
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
ICB/ICS	Integrated Care Board/System are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
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; imSIrove 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
MSOC	Medicines Safety Optimisation Committee
National Confidential Enquiries (NCEs)	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 Patient Safety Alerts (NPSA)	National patient safety alerts are issued by NHS Improvement to rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.
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
Patient Safety Incident Response Framework/Plan	New National incident reporting and investigation requirements.
PFI	Private finance initiative a way for the public sector to finance public works projects through the private sector.
Place based partnerships	Place based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing.
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
SIRO	Senior Information Risk Owner, this person takes on overall responsibility for the Trusts information risk policy.
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
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