QUALITY ACCOUNT

2023 - 24

EAST LANCASHIRE HOSPITALS NHS TRUST – QUALITY ACCOUNT REPORT 2023-24

1.0 PART ONE – INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

Our patients are at the heart of everything we do at East Lancashire Hospitals NHS Trust (ELHT). 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 high quality acute secondary and 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 Blackburn with Darwen and 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.

As part of 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 outcome
- 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 (LSC) 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 (LSC 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 ICS contributing to and learning from best practice across the region and working to ensure equity of care for our communities.

As our partners at the ICB and Place develop their new structures, plans and priorities in the coming years, so too will we. By adjusting and developing our plans, we will ensure our priorities and underpinning delivery are aligned. This will ensure maximisation of our combined partnership contribution to improving the health and wellbeing of the population of East Lancashire.

1.4 Our Approach to Quality Improvement

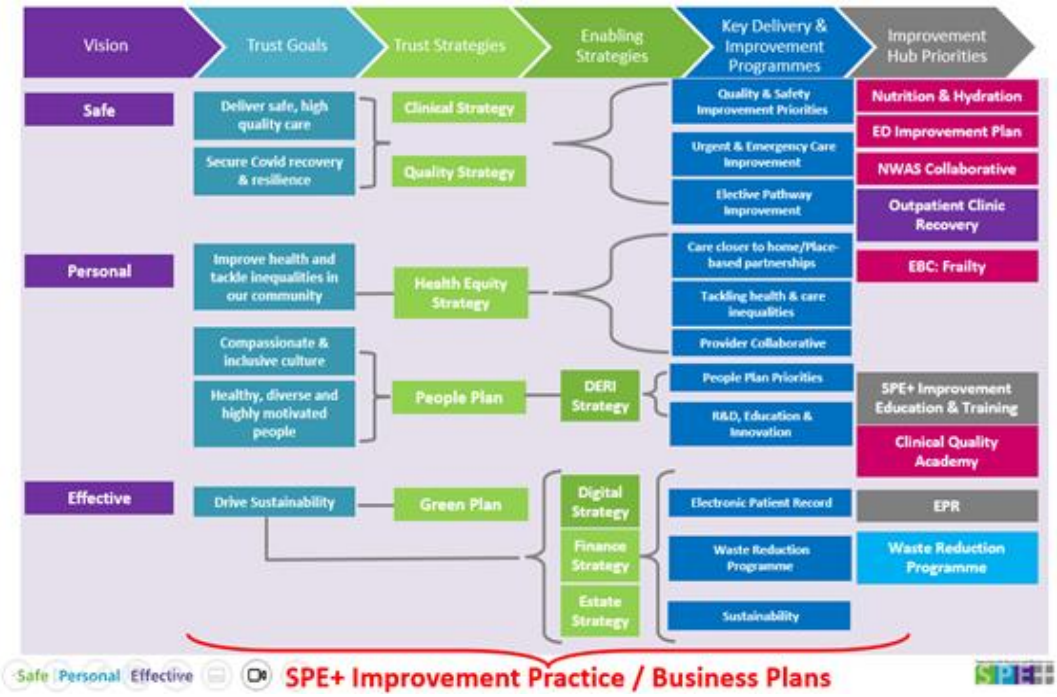
At ELHT, delivering the highest quality healthcare to our local communities is at the heart of everything we do. We have fantastic teams delivering safe effective care and every day we hear stories about how they go above and beyond. Quality is embedded in our culture, and we are committed to continually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

The Trust has implemented 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 patients and carers, our colleagues, our organisation and senior leaders and wider partners across Pennine Lancashire to provide better care and outcomes for our patients, colleagues, 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 an embedded process for the identification and agreement of key improvement priorities. The Trust has an agreed set of 11 Key Delivery and Improvement Programmes (see Figure 1). 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, that align with national requirements.

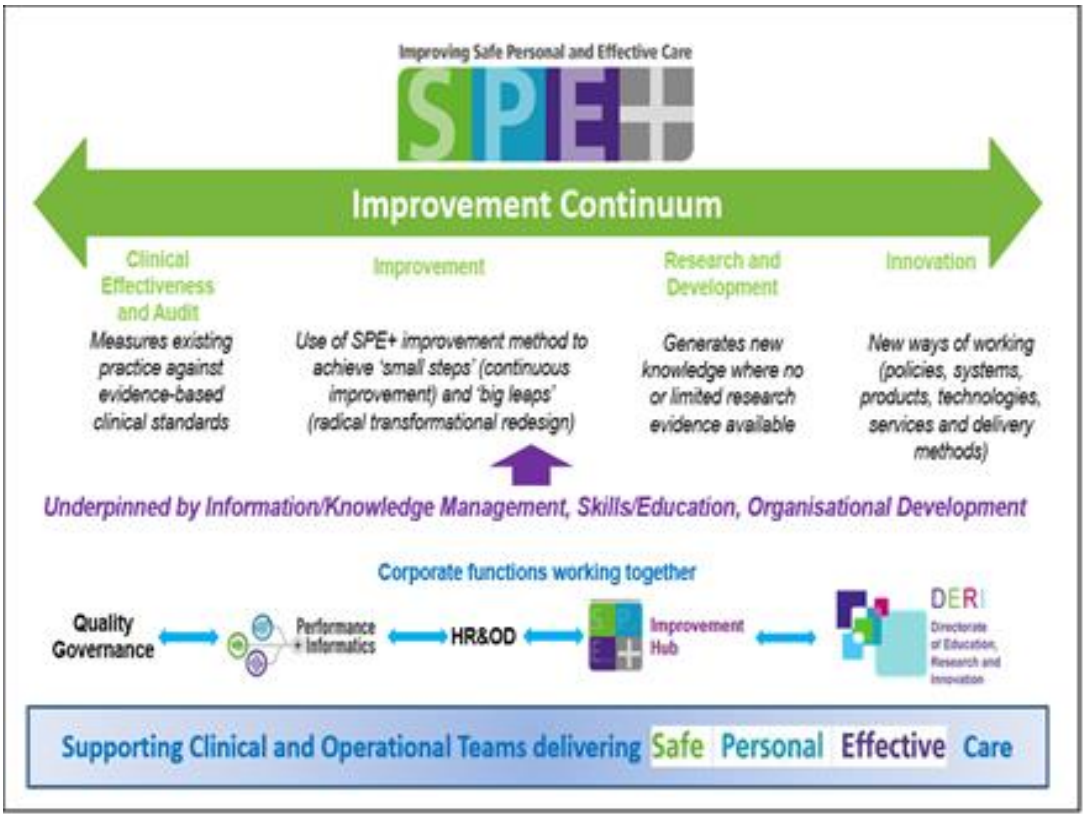
ELHT annually review and refresh key Trust and Enabling Strategies (see Figure 1). The SPE+ Improvement Practice is underpinning to support the delivery of improved outcomes and ELHT being recognised as a learning and improvement organisation (see Figure 2).

Figure 1



There is a Trust-wide approach that spans our Improvement Continuum, and any idea for better care and outcomes for our patients, colleagues and communities will receive the appropriate support the first time.

Figure 2



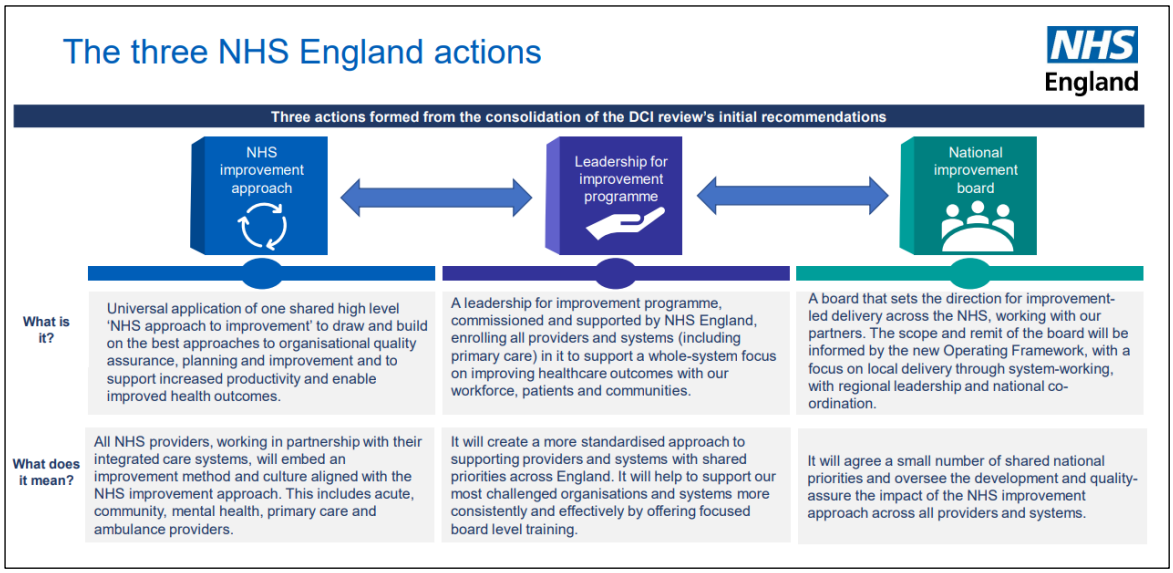
We continue to develop a comprehensive Improvement Network, across the organisation and wider system to bring together colleagues involved in improvement (Clinical Audit and Effectiveness, Improvement, Research and Development, Transformation, and Innovation) to support shared learning and spread and celebration of success (see Figure 3).

Figure 3

SPE+ Improvement Practice Components:

In April 2022 Amanda Pritchard requested a review of the way in which the NHS, working in partnership, delivers effectively on its current priorities while developing the culture and capability for continuous improvement. Led by Anne Eden, NHS Regional Director South East, with a steering group chaired by Sir David Sloman, Chief Operating Officer, NHS England, the review team co-developed 10 recommendations with health and care leaders that have been consolidated into three actions (Figure 4).

Figure 4 (https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf)



An NHS Approach to improvement

NHS England have set an expectation that all NHS providers, working in partnership through integrated care systems, will embed a quality improvement method aligned with the NHS improvement approach. This will inform our ways of working across services at every level of place: primary care networks, local care networks, provider collaboratives and integrated care systems. It will require a commitment from NHS England itself to work differently, in line with the new NHS operating framework. (Figure 5)

Figure 5 (https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf)

The SPE+ Improvement Practice element of the Improvement Continuum is comprised of three key elements which are encapsulated into an Improvement Practice Development Plan. They map to the five components of the recommended NHS improvement approach, and this is depicted below (Figure 6) and within the Practice Development Plan and Commitments 2022/25: Year 2 (Figure 7).

Figure 6

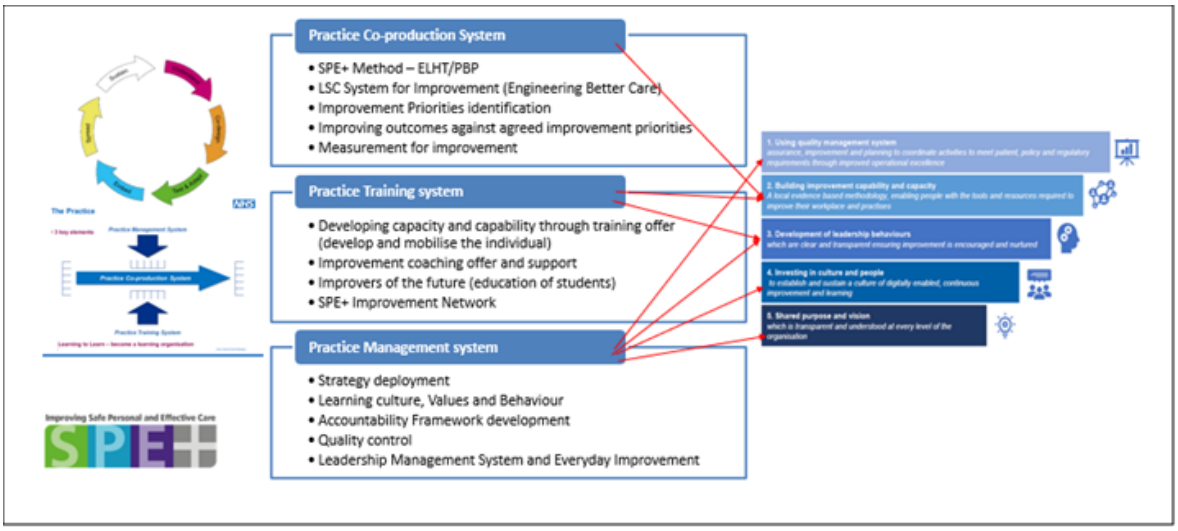


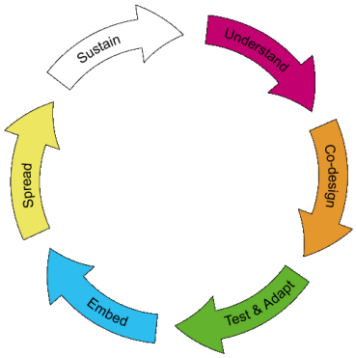
Figure 7: Practice Development Plan and Commitments 2022/25: Year 2

Practice Component	Aim	Objectives
Practice Management System	To **embed** improvement in all that we do.	1. To implement the Improvement Strategy. 2. To contribute to the learning culture where all colleagues strive for continuous improvement and innovation. 3. To celebrate success and share learning.
Practice Training System	To **empower** colleagues to make improvements.	1. To continue to develop capacity and capability of colleagues through the SPE+ Improvement Practice training offer. 2. To support colleagues on their improvement journey through high quality Improvement Coaching. 3. To create a SPE+ Improvement Network to support colleagues in sharing best practice.
Practice Co – production System	To **lead** change for better care and outcomes for our patients, colleagues and community.	1. Working with partners across Lancashire and South Cumbria to develop a consistent system-level method of improvement (Thinking, Method, Delivery). 2. Ensuring a robust approach to the identification of Improvement priorities. 3. Utilising the SPE+ Improvement Practice to support improved outcomes against agreed improvement priorities. 4. Ensuring robust systems for measurement for improvement.

Last updated 27.11.23

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 six 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. In 2022/23, we further developed our improvement practice training offer to include Kata Coaching, the Institute for Healthcare Improvement Breakthrough Series Collaborative and Engineering for Better Care frameworks.

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 colleagues 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. Colleagues in training, that is 'future improvers', are supported to develop, contribute and lead quality improvement projects - Multi-professional Preceptorship, Foundation Year 1 (FY1) Doctors, Foundation Year 2 Doctors (FY2), Junior Clinical Fellows (JCF), Internal Medicine Trainees (IMT), UCLan Year 4 Medical Students (SSC4) and UCLan Trainee Advanced Clinical Practitioners (TACPs).

A comprehensive colleague development programme in improvement skills is in place both internally and through our membership of the Advancing Quality Alliance (AQuA).

Other Key Enablers

e-Lancs - Electronic Patient Record

Over the last 12months, the Trust has implemented one of the biggest organisation-wide transformation programmes: an Electronic Patient Record (EPR). The EPR was launched at ELHT on Friday 16 June 2023 and has already completely transformed the way we work, with vast benefits for both colleagues and patients and their families.

- It provides clinicians with more information at their fingertips to make better, more effective decisions.
- Colleagues have automatic access to decision support tools, meaning their decisions are made based on the best available information.
- Colleagues are able to take information from many sources.
- It makes ELHT more efficient and creates a smoother care journey for our patients.
- It enhances communication across the Multi-Disciplinary Team (MDT).
- It reduces duplication and elements of the data collection burdens from people by capturing some things automatically.
- Paper records are systematically being replaced by digital records, thus contributing to sustainability and the NHS Green Plan, reducing our carbon, as well as the Waste Reduction Programme
- There will be new ways of working introduced, making several administrative tasks easier to manage as information flows around the organisation more easily.

The Improvement Hub supported the roll out of the EPR in June 2023 through leading and coordinating EPR control centres, engagement events and hosting 'Access Fairs' across the organisation. The team carried out 'walk abouts' engaging with colleagues within clinical spaces as well as hosting dedicated corridor stations. Feedback from the Improvement Team being 'out on the Gemba' was very positive.

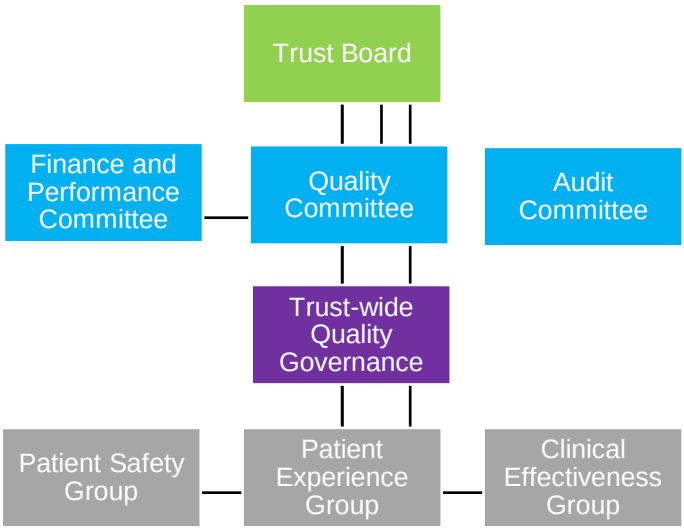
During the Access Fairs a total number of **2,701** individual contacts were made. Whilst it is recognised that colleagues needed to make contact during these fairs, to be 'Go Live' ready and support their ongoing IT access, it cannot be denied that being out, visible and attending work environments across all five hospital sites was a positive approach to engaging colleagues.

The Improvement Hub continue to help embed the EPR post 'Go Live' by supporting the Cerner Optimisation Coaching sessions. This One-to-one coaching is open to all clinical colleagues who use the FirstNet, Powerchart and Anaesthesia applications.

Monitoring and Assurance

Quality monitoring occurs through our corporate and clinical governance structure, reporting to the Trust board via the Quality Committee. Divisional Directors or their deputies attend and provide assurance at these committees.

Dr Jawad Husain remains as the Executive Medical Director and the Lead for Clinical Quality and in January 2024 we welcomed Dr Charles Thomson, as our new Deputy Medical Director for Quality and Effectiveness, replacing Dr Chris Gardner.



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. Other groups, such as Mortality Steering Group, Hospital Transfusion Committee and Safeguarding Committee, report directly to the Quality Committee through the Trust Wide Quality Governance Group.

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 Director 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.

Quality Improvements Triage

Each division has a governance route (for example, 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 Registration and Triage process.

Each division is responsible to provide updates on project implementation for all the projects within their division via the automated Project Update Form reminders.

Partnership Working

The Trust continues to build on its relationships and communication with the LSC ICB and the place-based partnership with Lancashire Place. 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 colleagues 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 (DSIRG) and presented at a monthly Trust Serious Incident Requiring Investigation (SIRI) 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 ICB 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 2023-24.
- 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 2023-24 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
Fusion House
Evolution Park
Haslingden Road
Blackburn
BB1 2FD
Email: qualityandsafetyunit@elht.nhs.uk

1.6 Our Regulator's View of the Quality of our Services

The last formal inspection of the Trust was within maternity services and took place on November 2 and 3, 2022. This inspection visited Lancashire Women's and New-born Centre in Burnley General Teaching Hospitals and Blackburn and Rossendale Birthing Centres, which were all confirmed as Good in both the Safe and Well-led domains. The CQC acknowledged elements of outstanding practices across all three sites. No formal inspection has taken place since this time.

However, the CQC completed a registration inspection of the Urgent and Emergency Care Department (UEC) on 4 October 2023. This was in support of the Trust's request to be registered for the provision of the assessment and treatment of patients subject to the Mental Health Act. The CQC have notified the Trust that following this inspection, they are happy to support this registration status for the short-term management of patients on the emergency care pathway only. The CQC have agreed with the Executive Teams recommendation that at this stage further work is necessary

to support the safe delivery of care to this vulnerable patient group in our acute ward settings. The work to address this is on-going.

The last comprehensive Care Quality Commission (CQC) inspection took place from 28 August to 27 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 12 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 five 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.

Our Transfusion and Haematology Services were inspected by the Medicines and Healthcare products Regulatory Agency (MHRA) on 29–30 November 2023. This has resulted in an Improvement Action Plan which is on-going under the leadership of an allocated member of the Executive Team.

1.7 Our Chief Executive's Statement on Quality

On behalf of the Trust Board and colleagues working at East Lancashire Hospitals NHS Trust (ELHT), I am pleased to introduce our Quality Account for the year 2023/24.

There is no denying it has been an incredibly challenging year for everyone working in the NHS but once again, colleagues have demonstrated that by working in new and innovative ways we continue to care for people both in hospital and in the community, often in their own homes.

It's important to put on record the huge thanks that is due to all colleagues across all services and settings for the sustained extraordinary efforts on a day-to-day basis, but also in preparing for and managing periods of industrial action, balancing the demands of winter, remedial work on our estate to remove substandard concrete and wider operational pressures, which continue to include our ongoing recovery following the pandemic.

Despite all of this, we have continued to make and sustain, improvements in quality and safety.

We ended the financial year 2023-24 well, achieving our financial plan, which at times felt almost impossible to do, especially considering the huge budget reductions we needed to make.

Positive progress was made on our 65-week cancer waits and the 62-day cancer target, and as a result, we ended the year ahead of our original trajectories. By the end of March 2024, only 191 patients had an ongoing pathway over 65 weeks, significantly better than the projected 628.

While we have maintained a high standard in most areas, meeting the target for admitting stroke patients to specialist beds within four hours remained challenging due to national pressures on non-elective services and bed availability.

Nevertheless, both our Acute and Rehabilitative services achieved a Sentinel Stroke National Audit Programme (SSNAP) score of 'A' - the highest rating available - in Q3 of 2023-24. Ten categories are individually scored as part of the SSNAP, ranging from scanning and specialist assessment to physio and discharge processes. The result for each category contributes to the overall score.

The endoscopy team once again achieved JAG (Joint Advisory Group) accreditation. JAG is a voluntary scheme that focuses on standards, identifies areas for development and is based on evidence linked to clinical quality, patient experience, workforce and training. It is the 'Gold Standard' for Endoscopy Departments and it is a real testament to the team that the service has met the required JAG accreditation standards.

A substantial amount of work and effort has been put into achieving these scores and accreditations, which reflects the dedication, hard work and drive within the teams to strive to provide a high-quality service.

Targets and measures are very important but what truly matters is that we provide safe, personal and effective care to our patients and their families. This is where my greatest source of pride lies, particularly given the exceptional challenges faced by the Trust throughout the year.

This is evident in our Friends and Family scores and other patient experience surveys which remained consistently above the 90% threshold for inpatients, outpatients, and community services.

Our Burnley site has received investment to create a new, modern Urology unit, demonstrating our commitment to growth, innovation, and transformation. This new unit consolidates all our urology services in one location, benefiting patients for years to come. It enables us to provide the highest levels of care and support in a welcoming and comfortable environment.

Further developments at the Burnley site include a multi-purpose simulation suite designed as a ward, providing healthcare professionals with hands-on training in an environment that mirrors their daily clinical practice. This realistic setting allows colleagues to enhance their skills, thereby improving patient care. The simulation suite will revolutionise our training approach, offering realistic scenarios in a safe environment to better prepare learners for real-world situations in our wards, clinics, and theatres.

Later in this report you will be able to read about more quality highlights which include award wins and a creative way of supporting rehabilitation, inspired by the Invictus Games.

The Improvement Hub Team facilitate and support the delivery of the agreed Trust Improvement Priorities and Key Delivery and Improvement Programmes of work (KDIPs), which covers seven of the 11 Key Delivery and Improvement Programmes underway across the Trust (Quality and Safety, Urgent and Emergency Care, Elective Pathway, Provider Collaborative, R&D, Education and Innovation, Electronic Patient Record and the Waste Reduction Programme).

How we performed against our 2023-24 improvement priorities:

1. **Emergency Department Improvement Plan** – Achieved an Amber NAPF in February 2024.
2. **NWAS Collaborative/Ambulance Handovers** – Achieved an increase of 24% from baseline in handovers completed in less than 30mins (39% - 63% range).
3. **Outpatient Clinic Recovery** – Commenced end to end review of Outpatient workflows.
4. **Nutrition and Hydration: Back to Basics** – We launched the first ELHT Nutrition and Hydration Breakthrough Series Collaborative, which includes 12 x cross divisional multi-disciplinary teams representing a cross-section of our specialties and hospital sites.
5. **Partnership Working: LSC Engineering Better Care for Frailty** – We launched the Primary Care Quality Contract and the ICB roll-out of the frailty posters and good practice guidelines.
6. **Waste Reduction Programme** – Demonstrated a reduction in the overall postal spend on 2022/23.
7. **Electronic Patient Record** – Over 2,701 colleagues were supported to attend access fairs across the organisation.

All achievements and progress can be found in more detail within section 3.1 of this report.

I am extremely proud of our colleagues who have focused on providing safe, personal and effective care and improving the quality of our services for our patients while taking the time to support and care for each other.

Our Improvement Hub supports building capacity and capability amongst individuals and teams from across the Trust and wider system to use our SPE+ (Safe Personal and Effective Plus) improvement methodology (Understand, Co-design, Test and Adapt, Embed, Spread and Sustain).

It is important to us at ELHT that colleagues can be directly involved in changes that affect and happen in their workplace. In 2023/24, 101 Quality Improvement Projects were registered and 591 substantive colleagues and colleagues in training were trained in our Level 2, Level 3 and Level 4 Improvement Practice Training.

We continue to be committed to the delivery of a comprehensive improvement practice training programme that will support the achievement of our future priorities and vision to improve our patient's care, experiences and outcomes.

In November 2023, in partnership with Blackpool Teaching Hospitals, the Trust launched its first Clinical Quality Academy. Through the academy, teams learn the key principles of the science of improvement from academic experts and thought leaders. The process encourages collaborative working to achieve the improvement aim.

The first cohort of projects include:

1. Pain Management in the Emergency Department – to provide good pain management to patients.
2. Developing the Hospital at Home service – to increase the range of hospital level interventions delivered in a community setting.
3. Bringing learning home - improving organisational learning from Patient Safety Events.
4. Anti-racism and Inclusion – to become an intentional, active and visible anti-racist organisation.

It has never been more evident that to provide high quality care to our patients, we must also provide the right level of support to the people who work within the Trust, so they are able to deliver our ambitions for excellence.

The last year, on the back of three previously problematic years, brought an incredible amount of large and difficult challenges that have impacted the experience of colleagues.

The immense challenges faced by colleagues, and our patients, were clear as teams coped with the dual demands of adapting to a new system while delivering essential care.

We continue to develop our colleagues' well-being offers to make sure help – whether this is for physical or mental health needs - is available to all who need it when they need it.

I would like to take this opportunity to thank all our colleagues, volunteers and partners who have shown incredible commitment to the care of our patients and colleagues. I am confident we will continue to go above and beyond for the patients and communities we serve.

Looking forward, our proposed Key Delivery and Improvement Priorities for 2024/25, and supported by the Trust Board are to:

- Prevent hospital attendance where alternatives cab be safely provided in the community to support patients in their own home.
- Support vulnerable and frail patients to receive the best possible care.
- Transform the delivery of outpatient services and develop elective services at Burnley General Teaching Hospital to support the best patient experience.

- Develop a culture of compassion and belonging and to become intentionally anti-racist on our inclusion journey.
- Implement Provider Collaboration Board Programmes such as Clinical Services Transformation and One LSC.
- Develop sustainable workforce models to deliver the best possible care.
- Digitally develop (including EPR optimisation) to support and enable the delivery of Trust priorities.
- Ensure the highest standards of financial management by using SPE+ improvement principles to identify and safely support the removal of waste.

I am pleased to confirm that the information in this report has been reviewed by the Trust Board who agree that it provides an accurate and fair reflection on our performance during the reporting period.

It provides a transparent picture of how patient safety, patient experience and quality improvement are key to the delivery of safe, personal and effective care here at ELHT.

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

Quality underpins the vision of 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 December 2021, the Trust implemented the new Patient Safety Incident Response Framework (PSIRF) as an Early Adopter representing the NHS North-West region. Over the last two years the Trust has been supporting other NHS Trusts within the region with their implementation of the framework. 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.

When launching PSIRF in 2021 the Trust identified five local priorities for investigation and learning:

1. **Treatment problem/issue, Diagnosis failure/problem and 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 and patient flow, inappropriate handovers, NEWS2 (National Early Warning Score Observations), Delays in treatment and Concern around care given.

All five local priorities have now been investigated and a thematic review of the learning from each case informed an organisational improvement plan, utilising the SPE+ improvement approach, for each of the five areas.

In November 2023, the Trust used a thematic analysis approach to determine new local patient safety priorities. Through our analysis of patient safety insights from data sources from January 2021 to December 2022, safety insights from key stakeholders and using the criteria in the National PSIRF, the Trust has identified three new local priorities it will focus on from November 2023.

- **Medication Errors** – linked to anticoagulant medication.
- **Discharge planning** – discharge between acute hospital beds to IHSS or care homes
- **Safeguarding patients with learning difficulties** – inappropriate use of the mental capacity act.

Routine patient safety response (PSR) investigation of incidents resulting in harm are conducted using a portfolio of tools, including round tables, clinical reviews, timeline analysis. These are coordinated within the divisions and reported/monitored at the Trust's 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 (for example compliance with local care bundles and alignment with other quality governance intelligence - incidents, risk, patient safety and experience etc.)
e. Relevant national guidance (for example NICE)
f. Relevant National Confidential Enquiry (NCE) recommendations
g. Getting It Right First Time (GIRFT) data and metrics

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. The implementation of EPR in June 2023 will provide further opportunities to streamline the process for collection and submission of data to national audit platforms as well as local quality audits. This activity continues to be led by the designated responsible Trust, Divisional and Specialty Clinical Leads, responsible for developing

a portfolio of evidence and providing assurance of compliance with appropriate standards through designated quality governance forums, supported by the central Clinical Effectiveness Team.

Improvement (SPE+)

The Improvement Hub Team supports the organisation by coaching and facilitating defined improvement programmes, projects linked to Trust and divisional priorities and educational requirements for our colleagues in training groups. These are Multi-Professional Preceptorship, Foundation Year 1 (FY1) Doctors, Foundation Year 2 Doctors (FY2), Junior Clinical Fellows (JCF), Internal Medicine Trainees (IMT), UCLan Year 4 Medical Students (SSC4) and UCLan Trainee Advanced Clinical Practitioners (TACPs).

Using the six 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 Key Delivery and Improvement Programmes of work (KDIPs), which cover **seven** of the **11 Key Delivery and Improvement Programmes** underway across the Trust:

1. Quality and Safety Improvement Priorities
2. Urgent and Emergency Care Improvement
3. Elective Pathway Improvement
4. Provider Collaborative
5. R&D, Education and Innovation
6. Electronic Patient Record
7. Waste Reduction Programme

The Quality Strategy improvement/PSIRP priorities for 2023/24 are defined within the current Patient Safety Incident Response Plan 2023 Policy (C0175 V3.0) 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:

	Incident Type	Description	Specialty
1	**Medication Errors**	Anticoagulant Medical Errors	Trust wide
2	**Discharge Planning**	Discharge between Acute hospital beds to Intensive Home Support Service and/or Care Homes	Trust wide
3	**Safeguarding Patients with Learning Difficulties**	Inappropriate use of the Mental Capacity Act	Trust wide

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 Harms Reduction Summary Closure Report was submitted to the ELHT Quality Committee in March 2024 (see section 3.2 – Harms Reduction Programmes).

The Quality Committee members were asked to support and agree to:

1. The full transition from existing Harms Reduction Programmes to the identified local PSIRF priorities
2. The withdrawal of current improvement resource to existing Harms Reduction Programmes to support the delivery of The Improvement Hub Priorities for 2024/25

Our Quality improvement programme currently comprises a combination of:

- The ELHT Nutrition and Hydration Breakthrough Series Collaborative (PSIRP Plan priority 2022/23)
- Support and step-down of the existing Harms Reduction Programmes into business as usual (BAU)
- Directorate and Divisional Quality Improvement Projects
- Quality improvement (QI) projects for Colleagues 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 colleagues in healthcare is influenced by the extent to which safety is perceived to be important. The Trust 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 over 2022 and 2023 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 colleagues 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.
- ELHT Patient Safety Alerts 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).
- In 2023 the Trust developed a new Patient Safety Incident Dashboard with key performance indicators for assurance at Patient Safety Group and Quality Committee
- A new Patient Safety SharePoint site to enable colleagues to have easy access to useful information regarding patient safety and learning.

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 Executive Medical Director or 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
- Medical Examiner Service Activity and Learning
- Adult SJR Mortality Reviews and Learning
- PSIRI process, where a death has resulted from an incident
- Perinatal, Neonatal and Child Deaths
- Learning Disability deaths, Reviews and Learning

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. The Trust completed 154 SJR reviews last year, which has fallen since previous years as some SJR reviewers have retired. New reviewers have been identified and a training session carried out.

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 Learning from lives and deaths – people with learning disabilities and autistic people (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 Maternity and Neonatal Safety Investigation (MNSI) programme 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 Maternity and Neonatal Safety Investigations (MNSI) programme 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.

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

Medical Examiners

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. The introduction of Cerner, as well as changes in submission of some data - for example the separation of Same Day Emergency Care data from the inpatient dataset - has led to some discontinuities in the mortality data. These are being explored and monitored closely.

Personal Care

The Trust's engagement with patient, carers and the public provide us with opportunities to stimulate change in our organisation. We know that establishing true collaborations with patients and families will help to enhance patient safety, care, innovations, and experience. The Trust's focus is to go beyond receiving feedback and to have those who use our service influence better healthcare.

Obtaining patient, carers and the public comments is well embedded within the Trust, captured through numerous sources such as:

1. Friends and Family Test; an easily accessible patient experience survey offered to all those who have received care within our inpatient and outpatient settings. The survey provides a snapshot of whether the patient would recommend the service or not. Colleagues at all levels can access the feedback to help shape short and longer term improvements. With the overall feedback monitored within the Trust's Patient Experience Group.
2. Patient, Carer, and colleagues stories are used Trust wide, reminding the organisation of the impact we can make on the experience and outcome of a patient and their family, when we are at our best or fall short of that. The stories are encouraged and embraced by colleagues and endure as one of the richest/influential sources of feedback.
3. We value the feedback contained within complaints and concerns, and whilst we are disappointed that someone has need to raise a concern. It provides the Trust the opportunity to critically reflect on the care, experience, and services offered. The Trust uses the themes captured to improve services and enhance patient safety and experience. The Trust is currently embedding key performance indicators to provide more timely responses to complaints.
4. The Trust undertakes the CQC required national surveys capturing the experiences of patients who have used our adult and children's in-patient areas, also our Emergency Department, and Maternity services. The respondents' feedback is used to build upon our existing service improvement initiatives.
5. The Trust aims to launch its Patient, Carer and Family Experience Strategy 2024-27 in May 2024. In amongst other aspects its core theme is amplify the influence of patients (adults and young people) through their direct involvement in service development, redesign and

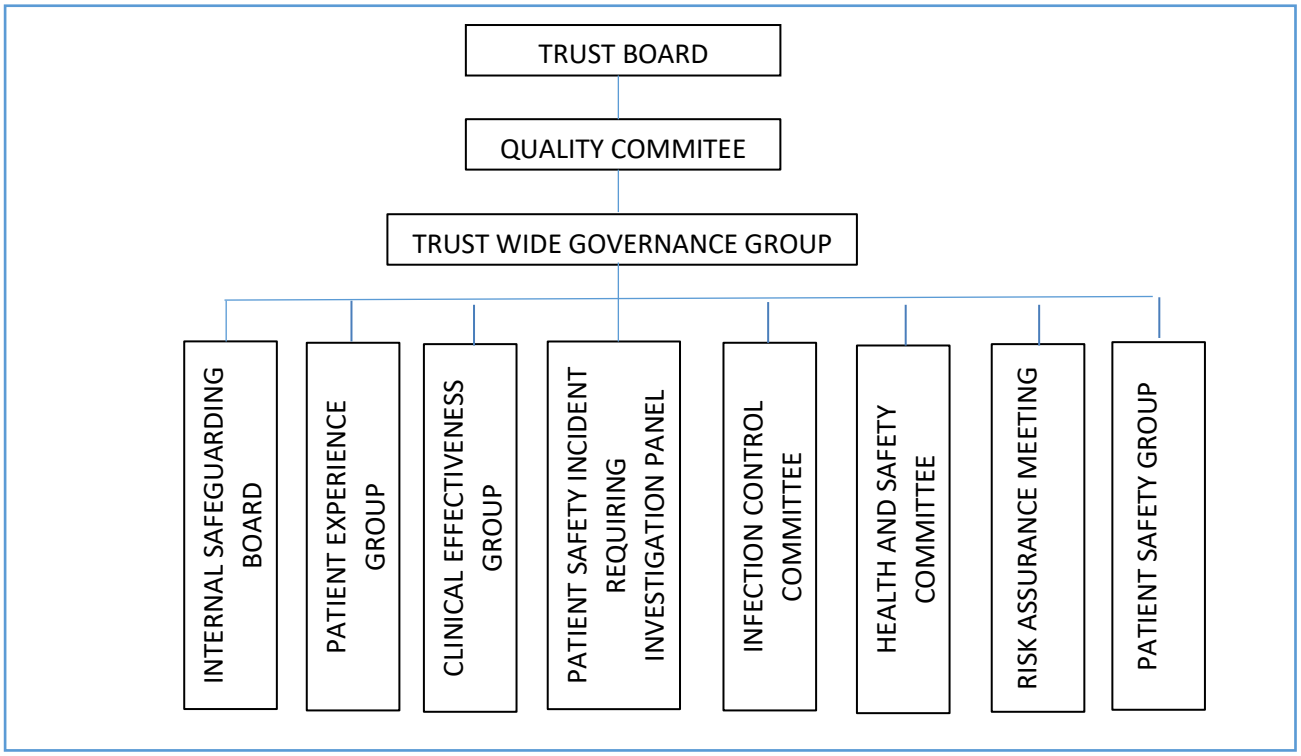
monitoring.

6. The Trust's Public Participation Panel continues to provide a critical friend role for the organisation, contributing and influencing within most of the Trust governance meetings. The Trust is working with the Panel to identify more areas for their participation.

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 2023-24 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 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 2023-24; have been managed by way of these reporting functions.
The income generated by the NHS Services reviewed in 2023-24 represents 98% of the total income generated by the East Lancashire Hospitals NHS Trust for 2022-23. (2022-23 98%).

2.3 Priorities for Quality Improvement 2023/24

The Trust co-ordinates a comprehensive rolling programme of Quality Improvement and PSIRP 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).

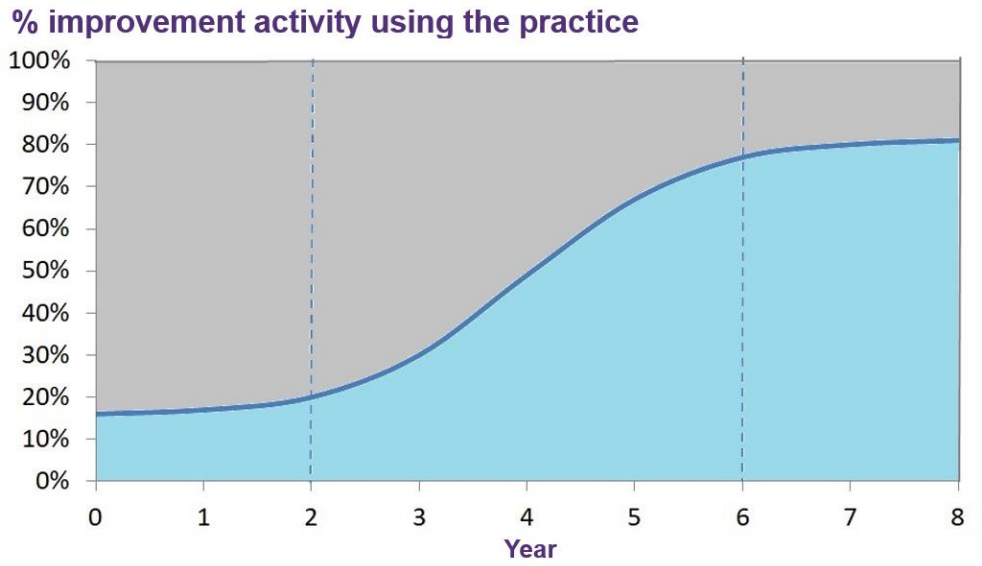
The Trust has identified a number of Key Delivery and Improvement Programmes to support the achievement of Trust goals. The Improvement Hub team will be deployed each year to directly

support delivery of a sub-set of these priorities through application of the SPE+ improvement approach. 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 SPE+ improvement approach. Over time the improvement practice will be used increasingly to support delivery of Trust Goals.

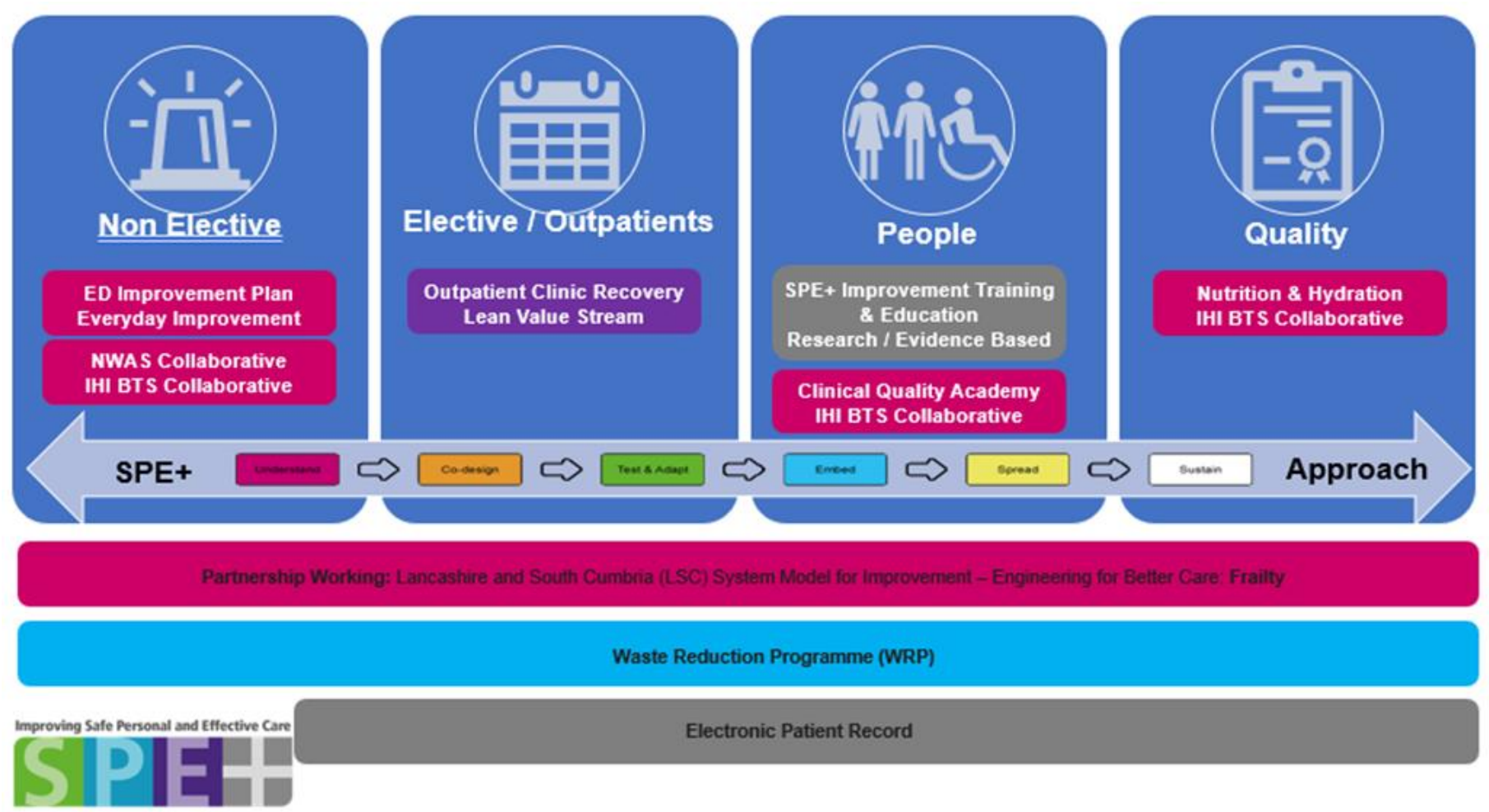
2023-24 Trust Goals and Key Delivery and Improvement Programmes

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 2023/24



Improvement Hub Team Priorities 2024/25

Our overall Improvement Programme for 2024/25 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 – Nutrition and Hydration Breakthrough Series Collaborative (12 x Teams)
Non-Elective	• Deliver safe, high quality care	• NWAS Ambulance Handovers • Emergency Department Improvement Plan • NWAS Conveyances
Elective	• Deliver safe, high quality care	• Elective Improvement Plan – Gynae Clinic Utilisation / Value Stream Analysis (VSA)
People	• Compassionate and inclusive culture • Healthy, Diverse and highly motivated people • Drive sustainability	• The Year of Improvement • Improvement Practice Training Offer – Launch of Level 1: Awareness • Continue to deliver Improvement Practice Training Levels 2: Contributor and 3 Lead • Clinical Quality Academy (Project Teams x 4) • Quality improvement (QI) training for Colleagues in Training Groups • Becoming an intentionally Anti-racist Organisation
Partnership Working	• Improve health and tackle inequalities in our community • Drive sustainability	• Lancashire and South Cumbria (LSC) System Model for Improvement launch – Engineering for Better Care: Frailty
Electronic Patient Record implementation (EPR)	• Deliver safe, high quality care • Healthy, Diverse and highly motivated people • Drive sustainability	• EPR Clinical Optimisation Coaching Sessions
Other		
Waste Reduction Programme (WRP)	• Deliver safe, high quality care • Drive sustainability	• WRP Training (Level 2 Improvement Practice: Contributor) **Agreed WRP Programme projects:** • Medical Absence (sickness and agency usage) • Postal Delivery – letters and taxi usage • Pharmacy – reusing patient medications

		• Pressure Ulcers – improving continence • Ward Ordering - supplies and stock
Pathology	• Deliver safe, high quality care • Healthy, Diverse, and highly motivated people • Drive sustainability	• Improving colleagues' capability and capacity re SPE+ improvement knowledge and skills (Level 2 Improvement Practice: Contributor and Level 3 Improvement Practice (Part 1): Lead) **Agreed areas of improvement focus:** • Systems and Processes (Primary Care, Transportation, Pathology Labs RBH and BGH) • People and Staffing (training and education, recruitment, Organisation Development) • Technology and Infrastructure (replace scanning equipment, maximise inpatient processing) • Equipment and Environment (6S – Declutter of department, orders and stock, replace and repair equipment, storage) • Communication (Visual management, Daily Huddles, Newsletters)

Other improvement priorities as required.

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 2023-24 52 national clinical audits and 13 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 46 (88%) 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 2023-24 also appears in the table below alongside the percentage of cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required / Sample Submission
Adult Asthma Secondary Care (NRAP)	RCP	Continuous	Yes	100%
BAUS Nephrostomy Audit	BAUS	Intermittent	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	NHS England	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NRAP)	RCP	Continuous	Yes	100%
Emergency Medicine QIPs: Care of Older People	RCEM	Intermittent	Yes	100%
Emergency Medicine QIPs: Mental Health (Self-Harm)	RCEM	Intermittent	TBC	TBC
Elective Surgery (National PROMs Programme)	NHS England	Continuous	Yes	100%
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC)	IBD Registry	Continuous	No	NA
Learning Disability Benchmarking Audit Year 6	NHS Benchmarking	Intermittent	Yes	100%
Learning Disability and Autism Programme (LeDeR)	NHS England	Continuous	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP) - National Cardiac Audit Programme (NCAP)	NICOR	Continuous	Yes	100%
National Adult Diabetes Audit – Core (NDA)	NHS England	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 Metastatic Breast Cancer (NAoMe)	NATCAN	Continuous	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)	NATCAN	Continuous	Yes	100%
National Audit of Metastatic Breast Cancer	NATCAN	Intermittent	Yes	100%
National Audit of Primary Breast Cancer	NATCAN	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 – Audit of NICE Quality Standards	NHSBT	Intermittent	Yes	100%
National Comparative Audit of Blood Transfusion –Bedside Transfusion Audit	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	TBC	TBC
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) National Cataract Audit	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 (NRAP)	RCP	Continuous	Yes	100%
Perioperative Quality Improvement Programme	RCA	Continuous	TBC	TBC
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%
Trauma Audit and Research Network (TARN)	TARN	Continuous	No	NA

Key to Audit Coordinator abbreviations	
BAUS	British Association of Urological Surgeons
BCIR	Breast and Cosmetic Implant Registry
BSR	British Society for Rheumatology
BTS	British Thoracic Society
FFFAP	Falls and Fragility Fractures Audit Programme
HQIP	Health Quality Improvement Partnership
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care Audit and Research Centre
MINAP	Myocardial Infarction National Audit Project
NATCAN	National Cancer Audit Collaborating Centre
NRAP	National Respiratory 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 2023 -24	Sample Submission
Medical and Surgical Clinical Outcome Review Programme: Juvenile Idiopathic Arthritis	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Crohn's Disease	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Community Acquired Pneumonia	NCEPOD	Intermittent	Yes	Yes	86%
Medical and Surgical Clinical Outcome Review Programme Testicular Torsion	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: Epilepsy	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Medical and Surgical Clinical Outcome Review Programme: Rehabilitation following Critical Illness	NCEPOD	Intermittent	Yes	Ongoing	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
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 morbidity confidential enquiry - annual topic based serious maternal morbidity	MBRRACE-UK, NPEU, University of Oxford	Intermittent	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 57 national clinical audit reports and 6 National Confidential Enquiry reports were received and reviewed by the Trust in 2023-24. 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.

255 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2023-24. 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 2023/24 that were recruited during that period to participate in research approved by a research ethics committee is 6029 recruited participants across 85 studies. In addition, ELHT recruited the first global patients (first in the world) to two studies.

2.4.3 National Tariff Payment System and CQUIN

A proportion of East Lancashire Hospitals NHS Trusts income in 2023-24 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 2023-24 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 2023-2024 there were 15 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 80% uptake of flu vaccinations by frontline colleagues with patient contact

National	Supporting patients to drink, eat and mobilise after surgery	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
National	Prompt switching of intravenous to oral antibiotic	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria
National	Compliance with timed diagnostic pathways for cancer services	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head and neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways
National	Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
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.
National	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.
NHS Spec Comm	Achievement of revascularisation standards for lower limb ischaemia	Percentage of patients that have a diagnosis of CLTI that undergo revascularisation, either open, endovascular, or combined within 5 days of a non-elective admission to vascular provider units.
NHS Spec Comm	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	The percentage of patients commencing treatment within 4 weeks of referral to ODN
NHS Spec Comm	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE QS17 recommendation

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.
National	Assessment and documentation of pressure ulcer risk	Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
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.
National	Malnutrition screening for community hospital inpatients	Achieving 90% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks
National	Routine outcome monitoring in CYP and community perinatal mental health services	Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.

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.

The Trust has additionally updated its Statement of Purpose (SOP) with the CQC to reflect the transfer of Community Diabetes, Lymphoedema and Complex Case Services from Lancashire and South Cumbria Foundation Trust (LSCFT) from March 2024.

An application for the provision of care to patients who are subject to the Mental Health Act has been agreed with restrictions by the CQC, in support of the wider system.

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2023-24 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 Dec 23 (most recent figures):

- Admitted Patient Care 112,182
- Outpatient Care 509,64

- Accident and Emergency Care 167,238

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

Performance for Apr 23 to Dec 23 (most recent figures):

- Admitted Patient Care 100%
- Outpatient Care 99.6%
- Accident and Emergency Care 97%

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

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

- Admitted Care 98.7%
- Outpatient Care 99.4%
- Accident and Emergency Care 98.9%

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 colleagues, contract reviews and a comprehensive information asset management programme. The Trust has a suite of Information Governance policies to ensure patient, colleagues 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 2023-24 is ongoing with the final submission due at the end of June 2024. 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

Data Security and Protection Toolkit Audit 2022-23 (200 episodes – carried out 8th – 20th September 2023) –

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 (50 episodes per coder x 2 audits)
- All coders have had 10 random spot checks, checking for co-morbidities and standards.

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 colleagues 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 2023 - 24, 2483 enquiries were received from a variety of sources (2519 in 2022/23). 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 2483 enquiries, 304 were logged as formal complaints during this period (344 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, colleagues 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 2023-2024, 15 complaints were referred to the Ombudsman, 1 is currently under investigation by the Ombudsman, 9 are being reviewed for possible investigation, 5 are closed (4 were not agreed for investigation and 1 was not upheld).

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 colleagues on the Trusts learning hub to access.

In 2023/24, 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:

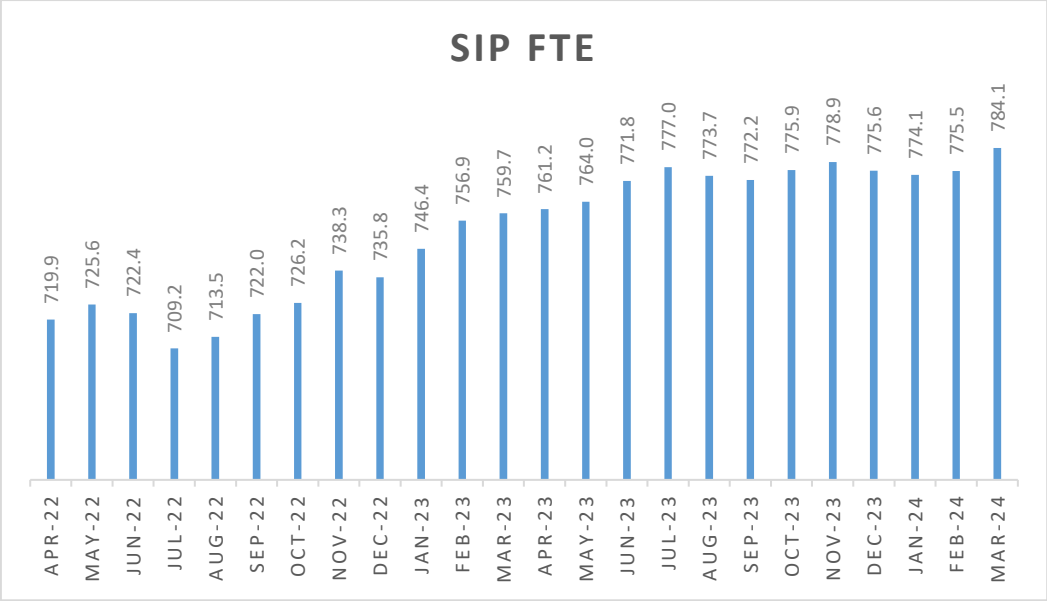
Indicator	Question	% Result
KF21 (Q15)	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	62.1%
KF26 (Q14c)	In the past 12 months how, many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	17.4%

For Q15, ELHT has seen a decline on the previous year's percentage (63.0%). ELHT is better than the national average of 55.8%.

For Q14c, ELHT has seen an increase in the previous year's percentage (15.5%). ELHT is better than the national average of 19.2%.

2.8 Medical and Dental Staffing

Medical and Dental gaps continue to be a challenge, the Trust continue to proactively monitor and innovate to manage the recruitment and retention of Medical and Dental (M&D) colleagues. The Trusts figures show a continued 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. Graph shows the growth in M&D Establishment:



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

We continue to develop retention pathways for our oversees doctors, with a new 'Locally Employed Doctor' contract in 2023 providing the same opportunities for Trust doctors as we provide for our Doctors in training. A successful programme for our Junior and Senior Clinical Fellows provides opportunities to retain and develop colleagues into substantive Specialty and Specialist posts. A successful CESR programme, in which we currently have 19 doctors signed up to in ED alone, supports the development pathway into Consultant posts outside of National training programmes.

Despite the increase in our Staff in Post over the last 2 years, there has still been a significant need for contingent medical workforce. The Trust is now looking at improving capacity/demand through workforce efficiencies listed below:

- Job Planning - There is currently a new round of job planning taking place, with every department across the Trust presenting their job plans to the Trusts Scrutiny Panel. A real focus on meaningful and transparent job plans that meet the service needs of each department.
- Annual Leave policy - MIAA are currently undertaking an audit of Annual Leave for Medical and Dental colleagues to ensure equity and transparency Trust wide. A new policy has been agreed to support all Medical and Dental working patterns.
- Sickness Improvement Project - MIAA also conducted an audit on M&D sickness absence and management. An Improvement project is currently ongoing with a small steering group improving the process for the management of sickness absence.

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	**2800: Emergency Department (ED) Improvement Plan**	For ED to achieve a Green NAPF status by the 30th of September 2024	• Build of the ED quality board and improvement wall • Weekly huddles – well attended, commitment to the improvement conversation Multiple tests of change related to the key measures identified, including: **1.** Implementation of the Acuity Project **2.** Updated ED Safety checklist **3.** Neutropenic Sepsis process change **4.** Start of 6s of Resus area **5.** ED patients transfer to Radiology test of change Impact / improvement seen to date: • Increased use of ED Safety checklists • Number of patients being offered Nutrition and Hydration • Increased completion of Pain score calculation documentation • Triage times improved • Improvement in staff measures such as

			vacancies, sickness, turnover • Positive feedback and Utilisation of the ED improvement wall – continue to mature and adapt overtime • Spread - Acute Medicine Unit now adapting the same approach to their quality improvement conversations
	2799: NWAS Collaborative – maximising alternative pathways	To reduce the number of ambulance conveyances to the ELHT Emergency Department by 30% by the 30th of September 2024	• Collaborative working with ED, CIC and NWAS colleagues • Full Observation week undertaken in ED during November 2023 • Stakeholder workshop held in December 2023 • Co-design workshop undertaken in February 2024 Tests of change undertaken/underway include: • Crews on scene direct access to IHSS • District Nurses escalating to IHSS (prior to 999) • Review and update of the Directory of Service • Improved referral process from Acute Wards to IHSS • Communications to patients known to IHSS but may not have used the service for over 12 months • Spread - Development of a Project improvement wall in the CIC Hub to create space for improvement conversation Impact / improvement seen to date:

			• ED NAPF (February 2024) = Amber *(Number of previous Reds (Inadequate) decreased from 5 to 4, Ambers (Requires Improvement) remain the same at 3 and Greens (Good) have increased from 4 to 5 from assessments completed in November 2023 to February 2024)* • Helping patients remain at home • Community services continue to adapt and perform well • Increased and continued idea generation and plans for future testing
	2748: Ambulance Handovers to the Emergency Department (ED)	For 90% of ambulance handovers to ED to occur within 30 minutes of arrival by the 31st of May 2024.	Review of the process and day of observations undertaken in January 2024 Established Task and Finish group Tests of change undertaken/underway include: • Introduction of the patient bedside handover – streamlining the process, as well as creating a safer handover process • Repositioning of the receptionists in process • Information sharing with colleagues re the process • Development of the "Perfect Handover" video as a resource for all colleagues and to help with sustainability • Information resource developed Impact / improvement seen to date: • Less than 30 minutes handover improved from baseline 39% to median 63%

			• A reduction of 7 >60 minute handovers per month (average) • Overall, HAS compliance has improved (achieved 100% for the first time ever on 29/04/24) • Positive colleague feedback re the process changes
Elective / Outpatients	**Outpatient Clinic Recovery**	Support adoption and optimisation of Cerner Outpatient Workflows	• End to end review of outpatient workflows to support updating of Standard Operating Procedures to improve outpatient booking and to identify additional training needs for outpatient clinicians underway • Creation of an Outpatient MPage to improve recording of outpatient procedures • Review of clinical administration processes to identify improvements to ways of working.
	Gynae Outpatients	To develop an outpatient value stream within the service of Gynaecology to improve the patient journey – end to end, reducing the length of time waiting for first appointment and supporting the elimination of 52 weeks waiters, reducing the overall waiting list size.	• New patient pathway for heavy menstrual bleeding implemented reducing requirements for hysteroscopy for initial 61% • Scoping of full pathway review underway.
People	**2598: SPE+ Improvement Training and Education** Total numbers trained may also include Bespoke Improvement Practice Training delivered in addition to scheduled training by both the Improvement Hub and Improvement Colleagues within Divisions / Workshops and Colleagues in Training / External Colleagues		
	Level 2	• 31 x Level 2 Improvement Practice Training Sessions: Contributor = 445	
	Level 3	• 5 x Level 3 Improvement Practice Training Sessions: Contributor = 20	
	Level 4 – KATA	• 1 x 2day Kata Improvement Coaching Session (Cohorts 3) = 15 Kata Coachees	

	Level 4 - Clinical Quality Academy	• 4 x Project Teams enrolled • 22 x Cross-Divisional and MDT Team Members • 8 x Virtual and Face to Face CQA Sessions held	
	1. The Learning Tree – Bringing Learning Home (2802)	To increase active engagement in the outcomes of Patient Safety Incident Investigations (PSII's) by the MfOP MDT (C1, C3, C5, C9 and C11) by September 2024.	• Established and sustained a rhythm and routine for Project Team meetings and momentum • Attended scheduled CQA sessions • Agreed a Scope • Developed a SMART Aim • Identified Quadrant of metrics to measure the impact • Identified and established relationships with Key Stakeholders • Process Mapped Divisional Patient Safety Incident Investigation x 6 (62 x process steps and 5 x decision points) • Identified evidence-based best practice / available knowledge • Identified existing governance structures, reporting and lesson learnt forums • Identified and met with our Lived Experience Partner • Met with and updated our Exec Sponsor • Launched an MDT Colleagues Survey • Identified and agreed first Test of Change
	2. Aarushi - Anti-racism and Inclusion To become an intentional, active and visible, Anti-racist organisation by the end of 2024 Four sub Projects within this on four key themes: **1.** Positively influencing leadership and culture to become an organisation that is demonstrably visible in its commitment towards proactive and intentional anti-racism - Increase Visibility of Trust leadership commitment to becoming an active,		Key Theme: **1. Positively influencing leadership and culture** • Intentional Anti-racism Statement and Charter were developed and launched on in March via the Trust Teams brief • Visible commitment in the Trust website, and

	intentional and visible antiracist organisation by 20% by end of 2024 **2.** Reducing inequities within recruitment to enhance equitable recruitment - Increase BAME representation among Midwifes across band 6 and above and especially band 7 by at least 4% by end of 2024. **3.** Reducing inequities in patient experience and enhancing equitable patient experience **4.** Reducing inequities within Colleagues lived experience and reduce inequities	through Trust Communications and Teams brief as interventions completed increasing visibility of Trust's intentional and proactive commitment to Anti Racism • An environmental mapping exercise has been completed across all sites at onset when visible cultural signs to demonstrate organisational visible commitment to Anti-racism were noted as 0% across all five sites • Comms Strategy initiated - the output from which will deliver both physical and digital content • Board interviews of Execs and Non-Exec Directors have been completed • Commitment demonstrated by Board to anti racism on Board papers review completed and this is already demonstrating an improvement • Anti-racism included as part of Trust strategic priorities for 2024/25 • Surveys developed and deployed to collect feedback • Policies, processes and procedures (including recruitment) are being revised with view to linking to Anti-Racism • Team invitations have been extended to include participants from midwifery • Application for Northwest BAME association submitted

			• Since the inception – the Aarushi Team have met weekly and have attended CQA events. **2. Reducing inequities within recruitment to enhance equitable recruitment** • SMART Aim and Staff Group identified and agreed • Implement an early EDI dashboard for robust governance through developing an accountability and assurance framework in maternity firstly and then scale up Trust wide
	3. The Healers - Pain Management in the Emergency Department (2801)	To reduce the number of formal complaints relating to pain management in ED by 20% by the 30th of September 2024	• CQA Learning Events attended • Project group meetings setup with a plan for communication • Shared progress in the CQA newsletter Tests of change undertaken/underway include: • Visual management in the triage area as a reminder to calculate the pain score • Social media video created for colleagues, which outlines the importance of good pain management What is next: • Information to be delivered to colleagues in the ED from members of the Project Team re what good pain management is • Bitesize learning, then infographic to be displayed in department for sustainability

			The Future: • Focusing on the re-assessment of pain during a patient stay in the ED – trying to change the system so that it improves the patient experience and enables colleagues to complete actions with ease.
	4. Hospital at Home - Developing the Hospital at Home Service (2807) We aim to develop a Virtual Ward that can reduce the number of Emergency Department attendances via new clinical interventional pathways, enhanced monitoring, wider inclusion criteria. We aim to reduce the number of patients attending ED and subsequent related hospital admissions through the provision of an increased range and complex range of hospital level interventions in a community setting, which will increase the utilisation of virtual ward. We plan to engage with primary and secondary care colleagues alongside the third sector informing them of the community service offer available for our patients in the form of engagement events, public events and collaborative working and hospital at home service.		• Established and sustained a rhythm and routine for Project Team meetings and momentum • Attended scheduled CQA sessions • Agreed a Scope • Developed a SMART Aim (subject to update as programme and experiments move forward) Identified Quadrant of metrics to measure the impact • Identified and established relationships with Key Stakeholders • Created an ideal state map • Identified evidence-based best practice / available knowledge for reducing hospital admissions within national guidelines • Presented at Blackburn with Darwen Frailty Conference to open future discussions and opportunities for test for change/experiments on providing hospital level therapeutic input (i.e., IV bolus fluids and antibiotics) in the place where people call home • Identified existing governance structures, reporting and lesson learnt forums, safe

			clinical practice forums. Nursing and Midwifery and Clinical Leaders. • Plan to meet with and updated our Exec Sponsor • Launched pilot for delivering IV fluids in patient own home • Delivered first test for change via PDSA methodology • A business case may be needed to support full implementation
	Colleagues 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 colleagues to develop their improvement skills and undertake improvement projects – '*Our Improvers of the Future'*	• 4 x Multi-Professional Preceptorship Level 2 Improvement Practice Training – Contributor sessions (286 x newly qualified colleagues) • 1 x Junior Clinical Fellow (JCF): Introduction to Level 3 Improvement – Lead • 2 x Internal Medicine Trainee (IMT): Introduction to Level 3 Improvement – Lead • 5 x UCLan Year 4 Medical Students (SSC4): Level 3 Improvement Practice Training – Lead Workshops (146 x SSC4 Medical Students 2023/24 cohort)	
	2667: Improving the SCC4 experience undertaking QI in Secondary Care	To improve the overall feedback from the SSC4 Medical Students that undertake their QI Projects within Secondary Care (ELHT).	• 2022/23 SSC4 cohort – Supported 91 x SSC4 Medical Students, provided QI Topics and 4 x workshops delivered • 2022/23 SSC4 cohort grades: 18 x Merits, 42 x Good Passes, 29 x Passes • 2022/23 SSC4 cohort tests of change: • 50% less Workshops • Secondary Care QI Topics more prescriptive of QI Topics of value to ELHT • Specified and condensed Improvement Tools for students

			• Clarity around the minimum acceptable amount of time for students • Clarity around ceasing undertaking QI Project date • Student Workbook • Dedicated MS Teams Channel • Dedicated Mailbox • IH Facilitator Supported Workshops • Introduction of SSC4 Newsletter • 2022/23 SSC4 cohort – Supported 146 x SSC4 Medical Students, provided QI Topics and 8 x workshops delivered • Introduction of QI Case-studies (Primary and Secondary Care) • Secondary Care QI Topics even more prescriptive of existing Harms Reduction Programmes, PSIRP priorities and 2023/24 and 2024/25 improvement priorities (15 x Secondary Care QI Topics offered) • All Theoretical QI (same starting point for each student - this has varied over the years) • Top Choices for QI Topic reduced to x 1 • Choices available as tickets on Eventbrite • Removal of Supervisors • Further condensed Improvement Tools for students • Introduction of group practical activities i.e. stakeholder matrix and impact resource matrix

			• Workshop activities and marking rubric elements facilitated within QI Topic student groups • 50% less Workshops - sustained (however duplicated because of student numbers) • Student Workbook - sustained • Dedicated MS Teams Channel - sustained • Dedicated Mailbox – sustained • Clinical Teacher at the UCLan School of Medicine writing up the SSC4 QI Project for publication.
	2620: PCB Nurse Bank and 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	• No off framework for over 2 months • No HCA agency for over 2 years • Achievement of agency cap target of 3.7% • Increase of Bank versus Agency split improvement from 63:35 to 71:29 • Improvement in bank shift rosters locked down • Reduction in Registered Nurse vacancies from 250 to less than 30 by March 2024 • Reduction in the cost of agency invoice process
Quality	**Harms Reduction Programme** To undertake a full review of the existing Trust-wide Harms Reduction Programmes (HRP) and produce a Closure Report.	• Full review of the existing 16 x Trust-wide Harms Reduction Programmes (HRP) / Other Quality Priorities with Project Leads and Teams completed in April 2023 • All key findings were collated into a Full Harms Reduction Report (August 2023). This full report provides a detailed overview of progress, key achievements and risks/areas that require further assurance up until April 2023 • Harms Reduction Summary Closure Report was submitted to the ELHT Quality Committee in March 2024 • Quality Committee Members confirmed that they were content to support and approve the full	

		transition of HRPs to local priorities and for improvement resources to be redirected to supporting other improvement priorities for 2024-25.
	Medication Errors	• Ongoing monitoring and delivery of the Medication Errors Improvement Programme via the Medicines Safety and Optimisation Committee (MSOC) • Standard Operating Procedure for the administration of Insulin within Community Nursing Services. Updated to include Band 3 HCA, Competency Assessment and Safe Delegation tool (April 2023) • Gentamicin Training figures = 296 (Train the Trainer = 38 and Cascade Training = 258) (May 2023) • Medicines Management Link Champions introduced in May 2023 • 4th Medicines Focus Bulletin: Making Anticoagulation safer (June 2023) • Focus of 2022 and 2023 has been Gentamicin • Last HRP update received as part of the HRP Closure Review in April 2023.
	MatNeoSIP / CNST	Ongoing monitoring and delivery of the MatNeoSIP / CNST Improvement Programme via the Perinatal Working Group. The optimisation workstream of MatNeo SIP is monitored by the Saving Babies Lives v3 (SBLv3) programme which in turn is incentivised for implementation by CNST. CNST and SBLv3 progress, escalations, issues etc go to Perinatal Governance Board each month. SBLv3 (with the optimisation figures within) has a data dashboard that is now presented to the maternity Speciality board bi-monthly. Overall CNST/ SBLv3 monitoring, assurance etc is also presented to Divisional Management Board each month and further detailed in the Mat Neo Trust Board Report bi-monthly. MatNeo SIP also has a deterioration workstream, the focus of the last few years has been optimisation due to the SBLv3 implementation. • **Workforce** – Digital Nurse Role for Neonatology • **Programme –** Regional team drop-in to ELHT with promotional posters, mugs etc to engage teams and ensure the optimisation measures are a key focus • **Directorate Management** – 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 • Last HRP update received as part of the HRP Closure Review in October 2022.
	Infection Prevention and Control	• Ongoing monitoring and delivery of the Infection Prevention and Control Improvement Programme via the Infection Prevention Committee • Bespoke IPC Level 3 Improvement Practice Training session delivered in March 2023 • Planned relaunch of the 'Gloves Off' QI Project (2201). This project was put on-hold due to the COVID-19 global pandemic • Last HRP update received as part of the HRP Closure Review in October 2022.
	SAFER Surgery	• No improvement support, training and/or facilitation requested • Delivery of the SAFER Surgery via the RBH and BGH Theatre Teams, embedded monitoring, and escalation routes in place • Last HRP update received as part of the HRP Closure Review in October 2022.
	Failure to rescue the Deteriorating Patient	• Ongoing monitoring and delivery of the Failure to rescue the Deteriorating Patient Improvement Programme workstreams via the Deteriorating Patient Steering Group (DPSG) • Resuscitation Procedures Policy (CO19) revised April 2023. Reviewed in November 2023 to ensure that it was still fit for purpose following the transition to an ePR • Restarted the Resus Trolley 'My Kit Checklist' project (2642) • New Project Lead and Team established for the Improving Clinical Observations at ELHT QIP (2645) • Clinical Observations Improvement Task and Finish Group restarted (April 2023) • Full review of Clinical Observations Policy (CP37) completed (February 2024) • Fluid Balance e-Learning Package developed (March 2023) • Full review of the Guidance for the Safe Transfer of patients (CO74) completed (June 2023) • ELHT Safe Transfer Patient Decision Matrix (ETS297) transferred onto the ePR • Safer Transfer spot-check prevalence Audit completed in March 2024 – 88.5% of patients had a Transfer Matrix present, 100% of these had the correct personnel undertaking the patient transfer • Rollout of the revised Pendle Community Hospital SOP (July 2023) • Quarterly Deteriorating Patient Link Nurse Meetings restarted (August 2023)

		• Development of an Organisational Standardised Resus Checklist and uploaded to Trust Intranet (July 2023 / October 2023) • Emergency Department Representation at the DPSG • Safe Transfers ED Risk added to the Risk Register (July 2023) • Educational Package in development for AIRVO machines to address how to set-up (September 2023) • Move from ILS to EILS and EPILS in order to deliver more training sessions (November 2023) • New Consultant Lead Nurse in post (October 2023)
	Patient Safety Incident Response Framework (PSIRF) - PSIRP Priorities / Plan Transition from existing Trust-wide Harms Reduction Programmes to Patient Safety Incident Response Framework (PSIRF)	• 2 x Developing New PSIRF Local Priorities Workshops held (July 2023) with Patients, Partners, Colleagues and Senior Teams • 6 x Key areas of focus emerged – Communication, Safeguarding Adults and Paediatrics, Discharge and/or Transfer Problems, End of Life Care, Nutrition and Hydration and Colleagues Well-being • 5 x Cross-cutting themes / contributing factors identified – Communication, MDT working, Leadership, Human Factors and Utilising Technology • 3 x New PSIRF Local Priorities identified and agreed for 2023/24 • 2023/24 Action Plan developed • Attendance at LSC PSIRF Community of Practice Meetings • Established relationships between Improvement Practice Programme Lead and Patient Safety Incident Investigation (PSII) Team
	1. Nutrition and Hydration - To reduce the number of nutrition and hydration incidents resulting in harm (moderate or above) due to preventable lapses in care by going Back to Basics	• 2day Institute of Healthcare Improvement Breakthrough Series Collaborative training attended by 3 x members of ELHT colleagues (Associate Director of Improvement, Quality Improvement Practice Programme Lead and MEC Assistant Director of Nursing) in April 2023 • 18month ELHT Back to Basics with Nutrition and Hydration Breakthrough Series Collaborative agreed by Exec Team as a Trust priority for 2023/25 • Planning and Guiding Team established with key multi-disciplinary team members and clinical experts (May 2023) • 2 x Exec Sponsors confirmed – Chief Nurse and Executive Medical Director/Deputy Chief Exec • 1 x Lived Experience / Public Participation Panel member confirmed • 12 x ward/department collaborative teams enrolled – Reedyford, Hartley and Ribblesdale (CIC), Surgical Specialities x 9 (SAS), Digestive Diseases Unit, Ward 19, Emergency Department, AMU A&B, D1 and D3 (MEC), COAU (Paediatrics) and Maternity (63 x ward/departmental based colleagues in total)

		• Engaged with enrolled teams over MS Teams • Change package of evidence based / best practice identified • Keynote speakers identified and Agendas drafted for Learning Session 1 – April 2024 • Baseline observations completed on five pilot areas (ED, C18a, C2, Postnatal Zone A and Ribblesdale) to provide a current state for Meal Service and Delivery (Delivery), Documentation (Quality), Patient Experience (People) and Food Waste (Cost ££ and carbon food waste) • 3 x Learning Sessions (6days in total) scheduled for: **1.** Learning Session 1 - Wednesday 24th and Thursday 25th April 2024 **2.** Learning Session 2 - Wednesday 10th and Thursday 11th July 2024 **3.** Learning Session 3 - Wednesday 27th and Thursday 28th November 2024 Other: • 6 x Nutrition and Hydration Priorities agreed for 2023/26 • Nutritional Support Team fully recruited as of March 2023 • MUST PowerBi Reports developed – 'live' and 'retrospective' (data source ePR) • ELHT win NHS Chef 2023 competition for the third time in just two years • Nutritional Support Team (NST) Referral form/criteria completed – awaiting upload to ePR • NST twice weekly ward rounds with consultants • NST Outpatient Clinic in place • Nil By Mouth (NBM) Decision Making Tool developed – ready for rolling out • Soil Association Bronze Food for Life Award in January 2024 • Food Waste Management System introduced in January 2024 • NHSE DrEaMing Breakthrough Series Collaborative commenced in October 2023 within Surgical Specialties • ELHT have achieved the DrEaMing CQUIN for 2023/24.
	2. Falls - To reduce the number of inpatient falls resulting in harm (moderate and above i.e., Fractured Neck of Femurs) due to preventable	• Ongoing delivery of the Falls Prevention Improvement Programme via the Falls Steering Group • Focus on the Post Falls Checklist • Levels of Enhanced Care e-Learning launched (August 2023) • Levels of Enhanced Care spot-check audit completed in September 2023

	lapses in care – Post Falls Checklist	• Enhanced Care Lead Post made permanent and successfully recruited to in September 2023 • Enhanced Care Yellow Badges have arrived and were distributed to 8 x surgical wards in September 2023 • Delivering Falls and Levels of Enhanced Care Training on the Healthcare Assistant (HCA) Induction • Delivering Falls and Levels of Enhanced Care Training on the Multi-Professional Preceptorship Training (Bi-annually) • Bedrails Training package developed following the MHRA alert • Full review of the Slips, Trips and Falls Prevention for Inpatients Policy (CO78) underway • Full review of the Levels of Enhanced Care Standard Operating Procedure (SOP004) underway • Falls Awareness Week: 18th – 22nd September 2023 • Low rise beds now in place on community and the RBH sites. Supporting SOP168 Guidance for the use of Ultra-low beds at ELHT has been developed and is available on Trust Intranet (October 2023) • Band 3 enhanced care bank workers recruited (October 2023) • Levels of Enhanced Care Risk Assessment Training via MS Teams delivered (March 2024) • Levels of Enhanced Care Risk Assessment transferred onto ePR – currently being amended • Post Falls Nursing and Medical Checklists transferred onto ePR • Improvements seen in March 2024 re the compliance and completion of the post falls checklist.
	3. DNACPR - To reduce the number of incidents related to poor DNACPR communication with patients and families	• 2 x SSC4 Medical Students undertook a QI Projects in 2022/23 (DNACPR - Communication with GP Colleagues in Primary Care and DNACPR - Communication with Patients and Relatives) • 2023/24 - Associate Medical Director for Improvement completed a full review of the current state / pathway and processes. Next steps/recommendations: 1. Senior Clinical Leaders to agree this as a priority and establish senior oversight 2. Establish a small improvement project team to explore the scope of work, and evidence of current practice 3. Assign Improvement Coach and commence improvement A3 4. Identify gaps for the Understand Improvement Phase 5. Improvement Project Team to draft a Driver Diagram together (for further work at workshop – see below) 6. Plan Improvement Workshop to complete Understand and move to the Co-design Improvement Phase.

	4. Inappropriate Handovers - To reduce the number of inappropriate handovers resulting in harm (reduction in overall number of incidents) due to preventable lapses in care	• eSBAR Handover Improvement Task and Finish Group commenced (January 2023) • Key stakeholders identified (January 2023) • PSII Safety Bulletin content developed January 2023) • Improvement Project A3 commenced • Problem Statement, Background, Trigger, draft SMART Aim, Scope, Vision – completed, metrics and contributing factors (root cause) identified, driver diagram commenced • Project review undertaken post EPR 'Go Live' (July 2023) to: 1. Reflect on the impact that the EPR has had on the original problem/issue - is it still relevant? 2. Check stakeholders - who are we still missing and who do we now need in addition to? 3. Confirm Project Leads / Decision makers 4. Identify what would have the biggest impact / any change ideas 5. Review of baseline data • Understanding of the eSBAR workflow since the ePR 'Go Live' (September 2023) • Ward Champions identified • This project is currently on-hold due to a Clinical Lead vacancy, however, was previously in the Co-design Improvement Phase. Request for meetings to be restarted.
	4. Inappropriate Transfers - To reduce the number of inappropriate transfers resulting in harm (reduction in overall number of incidents) due to preventable lapses in care	• See Failure to rescue the Deteriorating Patient key achievements section for Trustwide Improvement work.
	5. 104day Cancer Breaches - Reducing 104day Cancer Breaches	• No improvement support, training and/or facilitation requested. Owned and delivered by the Cancer Services Team.
	Quality Accounts	Contributions to Sections: • 1.4 – Our Approach to Quality Improvement • 2.1 – Improvement • 2.3 – Priorities for Quality Improvement (2023/24 and 2024/25) • 3.1 – Achievements against the Trust Priorities • 3.2 – Harms Reduction Programme
	CQA Well-Lead Self-Assessment	Improvement evidence uploaded and submitted for: • QS1 – Shared Direction and Culture • QS2 – Capable, Compassionate, Inclusive Leaders • QS3 – Freedom to Speak-Up

		• QS4 – Workforce Equality, Diversity and Inclusion • QS5 – Governance, Management and Sustainability • QS6 – Partnership and Communities • QS7 – Learning Improvement and Innovation • QS8 – Environmental Sustainability
Partnership Working	**LSC System for Improvement – Engineering Better Care (EBC)** To develop a system-wide model for improvement to tackle LSC-wide improvement opportunities LSC has an aging population, with over 365,740 people over 65 which equates to 20% or 1 in 5 of our total population. We have acknowledged gaps in the identification and assessment of frailty, with extremely low numbers of care plans completed in the community. Work has been undertaken through the Engineering Better Care Programme to design and implement the mechanisms for the identification of Frailty at scale across the LSC population including training support for primary and community services. The roll out of frailty identification will then support the agreement of proactive care plans to promote ageing well and prevent deterioration of frailty. The GP Quality Contract has been adjusted for 2024/25 to support the identification of Frailty and is currently being rolled out as a first step, leading to further actions then relating to proactive care planning and supporting care in the community as an alternative to attendance and admission to hospital. Targets for reducing ambulance conveyances and admissions to hospital have been agreed with commissioners and will be monitored through the Frailty measurement dashboard. The aim for Pennine Lancashire is to prevent 664 hospital conveyances and 1328 hospital admissions. Work is underway to quantify the impact on this.	• Action on Frailty Oversight and Governance Task and Finish Group underway • ICB-wide rollout of the frailty posters and good practice guidelines • Launch of the Primary Care Quality contract • ICB Frailty Strategy/Framework well received • Rollout of the “speed dating” frailty training – starting with East Lancashire • Dashboard launched and data packs created using Aristotle Xi • Improvement in skills, knowledge and confidence of colleagues attending the training pre versus post sessions • Logo and branding rolled out across the ICS • Launch of the Primary Care Quality contract linked to the EBC outputs • Planned place and place+ workshops scheduled for May and June 2024 to review pathways and services alongside the workforce
	LSC System for Improvement – Thrombectomy	• Met with the teams at ELHT and the ICB Collaborative

	We aim to improve the access to thrombectomy for all eligible patients presenting to ELHT in collaboration with Lancashire and South Cumbria (LSC) ICB and provide assurance that all patients eligible have been referred and treated appropriately. Using time sensitive treatment points within the hyperacute stroke pathway and the eligibility criteria for thrombectomy treatment to gather data and provide assurances that all eligible patients are being considered and appropriately referred for treatment and to have a robust system in place by the 30th of September 2024		• Understand what support is required - completed • Gemba walks across ELHT and the ICB - completed • Established links with the Royal Preston Hospital (RPH) to identify the number of patients were referred to RPH from ELHT - completed • Design a SharePoint site – in-progress • To have one standardised data collection tool – currently identified as a risk – in progress • Design a referral form which is to be used across the ICB – in - progress
Waste Reduction Programme (WRP)	**2540: Waste Reduction Programme (WRP)**	To identify waste reduction opportunities that contributes to the Trust WRP target	• Identified and established several cross divisional waste reduction projects • WRP Improvement workshop held in February 2024 with key senior stakeholders - current processes, ideas, designed the future state process • A WRP Delivery and Assurance group was established with plans to create a standard methodology to support quantifying non-cash releasing reporting of projects • Bi-weekly meetings set-up with each division to work through their WRP tracker • 3 x Executive Board / Divisional WRP workshops held during March 2024

			• ELHT / Finance launched 'It All Adds Up' campaign • 35 x cost saving ideas submitted through the Improvement WRP portal supporting the Trust-wide campaign.
	2562: Assign Outpatient Letter to the most appropriate form of postal delivery	To reduce the number of patient letters being sent via the ELHT post department* by 50% by the 31st of March 2025 (*includes 1st and 2nd Class and via Taxi)	• 6/12 months have demonstrated a decreased spend of £78,732.62, however data indicates that we still had an overspend for 2023/24 • Attended Finance and Assurance Board (FAB) to feedback on success of the project (August 2023) • Monthly Task and Finish group established and supported by the Director of Finance as the executive sponsor for the project - 2 x meetings have already been undertaken • Revised ELHT Postal Service SOP156. This is to be rolled out across the Organisation, with the inclusion of the digital platform (Envoy and Patient portal) • Rollout of the poster to educate colleagues across all administrative functions within the process • Inclusion of the patient voice - Attending the ELHT Public Participation Panel to understand what the impact on the patient and local community could be, by exploring a more digital approach • Working with the COAS Directorate Manager to understand the opportunities of moving

			to a text message (Envoy) function and full patient portal • Baseline data collected on all 4 x Quadrants (Delivery, Quality, People and Cost)
	2607: Emergency Department (ED) 6S Workplace Organisation and Flow Improvement Event	Empower colleagues in ED to create and sustain a safe, well-organised workplace and productive environment, which contributes to reliable delivery of Safe, Personal and Effective care, by the 31st of March 2023	• ED Equipment and Environment Steering Group was created post the two improvement workshops in 2022, an Executive of the Trust chaired the group. It was established to monitor actions and progress • Steering group was closed at the end of 2024 (December) as the majority of actions were completed, any outstanding actions were sent to the responsible owner • Actions relating to the environments, equipment etc.… will now feed into the ED Improvement Plan project.
	2806: Improving the ordering of supplies and equipment	To understand and rationalise the ordering of supplies and equipment	• Process mapping to improve the ordering of supplies and equipment was completed in February 2024 • Improvement workshops held in March and April 2024 - considering roll out of findings across all wards and departments • A *'Dragons Den'* style event for colleagues to submit improvement ideas has been scheduled for June 2024.
	2805: Improving Continence care	To improve continence care leading to a reduction in use and spend on pads, barrier	• Trust-wide audit underway to establish current practice and patient care

		creams, and associated skin damage	• Training and educational opportunities have been developed and offered to colleagues • Steering Group set-up to monitor progress and actions.
	2784: Incident improvement / reduction project	All IR2 incidents to be ready for finalisation within 30 days from the date of incident by the 30th of June 2024	• Open incidents >30 days reduced from 550 to 211 (between Nov 2023 – Mar 2024) • 2 x workshops completed with 15 x colleagues including matron and members of MEC Quality Improvement team • Data collection / colleagues survey completed • Process mapping completed • Task and Finish group set up • Joining the dots - Project Lead linked to 'The Learning Tree' CQA project • Currently tasked with co-designing flow charts and training in order to run further PDSA cycles.
	2593: Medical Staffing workforce sickness / absence	To improve the sickness reporting of substantial medical and dental colleagues to 100% by December 2024	• Improvement workshop held with key stakeholders in December 2023 • Baseline data collected on all 4 x Quadrants (Delivery, Quality, People and Cost) • Reported at the Exec wall and to Clinical Directors • Established a monthly Steering Group • Developed a standard future process in adherence with current policies.
Electronic Patient	**Electronic Patient Record (EPR)**	The Improvement Hub team supported the roll out and the implementation of the Cerner Millennium EPR throughout June 2023 by:	

Record (EPR)		• supporting over 2701 colleagues to attend access fairs across the Organisation • functioned as floorwalkers over the 2 week Go-Live period across all five hospital sites within clinical areas, covering days, evening and weekends • Feedback from the Improvement Hub team being *'out on the Gemba'* was very positive. Whilst it is recognised that colleagues needed to make contact during these fairs to support their ongoing IT access, it cannot be denied that being out and visible and attending work environments was a positive approach to engaging colleagues. • functioned as EPR Hub coordinators • contributed and supported the development of the ePR Documentation Downtime Pack • coordinated task and finish group and developed the EPR Training for colleagues in non-substantive roles - Temporary Staffing SOP159 • EPR Outpatient Taskforce Group – To engage with the Outpatient Teams and help identify the root causes of frustration and opportunities of improvement. Co-designed the approach with Associate Director of Service Development and Chief Information Officer (August 2023) • supported colleagues post Go-Live to participate in 1:1 optimisation training sessions • and continue to support the optimisation of clinical documentation as part of all improvement projects where identified and appropriate.	
Other Improvement Priorities / Support			
	2734: Elective Outpatients Improvement Programme	All outpatient booking, New, Follow Up, waiting list, holding list, Advice and Guidance, Patient Initiated Follow-Up, and Video Consultations	Development of an Outpatient Transformation Programme for 2024/25 Outpatient Transformation Programme scoping complete for launch in 2024/25.
	Pathology	**1.** Reduce the volume of samples arriving for processing between 4PM and 8PM **2.** Reduce current over-spend in department (associated with over-time, bank, transportation and equipment) **3.** Implement a sustainable workforce	• 9 x engagement, team building and training workshops with colleagues from all areas of Blood Sciences (16 x colleagues attended in total) • Current and Future state Process Mapping completed • Failure Mode and Effects Analysis (FMEA) • 23 x Improvement Change ideas have

		plan by the 31st of March 2024	been identified to as key priorities • Improvement Business Case supported and approved • Observations undertaken within RBH and BGH laboratories (inc evenings) • Capabilities at BGH laboratory assessed • 10 x GP Surgeries visited to engage with colleagues around the samples process • Engagement with Outpatient services with RBH and BGH • Key Improvement Steering Groups and engagement with wider stakeholders to understand and identify opportunities to improve sample flow in Blood sciences, for example Transport • Colleague focussed Newsletter to share improvement and Pathology implementation updates • Blood sciences Power Bi report in the initial stages of development • Improvement Champions identified and recruited • Improvement wall currently being codesigned with pathology team. • Key internal and External stakeholders identified and engaged with. • Open Door Event in Path Lab planned for May 2024

			• Transport Delay escalation process agreed and tested • Running 30, 60, 90 day action plan in situ aligned to Pathology Improvement and implementation Plan • Attended GP Managers Forum to present and engage • Initiated Improvement Work in Cell Path (Histology, Cytology and Non-Gynae).
	Longer Length of Stay (LLoS) To support the ongoing winter pressures and the additional number of patients occupying acute and community beds over 21days in the RBH site. We have designed a three-phase approach to support a safe and effective reduction. With the intention of creating capacity to support the number of patients in the Emergency Department with a D2A (Discharge 2 Assess). Being digitally enabled using the Discharge Dashboard and Whiteboard on CERNER ePR.		• Initial success seen in a 40% reduction in 21-day plus LLOS • Agreement on the use of the Discharge Dashboard • Rollout plan developed for the Discharge Dashboard • Joining the Dots - Linkage to the Urgent and Emergency Care Delivery Board (UECDB) Plan on a page • Has governance and oversight at Emergency Care Improvement Plan (ECIP) • Optimising Discharges Meeting underway • Process Mapping Session with Senior nursing team completed.
	Creating Better Data Customers **1.** Engaging with others **2.** Having the right data skills and knowledge **3.** Having the right systems **4.** Knowing the data, you have **5.** Making decisions with data **6.** Managing and using data ethically **7.** Managing your data **8.** Protecting your data **9.** Setting your data direction **10.** Taking responsibility for data		• Creating Better Data Customers Course co-designed and delivered by Improvement and DERI team members • 5 x sessions delivered • 56 x colleagues fully attended • Bespoke session planned for Optimising Discharges Steering Group.

	2118: End of Life / Bereavement (including recognition of the dying patient and Advance Care Planning)	To improve the quality of care of inpatients in the last days of their life, at ELHT to at least National Average (NACEL) in all 4 categories by 2024 (based on the 2023 NACEL report) **1.** Communication with the dying person (ELHT 6.9 – UK 8.0) **2.** Communication with the family and others (ELHT 6.5 – UK 7.1) **3.** Involvement in Decision making (ELHT 8.6 – UK 9.2) **4.** Individualised Plan of care (ELHT 7.6 – UK 7.8)	Recognition of the dying patient: • Ward teams encouraged to refer to the end of life / bereavement team or specialist palliative care where support is needed relating to decision making • Recognition of dying training included in the care of the dying training for nursing colleagues • Recognition of dying training to be added into palliative medicine junior doctor training sessions • Development and implementation of - Medical anticipatory clinical management plan Advance Care Planning (My Wishes): • Utilising the ePR for EOL care - Identifying what works well and what requires optimisation within the ePR • Ensuring colleagues understand the features of the ePR which support end of life / bereavement care • Development of a nursing individualised plan of care and care after death document Other: • Patient experience information to improve EOL care developed • Community engagement events with local communities completed • Meeting held and various topics discussed including DNACPR, symptom management,

			care after death and bereavement • Understanding and triangulating different sources of patient experiences to inform and improve end of life and bereavement care • Essential to Role training • End of life and bereavement training included in induction training • Improving the Hospital environment for EOL care • Improving the environment for having conversations with relatives - Walk round completed to look at ward quiet spaces and information shared at the End of Life Strategy Group and with Estates and Facilities colleagues • Area for Bereavement Suite identified • This project will continue for the year 2024/25 – improvement priorities currently being identified with SMART aims written.
	2547: Hands First National Quality Improvement Collaborative	To improve clinical outcomes regarding hand trauma by reducing variation in management and reducing time to surgery	• One of 20 Trusts involved in the National Collaborative hosted by the Royal College of Surgeons • Hands First – ELHT Project Team recognised by the Royal College of Surgeons as the example of how to use PDSA's • Improved the % of patients that have received their surgery/initial treatment for closed hand injuries

			Tests of change undertaken/underway include: • New referral and triage process (pilot) • Hand Therapist based in a Fracture clinic for expert advise • Hand Therapy Team screening calls • Hands First 2 – Asked to be part of the collaborative • Scoping and mapping of the process undertaken • Designing change ideas
	2669: Public Panel Participation (PPP)	To improve the Role and Effectiveness of the ELHT Public Participation Panel by March 2025	• 2 x Workshops held (August 2022 and August 2023) • PPP Members have completed Level 3 Improvement Practice Training Lead (Part 1) as part of the Workshops 1 and 2 • Core Planning and Guiding Group establish – support by Patient Experience and Quality Improvement Practice Programme Leads • 4 x Key Root Causes identified – Data and Metrics, Involvement, Recruitment and Marketing and Comms • Enablers and PDSA Plans for each Root Cause developed and underway • Identified Quadrant of metrics to measure the impact – review of existing data sources underway • Identified and established relationships with Key Stakeholders • Links identified within the Patient Experience Strategy (due to launch April 2024)

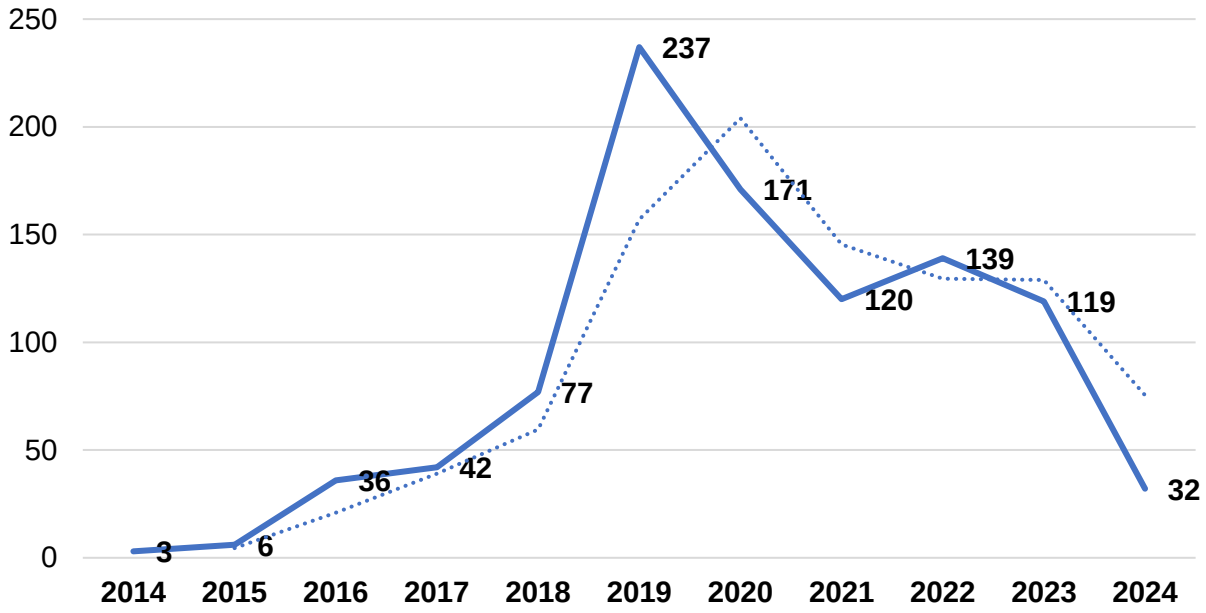
			• A number of enablers underway or completed for 3/4 of the Root Causes (Involvement, Recruitment and Marketing and Comms)
	Stroke Ward (Less than 4 Hrs)	To increase the % of patients directly admitted to an acute stroke ward within 4 hours of clock start from 38% to 60% by the 30th of September 2024	Observations in ED and ward completed Staff survey completed Data collection ongoing within the stroke team Process mapping and idea generation complete Fishbone developed Awaiting further data and patient/relative feedback before co-design.
	Improving the Divisional Complaints Process	To improve the timeliness and quality of open complaints, across all Divisions by the 31st of July 2024	• 4 x Workshops scheduled to take place with key stakeholders on: **1.** Workshop 1 Understanding the current state, divisional processes and challenges, what would good look like? – Thursday 18th April 2024 **2.** Workshop 2 Data and Metrics, creating one version of the truth – Wednesday 8th May 2024 **3.** Workshop 3 Data and Metrics, Part 2 - Thursday 30th May 2024 • Workshop 4 Bringing everything together, opportunities to work smarter and identify areas for improvement / change ideas and PDSA's – Tuesday 4th June 2024 • 2 x PDSA's undertaken to date.
	ELHT Patient Experience, Engagement and Involvement Strategy To work collaboratively with patients and the public, using their knowledge of what the process of receiving care feels so we can drive continuous quality improvement and ensure our		• Improvement Hub Representative attending the Patient Experience Strategy Group meetings

	services are the very best they can be for our patients.	

Improvement Hub Activity

There are currently **605** 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 2024.

Total number of Improvement Projects Registered (2014 – April 2024)



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.

Improvement Projects Registered by Key Word Condition (2018 – April 2024)

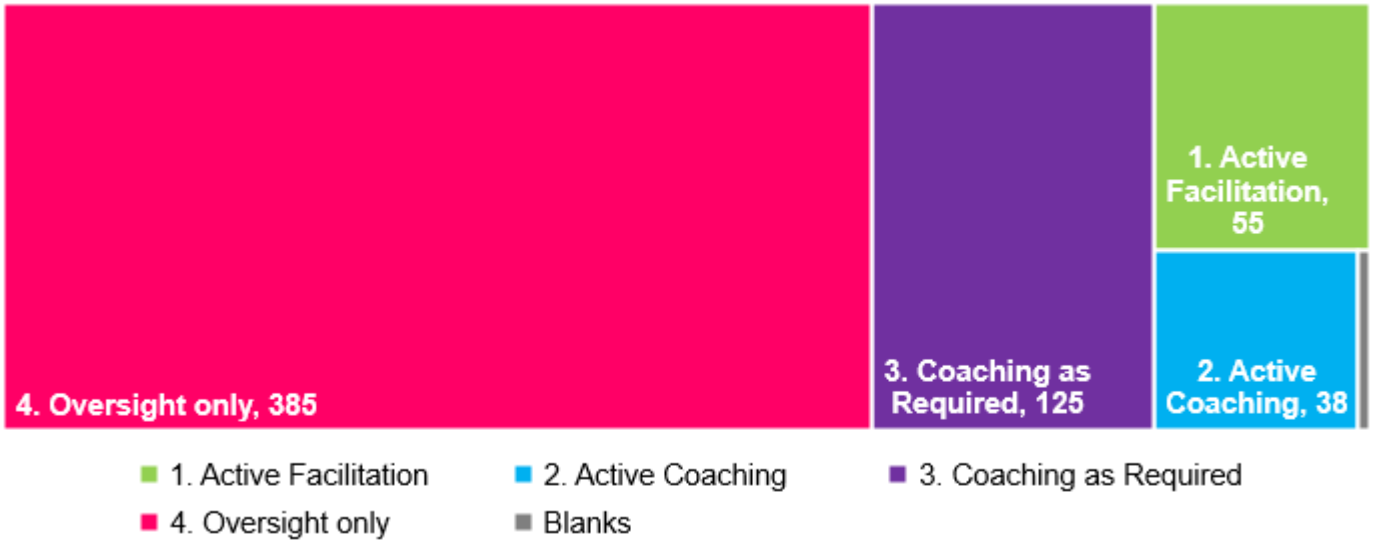
Improvement Projects Registered by Key Word Process (2018 – April 2024)

Total number and % of Improvement Projects Registered per Phase (2018 – April 2024)

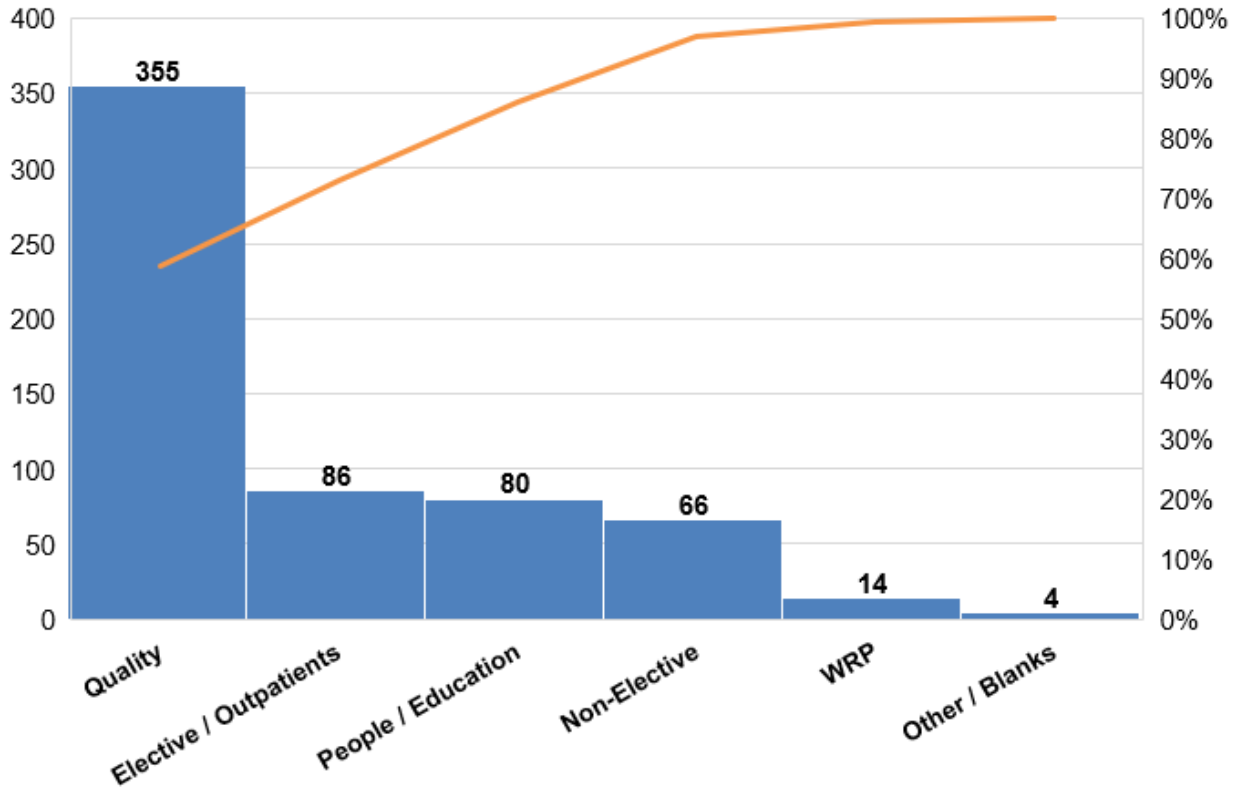
Understand	Co-design	Test and Adapt	Embed	Spread	Sustain
268	40	92	41	15	149
44%	7%	15%	7%	2%	25%

In 2023/24 we have seen an increase in the % of QI Projects in Embed, Spread and Sustain 34% (n=205) compared to the same period in 2022/23 30% (n=164).

Total number and % of Improvement Projects Registered per Phase (2018 – April 2024)



Total number and % of Improvement Projects Registered per Key Delivery Improvement Programme (2018 – April 2024)



3.2 Harms Reduction Programmes

In March 2024, a Harms Reduction Summary Closure Report was submitted to the ELHT Quality Committee. The ELHT Quality Committee members were asked to:

1. Acknowledge the assurance provided by the review of the Harms Reduction Programmes

2. Accept the move from direct Quality Improvement support, into a Business-as-Usual monitoring approach from the allocated groups identified, and with an escalation route through governance structures. (Transition planned to complete by end of June 2024).

3. Note the ongoing input and leadership of the Improvement Hub Team for Nutrition and Hydration (via the Nutrition and Hydration Collaborative) and End of Life Care (coaching support) and process for escalation / agreement of future support if required. A full update on improvement work being supported by the Improvement Hub team in 2024-25 as agreed through annual planning for 2024-25 will be brought to Quality Committee in April 2024 including proposals for ongoing and regular reporting.

4. Consider the integration of these ongoing areas of work into the Committee workplan to ensure assurance monitoring.

Executive Summary

Following the introduction of The Patient Safety Incident Response Framework (PSIRF) by NHS England in August 2022, all organisations were expected to transition from the Serious Incident Framework (2015) to PSIRF within 12 months of its publication and the transition was expected to be fully completed by Autumn 2023.

The PSIRF priorities now supersede the existing Harms Reduction Programmes as part of this Framework, but the work of the existing Harms Reduction Programmes is ongoing and continues to be important as part of our business-as-usual arrangements.

The purpose of the paper was to outline the arrangements for the existing Harms Reduction Programme priorities going forwards as part of the quality governance and assurance structures within the organisation.

To provide assurance to the committee members, a joint review has been undertaken by the Quality Governance and Improvement Hub Programme Leads for each of the existing Harms Reduction Programmes and the following report summarises the review of each of the Harms Reduction Programmes:

1. **Falls Reduction**
2. **Medication Errors**
3. **Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) / CNST**
4. **Infection Prevention and Control**
5. **SAFER Surgery**
6. **Deteriorating Patient**
7. **Nutrition and Hydration**
8. **End of Life Care**

Harms Reduction Programme Review Process

Over a seven-month period (October 2022 – April 2023) the Improvement Practice Programme Lead for Quality met with all of the Harms Reduction Programme Project Leads / Teams. There are six existing HRP's (please note that the Deteriorating Patient HRP contains seven workstreams within it) and two additional Quality Priorities (please note that the End-of-Life Care priority contains one additional workstream within it). This assurance process mirrored some of the expected standards required for quality improvement, which evidence if improvement is being achieved.

As part of the review the HRP Project Leads / Teams were asked to consider a set of standardised questions, provided with a scoring card and definitions (previously used within the Developing the Quality Priority Workshops) and a copy of the last HRP review document prior to the meeting.

All key findings were then collated by the Improvement Practice Programme Lead for Quality into the Full Harms Reduction Report – August 2023. This full report provides a detailed

overview of progress, key achievements and risks/areas that require further assurance up until the time of the HRP Closure Review meeting date.

Harms Reduction Programme Review Outcome

A total of 345 achievements / updates and 274 Quality Improvement Projects (2018 to August 2023) have been identified across the existing HRP's.

For more information and in-depth detail, a full copy of the Harms Reduction Report – August 2023 is available, however as this is over 200 pages this has not been included in this report.

The Improvement Hub Team have provided significant support and training in improvement methodology to the receiving group chairs to enable the handover of the HRPs and continue to provide arm's length support to key areas.

A clear escalation process to reconsider the need for improvement support is in place through the link into governance reporting structures or these areas could be considered as part of the standard annual review of organisational improvement priorities as part of the Trust annual planning process.

Quality Committee Outcome

Quality Committee Members confirmed that they were content to support and approve the full transition of HRPs to local priorities and for improvement resources to be redirected to supporting other improvement priorities for 2024-25.

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 October 2023 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Latest published rolling 12 months to Oct 23
East Lancashire NHS Trust SHMI Value	1.120
East Lancashire NHS Trust % of deaths with palliative care coding	28
East Lancashire NHS Trust SHMI banding	as expected
National SHMI	1.00
Best performing Trust SHMI	0.722
Worst performing Trust SHMI	1.206

East Lancashire Hospitals NHS Trust considers that this data is insufficiently robust to draw conclusions. Substantial issues with data submission have arisen since the introduction of the Cerner EPR. These have occurred for the following reasons.

- Considerable and ongoing work has been required to identify the correct areas of the record from which to submit data, and to carry out verification.
- Significant delays in clinical coding have arisen, due to vacancies in the team and overheads from working with a new system.
- Consistent use of structured data entry is not yet embedded within clinical users, limiting automated extraction of data.
- The introduction of Cerner was used as an opportunity to move to the future process of classifying same day emergency care (SDEC) as part of the Emergency Care dataset, as opposed to the inpatient dataset on which mortality is calculated. Trusts which are early adopters of this have noted significant changes in standardised mortality ratios as a result of the substantial reduction of low-risk spells included.

An alternative mortality ratio is the HSMR. The Trust has not yet submitted sufficient data since Cerner to receive a calculation of HSMR. A bulk submission of SUS data will be made in April 2024 which should improve data quality. However, the large backlog in clinical coding and the removal of SDEC will continue to impact mortality figures. This indicator has historically been higher than expected, which is known to be at least partially reflective of low palliative care coding (see 3.3.2). There is a substantial revision of the HSMR methodology expected in 2024 and this will create a further discontinuity and the impact of this remains to be determined.

The Trust Crude Mortality statistics - the number of deaths per admission, and the absolute number of deaths - are being closely monitored to ensure that mortality is not increasing.

East Lancashire Hospitals NHS Trust is taking the following actions to improve

- Urgently improving the quality of data submission to ensure that more accurate mortality data can be produced.
- Continuing the 'Learning from Deaths' processes and introducing quality improvement work to address alerting groups.
- Building on the introduction of the bereavement team and the seven-day palliative care team to ensure patients receive the optimal care at the end of life.

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	28%
National percentage of deaths with palliative care coding	42%
Trust with highest percentage of deaths with palliative care coding	66%
Trust with lowest percentage of deaths with palliative care coding	16%

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:

- The Trust has introduced seven-day palliative care service.
- The Trust continues to enhance the end of life / bereavement team.
- The Trust will be launching a quality improvement project relating to end of life and advanced care planning.

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 measure 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.
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3.3.3.1 Hip Replacement Surgery

Hip Replacement Surgery	2019-20	2020-21	2021-22	2022-23	2023-24
ELHT	89.9%	No Data*	88.5%	100%*	No Data
National Average	89.4%	90.7%	90.1%	90.4%*	No Data

3.3.3.2 Knee Replacement Surgery

Knee Replacement Surgery	2019-20	2020-21	2021-22	2022-23	2023-24
ELHT	85.0%	No Data*	84.2%	85.7%*	No Data
National Average	82.4%	82.2%	82.5%	83.1%*	No Data

**PROMs outcome data covering April 2020 to March 2021 published by NHS Digital Hospital, shows no returns from ELHT during this period for both Pre and Post op questionnaires – ELHT records show that only 5 pre-op questionnaires were completed for this period due to the COVID Pandemic. Outcome figures for 2022-23 are provisional.

NHS Digital have added the following statement to their PROMs web page: To add to the value of the PROMs questionnaire data, they are linked routinely with Hospital Episode Statistics (HES) episode-level information. In 2021 significant changes were made to the processing of HES data and its associated data fields which are used to link the PROMs-HES data. The linking methodology has now been updated and an overview of these changes described below.

The completion of the development and assurance work in our operational processes needed to update the linkage methodology was longer than expected which has caused a subsequent delay in the timeliness of our PROMS publication series. The provisional April 2021 to March 2022 publication which normally would have been published in August 2022 will therefore be followed by publication of the finalised publication of PROMS data which normally would have been published in February 2023 for the time period in July 2023. This will bring our publication reporting sequence of PROMS data up to date for users of these statistics. Additionally, we once again apologise for any inconvenience this delay may have had for the users of these statistics.

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. The figures shown below represent internally validated figures as at April 23:

All ages	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Readmission Rate	8.33%	8.20%	8.61%	9.07%	9.73%	9.57%	8.83%
Age Band	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
0-15	13.12%	11.74%	12.52%	12.02%	11.43%	13.09%	13.87%
16+	7.28%	7.45%	7.81%	8.53%	9.46%	8.91%	7.80%

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 8.83% 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 13.87% 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 7.80% 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 higher than expected due to the fact that our assessment units (including COAU) are coded as an 'inpatient admission'. Many of our pathways readmit children into the assessment unit for check-up or post discharge diagnostics. We feel this pathway is clinically appropriate and efficient as it can support earlier discharges, but it also does therefore make our readmission rate look higher, especially compared to others that may not have this pathway. 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. Others in the LSC region our interested in adopting our model for SDEC as it is seen as explore. We will work to review if any of the children brought back to COAU may be assessed more efficiently in an outpatient clinic.

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

- Review the use of Hot clinics and emergency clinic slots for urgent paediatric consultant input – as an alternative to admission or readmission. Slots are accessed directly from GPs.
- Continue to use the ‘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

- Telephone advice line for GPs directly accessing a consultant paediatrician – to help GPs manage care in practice rather than referring back to hospital.
- Advice and 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 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 initiated Follow up' so that parents can contact the department directly for an outpatient consultation after last appointment. This allows parents control on required further help and advice and offers a more suitable alternative to readmission.
- Allergy specialist nurse support 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 Family Hubs established.
- 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.
- 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
- Palliative care nurse to support care at home
- Epilepsy nurse specialists 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.

3.3.5 Responsiveness to Personal Needs of Patients

The Trust values and encourages feedback on how its services perform and uses 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 and have a well-established Public Participation Panel (PPP) which helps the Trust build on established relationships between health professionals, patients, carers and the public. PPP members ensure we are putting the voice and needs of patients at the forefront of decision making and that the views of patients, carers and families are represented at all levels of the organisation.

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 to develop action plans to address any issues identified.

The Adult Inpatient Survey sampled 1250 consecutively discharged inpatients, working back from the last day of November 2022. There were 433 responses received giving a final response rate of 37%. This is an increase on the response rate of 34% in the 2021 survey.

Table 1 below details the top 5 scoring questions for the Trust in 2022 with a comparison with the 2021 if available. The wording on some questions changed in 2022 so a direct comparison may not be available.

Question	Score	
	2021	2022
During your time in hospital, did you get enough to drink?	95.7%	98.0%
Were you given enough privacy when being examined or treated?	94.7%	96.1%
Overall, did you feel you were treated with respect and dignity while you were in hospital?	90.3%	91.6%
Did you have confidence and trust in the nurses treating you?	89.2%	91.5%
Do you think the hospital staff did everything they could to control your pain?	88.3%	91.1%

Table 1 – ELHT top 5 scoring questions

Table 2 below details the bottom 5 scoring questions for the Trust in 2022 and a comparison with the 2021 score if available.

Question	Score	
	2021	2022
During your hospital stay, were you ever asked to give your views on the quality of your care?	14.8%	17.8%
Thinking about any medicine you were to take home, were you given any information?	n/a	40.8%
Were you ever prevented from sleeping at night by any of these? None of these	45.7%	45.5%
Were you able to get hospital food outside of set meal times?	56.1%	54.3%
How long do you feel you had to wait to get a bed on a ward after you arrived at hospital?	59.3%	55.3%

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 taking part. Results of the 2022 survey remain generally consistent with 2021. There are continuing challenges around the number of patients attending Emergency Departments and requiring admission and hospital waiting times.

IQVIA, who administer the survey on behalf of the Trust, 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.

3.3.6 Recommendation from Colleagues 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 colleagues feel the Trust provides a positive experience of care for our patients.

- 59% of colleagues said – if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation.
- 75% of colleagues said – care of patients/services users is the organisations top priority.

The Trust scored 6.9 for the overall colleague engagement score on the 2023 national staff survey which is slightly below the national average of 7.3 for Combined Acute and Community Trusts in 2023.

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

The Friends and Family Test (FFT) is a well-established means to measure the experience of patients that have recently received care within acute hospital Trusts.

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 colleagues to drive improvement.

Patients are able to 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 and Emergency, Outpatient attenders, maternity and community services.

The following table sets out the percentage positive rating for the period April 2023 to March 2024 for inpatients and emergency care and also how these results compare with other Trusts nationally.

	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024
Inpatient positive % rating												
ELHT	97	97	97	96	98	97	96	97	98	96	94	96
Nat Ave	95	95	95	95	94	94	94	95	94	94	94	94
A&E positive % rating												
ELHT	77	73	72	98	81	80	80	74	74	69	73	72

Nat Ave	83	81	80	82	82	79	79	79	78	78	77	78

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

We value the feedback from our patients and ensure it influences how we develop and deliver our services; therefore, colleagues are supported to collect information from patients.

Over 22,000 inpatients and emergency care attenders have provided feedback during the period April 2023 – March 2024. The Trust has received consistently high scores from inpatients, with an average of 97% of inpatients rating their overall experience as either very good or good.

The ongoing increased activity within the Emergency Department and Urgent Care Centres has impacted on the positive response rate across Emergency Care.

Following the introduction of a new electronic patient record in the summer of 2023, the collection of FFT feedback via SMS text had to be paused. This impacted on the number of FFT responses received, particularly within emergency care who primarily use SMS text messaging to gather FFT feedback and resulted in a higher than usual number of positive responses. SMS text messaging recommenced in November 2023.

Advice and support will continue to be provided to specific areas so that feedback is collected and recorded in a timely manner and used to influence service improvements.

3.3.8 Venous Thromboembolism (VTE) Assessments

	VTE RISK Assessments 22-23	1st April 2023- 31stMarch 2024				
		Q1	Q2	Q3	Q4	Total
ELHT	Number of VTE-risk assessed Admissions	25870 (96.8%)	NIL Data	NIL Data	Nil Data	Nil Data
	Total Admissions	26,689 Data till mid-June 2023				
National	Number of VTE-risk assessed Admissions	ELHT reporting on VTE is currently under development since the transition to Cerner as it was discontinued since end of June 2023. Nil VTE data is available for the three quarters between July 2023 to March 2024				
	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 from 1/7/2024 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 from 1/7/2024 https://www.england.nhs.uk/?s=VTE

The above partial data for Quarter 1 1/4/2023 to Mid-June 2023 only is available and data is not available for the remaining three quarters of 2023/24 between July 2023 to March 2024 since the Trust transition to Cerner EPR. Trust Informatics team are currently working on developing a reliable reporting system using clinical coding from Cerner data on completed hospital episodes on inpatient admissions. This will need to be revised and updated to ensure that it is accurate and robust and reflective of all true in-patient admissions that require a VTE risk assessment on admission as per NICE guidelines.

The National data submission was suspended by NHSE in view of the Covid 19 pandemic since 01/04/2022 and yet to resume. The National VTE data submission portal is anticipated to be re-opened from 01/07/2024 and Trust Informatics team have assured the reporting system that is fit for purpose will be enabled and ready before then. The informatics team is working closely with a Task and finish group commissioned by the Trust VTE committee to address this before the deadline of 01/07/2024.

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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 the year 2021/22 was 98.45% which was an improvement from previous year by 0.55%. VTE risk assessment figures in 2022/2023 remained same as compared to the previous year. However, the absence of this data for the last three quarters of 2023/2024 has been a challenge to theTrust VTE committee to be able to monitor the Divisional and Directorate VTE risk assessment figures and Trust figures with action plans as part of the VTE Harms reduction program. Live data reporting of VTE figures of real time in-patients in beds was facilitated as part of recent reporting enabled by Informatics and this is being evaluated currently as part of a QI project in its planning stages through a trust wide QI group for VTE.

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

- Systems and processes are in place at ELHT for risk assessing all appropriate patients utilizing the national VTE risk assessment tool on admission on Cerner EPR system.
- The current risk assessment system has moved to an electronic system on Cerner EPR from mid-June 2023 having moved from the previous online system of VTE risk assessment on Alcadion or Hospidea system.
- Trust VTE performance metrics is not available for the year 2023/24 apart from first quarter until Mid-June 2023 as in table above which revealed 96.8% for that quarter. However, it is to be noted that the June 2023 data does not cover the entire month and covers only till mid-June 2023 when the transition to Cerner EPR happened Trust wide.
- While past assurances were robust with consistent improvement of VTE risk assessment and sustained high performance, presently this annual data is not available and is currently being developed by the informatics team.

- Trust VTE risk assessment 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 which resumed Trust trajectory at 98.45% in 2021/22 and 2022/23.Trust VTE risk assessment figures continued to be significantly above National average of above 95% at 98.47% for the last two consecutive years. However, there is paucity of reporting data enabled by Informatics for 2023/24 since transition to Cerner EPR.

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

- VTE committee was reinstated after a period of pause for nearly 18 months from November 2023 with identified appropriate level of administrative support through Trust Quality and Safety/Governance team.
- VTE committee terms of reference updated to bi-monthly frequency and to reflect the governance reporting arrangements currently in place.
- Monitoring of identification, reporting and management of Hospital acquired VTE through formal reporting by all divisions resumed through the Trust VTE committee which functions as a sub-committee of Trust Patient Safety group.
- Trust policy CP17, Part 2 on Diagnosis and Management of VTE was updated in line with all relevant updated National/NICE guidelines and ratified and is available on the intranet which is freely accessible for all colleagues.
- VTE committee working group is working closely with the Trust informatics teams and Robust Informatics reporting that is fit for purpose, is anticipated to be enabled in time to recommence organizational submissions of VTE risk assessment data on all admitted in-patients based on clinical coding of completed hospital episodes extracted from Cerner EPR ahead of the 1st July 2024 submission deadline announced by NHSE.
- Educational event was delivered for Foundation year trainees in February 2024 with live Cerner demonstration of VTE work streams and task lists on Cerner to enable better compliance with risk assessment as well as prophylaxis prescribing. Further training is planned in May 2024 and at periodic intervals after that.
- VTE champions have been identified across all Divisions and plans in place for a Trust wide Quality improvement initiative to monitor the live reporting data enabled through Cerner as a new reporting process and to validate its accuracy and consistently improve VTE risk assessment as it had been pre-Cerner. The QI team is supported by the Divisional governance leads and matrons besides the Clinical audit and effectiveness lead and team. 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 as part of QI interventions.
- 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 pre-Cerner 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 VTE committee. Impact of this change will only be known after the informatics team enable the reporting processes as anticipated before 1st July 2024 and this 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. Until transition to Cerner, the data for organizational VTE reporting was captured from Hospidea and linked to the Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS) and this linkage with clinical coding for completed hospital episodes was assured to continue even after transition to Cerner system for Organisational reporting purposes which is awaited.

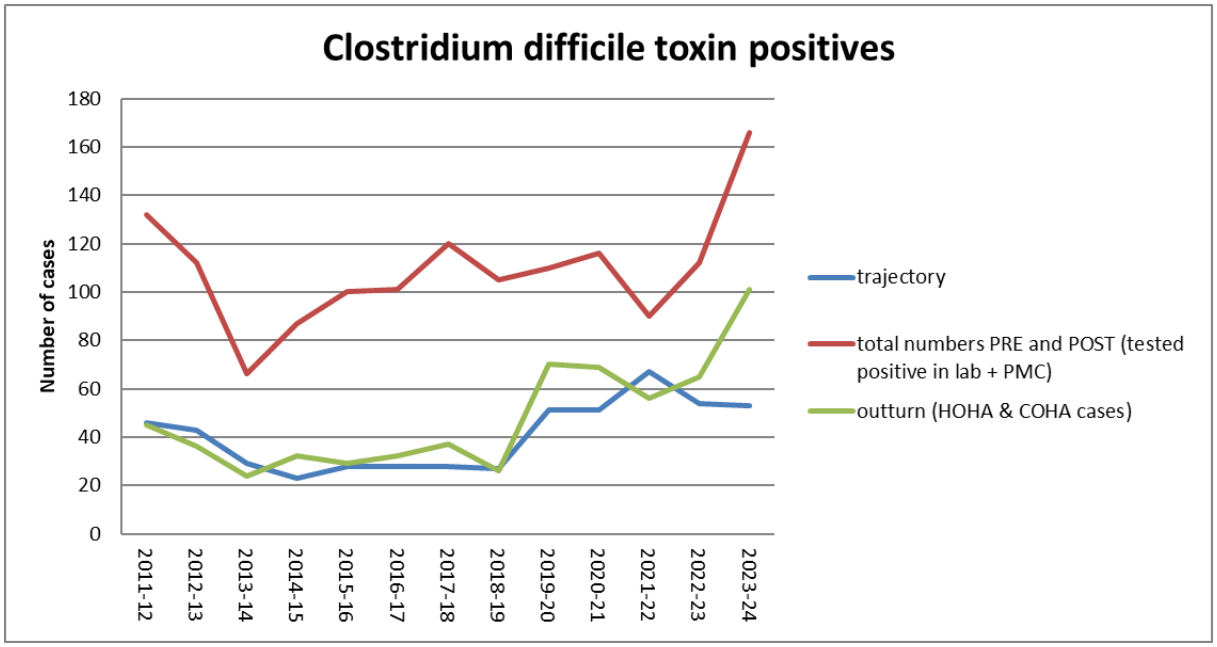
- A ward-based spot audit on VTE risk assessments and prescribing was undertaken in the surgical ward by a trainee which was shared at the VTE committee and paved the way for further QI work planned through VTE champions and QI group.
- An evaluation of trainee views on factors impacting VTE risk assessment and prescribing was undertaken by another trainee among FY trainees and both above results were shared with VTE committee and incorporated into the QI project planned as a Trust wide initiative for 2024.
- Trust wide audit on Hospital acquired VTE reporting and evaluation for lessons learnt is commissioned by VTE committee through the clinical audit and effectiveness team for 2024/25 year.

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 101 clostridium difficile positives 81 HOHA and 20 COHA the trajectory for 2023/24 was 53.

Clostridium difficile toxin positive results from April 2023 – March 2024:



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 and COHA are reviewed the themes, lapses and areas for learning are discussed at the C. difficile multidisciplinary ICB meeting and shared divisionally. Nationally there has been an increase in Clostridium difficile more evident in the North of the country.

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

Ongoing quality improvement projects around improving compliance to hand hygiene and glove usage, improving environmental cleanliness with the introduction of the National Standards of Cleanliness and continued workaround improving antimicrobial prescribing. Post infection reviews will be replaced by patient safety reviews aligning Infection Prevention and Control with the Patient Safety Incident Response Framework. No new themes were emerging from the post infection review process. Focusing on areas with a high incidence or clusters of infections will enable the Infection Prevention and Control team to provide education and support. The Trust will continue with its current approach of zero tolerance to hospital acquired infections and will aim to reduce the rate of Clostridium difficile infections to 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.

Since September 2023 this data has been paused following the introduction of the Learning from Patient Safety Events (LFPSE) system. Trusts are gradually moving over to reporting to LFPSE instead of NRLS.

East Lancashire Hospitals NHS Teaching Trust can 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.

Due to the data from NRLS no longer available the Trust has calculated the reporting rate below using the number of patient safety incidents reported on the Trust Governance System (Datix) and the occupied bed days (per 1000); this may translate into a significant increase in the rate number of reported incidents. As such we are unable to provide the Cluster rates and therefore compare ourselves to other Trusts within the cluster.

Patient safety incidents per 1000 bed days	**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**	**Apr 2022 to Mar 2023**	**Apr 2023 to Mar 2024**
ELHT number reported	7032	7401	6426	6398	8128	8269	11142	12887	21241	22550
ELHT reporting rate	45.5	46.4	42.0	40.9	52.0	53.2	44.0	43.1	62.5	66.7
Cluster average number	5226	5449	5583	5841	6276	6502	12502	14368		
Cluster average reporting rate	43	43	44.5	46	50	51	58	57.5		
Minimum value for cluster	1133	1311	566	1278	1392	1271	3169	3441		

Maximum value for cluster	15228	19897	23692	22048	21685	22340	37572	49603		
Patient safety incidents resulting in severe harm	**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**	**Apr 2022 to Mar 2023**	**Apr 2023 to Mar 2024**
ELHT number reported	14	9	6	9	5	6	19	20	22	35
ELHT % of incidents	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.2
Cluster average number	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	0.2	0.3	0.3		
Minimum value for cluster	0	0	0	0	0	0	4	2		
Maximum value for cluster	92	78	74	62	76	91	137	157		
Total incidents across cluster	1821	1810	1771	1780	1896	1870	3,817	4603		
Cluster % of incidents	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.3		
Patient safety incidents resulting in death	**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**	**Apr 2022 to Mar 2023**	**Apr 2023 to Mar 2024**
ELHT number reported	2	2	1	6	4	6	17	8	7	24
ELHT % of incidents	0	0	0	0.1	0	0.1	0.2	0.1	0.03	0.1
Cluster average number	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	0.2	0.2		
Minimum value for cluster	0	0	0	0	0	0	0	1		
Maximum value for cluster	29	24	22	23	24	22	146	81		
Total incidents across cluster	661	712	706	678	628	666	3011	2513		
Cluster % of incidents	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 2023/24 has increased from 2022/23. Colleagues are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared.

ELHT 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 the Quality Improvement Team and Quality Governance which provides assurance of the reduction in harms to the Trusts Quality Committee.

The Trust continues to make improvements to investigation processes and dissemination of learning, in line with changes made to the Patient Safety Incident Response Framework, following its national rollout, and as other Trusts within the ICB begin working under the framework:

- Introduction of a Trust wide Patient Safety Bulletin to share learning and improvements identified by Patient Safety Incident Investigations (PSIIs) with all colleagues across the Trust.
- Working with the ICB led PSIRF Community of Practice, to identify changes to processes highlighted by other Trusts, improve working relationships in relation to joint investigations and align processes, and development of a shared resource for improvements to Patient Safety Training.
- Introduction of a new set of local PSIRF investigation priorities and handover of previous priorities to the Quality Improvement team to use the learning identified with relevant Quality Improvement projects.
- In-house investigation training is being developed and introduced over the course of the year for those colleagues responsible for investigating incidents not subject to a PSII. This training will incorporate human factors and a systems-based approach to incident investigation.
- The national Patient Safety Training levels 1a, 1b and 2 have been made mandatory training for all relevant colleagues.

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 colleagues. Over 2023/24 the Trust has reported 3 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Transfusion of ABO-incompatible blood component	1
Wrong implant	1
Misplaced naso-gastric tube	1

All three Never Event incidents have been fully investigated and the Trust found important learning that has been shared with colleagues across the organisation, with our commissioners and the patients. Detailed safety improvement plans for all 3 incidents have been developed, updated and assurance on the completion and embedding of learning has been overseen by Patient Safety Group and Patient Safety Incident Requiring Investigation panel.

Learning from Never Event Incidents

On three occasions within 2023-24 the Trust has not met the expectations of **Safe**, **Personal** and **Effective** care regarding Never Events. The Trust has identified several key changes in systems and processes from the 3 incidents and processed a Trust Patient Safety Bulletin which highlighted learning and actions to be taken across the Trust. These include:

Transfusion of ABO-incompatible blood component:

- A Patient Safety Alert which was circulated across the Trust to highlight the issues raised in this investigation.
- Relevant blood transfusion policies and Standard Operating Procedures were reviewed and updated to avoid any ambiguity about side-by-side checks.
- The Hospital Transfusion Committee / Blood Transfusion Practitioners were asked to support clinical colleagues when undertaking blood transfusions, for example, through training and raising awareness.

- Blood transfusion provisions currently in place on Cerner were reviewed to understand data capture and whether further safeguarding could be introduced. A Blood Track system is also being introduced in May 2024.

Wrong implant:

- Improvements to the layout, labelling and organisation of the implant storage areas with weekly checks implemented. Storage trolleys procured so that each theatre has access to one.
- Work with the Theatre nursing and medical team to make improvements to the silent focus process and strengthen the safety culture.
- WHO and (NatSSIPs) 2 observational audits implemented to ensure that key safety processes are followed and areas for improvement identified.
- A handover process has been implemented when additional colleagues join the team during an operation.
- The Standard Operating Procedure 'Checking of any Implantable Item Prior to Implantation Intraoperatively' has been updated in accordance with NICE Quality Standards and National Safety Standards for Invasive Procedures (NatSSIPs) 2.

Misplaced naso-gastric tube:

- A one-page quick reference guide for all colleagues to follow when inserting and managing nasogastric tubes has been developed.
- The Quick Reference Guide to provide clarity on who has responsibility to confirm tube placement and the requirement to be clear with documentation when confirming placement and to clearly document 'safe to use' or 'not safe to use'.
- The Trust has gained assurance that all paper Nasogastric Tube Care Bundles have been removed from all clinical areas.
- The e-Learning training package for the insertion and management of nasogastric tubes has been reviewed and updated considering the findings of this investigation and rolled out across the Trust.

3.3.12 Learning from Deaths

Throughout 2023-24 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 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 patient safety investigation of the case is undertaken and presented to the Divisional Serious Incident Reporting Group or 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.

Breakdown of deaths in 2023-24 and number of completed SJR's for this time period.

Total number of inpatient deaths 2023/24	**Completed**	**2023-2024**		
	Q1	520		
	Q2	476		
	Q3	569		
	Q4	570		
Total		**2,135**		
Number of Stage 1 and 2 SJR's completed 2023/24 (May contain deaths from current and prior years)		**SJR 1**	**SJR 2**	**Deficiencies in care which may have contributed to death**
	Q1	50	4	0
	Q2	33	4	0
	Q3	32	5	1
	Q4	39	7	3
Total		**154**	**20**	**4**

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 for 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 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 2023/24	**Q1**	2	1	2	0
	Q2	6	0	1	1
	Q3	2	4	0	0
	Q4	2	0	3	0
Total		**12**	**5**	**6**	**1**

	Completed	PMR 1	PMR 2
Number of Stage 1 and 2 PMR's completed during by quarter 2023/24 (May contain deaths from current and prior years)	**Q1**	8	9
	Q2	8	15
	Q3	6	6
	Q4	5	7
Total		**27**	**37**

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 it 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 27 deaths reported to LeDeR, and 2 referrals to coroner.

Breakdown of Learning Disability deaths in 2023-24 and number of completed LeDeR's for this time period by financial quarter:

Adult inpatient deaths and number of thoase which had a Learning Disability or Autism Stage 1 and 2 LDA-SJR's completed 2023/2024 (Completed LD-SJR's may contain deaths from prior quarters/years)	**Quarter**	**In-patient Deaths**	**LDA-SJR 1 Completed**	**LDA-SJR 2 Completed**	**Deficiencies in care which may have contributed to death**
	Q1	520	4	0	0
	Q2	476	5	1	0
	Q3	569	5	2	1
	Q4	570	5	2	0
Total		**2135**	**19**	**5**	**1**

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

- Collaborative work, Palliative care and LD and autism nursing team
- Use of hospital passports informing care planning

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

- Documentation errors on DNSCPR and incomplete DNACPR documentation.
- Issues with MCA, lack of capacity assessments, referrals where required to IMCA for best interest decision making.
- No referral to LD nurse and recommendations made by LD nurse not recorded in case notes.
- No LD flag on electronic system
- Issues with end-of-life care planning and delays in access to management plans
- Lack of use of hospital passports to inform care.
- Review best practice in LD and mouth care.

3.3.13 Seven Day Service Meeting the Clinical Standards

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

Consultant job plans are designed to enable the review or delegated review of patients by a consultant within 14 hours of acute admission in all specialities 7 days a week. However, delays in the emergency pathway of patients transferring to speciality from emergency medicine has made this very challenging to achieve in Medicine.

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. This has been supplemented by the Call for Concern approach for patients and families. 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.

Our electronic patient record was implemented in June 2023. This will enable us to measure and audit against the timed standards in a comprehensive and efficient manner, although these audits are not currently in place.

3.3.14 Colleagues 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 colleagues 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 colleagues, 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 colleagues 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.

Colleagues 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 colleagues 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 colleagues 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 colleagues and what actions are being taken to address any problems.

3.3.15 NHS England National Improvement Standards for Learning Disability

The NHS England National Improvement Standards for Learning Disability audit 2022/23 was completed and submitted to NHS England in December 2023. The outcome report will follow in the next few months which will outline areas for action this coming year.

The delivery plan for learning disability is under development which includes current actions for service improvement based on recommendations from previous NHS standards audit, LeDeR actions from learning and anticipated action recommendations from this years benchmarking audit. This delivery plan will be submitted to the ELHT safeguarding committee for agreement. The outcomes of the plans actions will be monitored and reviewed at the learning disability and autism operational group with a quarterly report to safeguarding committee and Patient Experience Group with action progress and completions.

3.4 Other Quality Achievements

3.4.1 £2million research project set to get underway

East Lancashire Hospitals NHS Trust is leading a major UK research project after securing £2million of funding from the National Institute for Health Research. The grant was approved following a bid by a national team of clinicians, academics and patients, led by Mr Panos Kyzas, a Consultant Surgeon at the Trust.

The research will look into the use of antibiotics following surgery for mandible fractures, common facial fractures that often need surgery and carry a high risk of infection impacting over 6,000 people every year.

The trials, led by Mr Kyzos will take place at various hospitals across the country, looking at different antibiotic approaches following the surgery and is the UK's biggest oral and maxillofacial surgery research project.

3.4.2 East Lancashire Hospital Trust's veterans team shortlisted for a prestigious national award

The Veterans team at East Lancashire Hospitals NHS Trust, who have so far supported more than 1,300 veterans since it was set up last year, were shortlisted in the Most Outstanding NHS/Healthcare category of the Services Awards 2023.

The Awards celebrate the very best of the Armed Forces and Emergency Services.

Over the past year the Veterans team has helped find accommodation for homeless veterans, found support for veterans in financial difficulty and worked with a vast network of charities and organisations to help support veterans in crisis. They have made it their mission to make sure veterans have the individualised patient-centred care they need to recover and thrive.

ELHT has previously gained the Trust Veteran Aware status and Employer Recognition Scheme Gold Award. The Veterans team has also been finalists in the HSJ Awards and the Best Team category at the Who Cares Wins Awards organised by The Sun in partnership with NHS Charities Together.

3.4.3 Helping patients return home earlier

Over 14,000 East Lancashire residents have been supported to return home from hospital at the earliest opportunity through the Home First team at East Lancashire Hospital's NHS Trust and Lancashire County Council.

The team meet patients who are ready for discharge but may have aftercare needs, to see how they can be helped to remain at home safely.

They visit them at home, put in place equipment and organise support, working closely with a range of other community services including Supporting Together (home care), Age UK, Carers Link, hospice services and a range of community health services.

This has reduced unnecessary delays in hospital when individuals are well enough to leave.

3.4.4 Hyndburn Rural District Nurses presented with Cavell Trust award

Hyndburn Rural District Nurses have been presented with a national award for providing exceptional patient care.

The team from East Lancashire Hospitals NHS Trust received a Cavell Star Award, which celebrates nurses, midwives, nursing associates and healthcare assistants who go above and beyond.

The Cavell Trust is a charity supporting UK nurses, midwives and healthcare support workers. They encourage nominations for awards for those who show exceptional care to colleagues, patients and patients' families.

3.4.5 East Lancashire pancreatic cancer nurse wins NHS Parliamentary Award

Pancreas specialist nurse Vicki Stevenson-Hornby won the Nursing and Midwifery category at the prestigious NHS Parliamentary Awards on Wednesday, 5 July – the NHS's 75th birthday.

The Royal Blackburn Teaching Hospital-based nurse was recognised for her passion in raising awareness of pancreatic cancer and the need for early diagnosis.

Vicki – known as 'Vicki Pancreas' by colleagues owing to her passion for her work – even dyed her hair purple, the colour of Pancreatic Cancer Awareness Month, for the ceremony to further raise awareness of the disease.

Vicki has been instrumental in supporting the development of the Trust's diagnostic pathway for pancreatic cancer, helping reduce the time patients wait between referral and confirmed diagnosis.

She was put forward for the Award by local MPs Sir Jake Berry, Nigel Evans, Antony Higginbotham and Andrew Stephenson.

3.4.6 Gold award for Charity Hub

East Lancashire Hospitals NHS Trust's multi-purpose retail charity hub at Royal Blackburn Teaching Hospital has won a gold standard award just months after opening.

The hub was launched in December by the hospital's charity, ELHT&Me, providing a retail area for patients, visitors and colleagues as well as central office space for the charity's volunteers and co-ordinators.

It has now been named a gold standard winner at InfraRed's Creating Better Futures Awards, celebrating impactful projects within the InfraRed portfolio that focus on innovation, community need, collaboration and efficiency.

The hub was made possible thanks to a collective effort and support from local businesses and is located in the main entrance of Royal Blackburn Teaching Hospital.

3.4.7 New Urology Unit opens at Burnley General Teaching Hospital

A state-of-the-art Urology Unit which will benefit local communities and help to attract the very best medical talent has been opened at Burnley General Teaching Hospital.

The new Unit has seven rooms, including two treatment rooms, a new scanner, new digital flexible cystoscopes for the diagnosis and management of bladder cancers and new laser machines for the treatment of bladder cancers and kidney stones treatment. It brings together all urology services in one place and will benefit patients for years to come, helping the Trust provide the highest levels of care and support, in a welcoming and comfortable environment.

3.4.8 An image of success for new community diagnostics centres

Patients in Burnley and Rossendale are reaping the benefits of two new community diagnostic centres (CDC) which are exceeding all expectations when it comes to the number of patients being scanned.

Burnley CDC delivered 1,678 non-pregnancy-related ultrasounds between 1 April 2023 and 30 July 2023 - a 194% increase against their planned activity.

The CDC in Rossendale also delivered 4,479 MRI scans and non-pregnancy-related ultrasounds in the same period - 11% over the predicted number.

The new Rossendale CDC became operational in October 2022 following a £1.2m investment from national funding allocated to reduce scan waiting times and bring services closer to patients' homes.

3.4.9 Quality award for support to international healthcare professionals

The Trust has been awarded the prestigious NHS Pastoral Care Quality Award for its support to international nurses and midwives.

The national award scheme was launched last year to recognise organisations with high-quality care and wellbeing support for new people joining the NHS from overseas.

The Trust has a dedicated recruitment and induction programme helping healthcare professionals from around the world start their career with the NHS in East Lancashire. The wrap-around care starts from the moment of interest and continues for as long as people need it, including personalised educational support as they complete professional UK assessments.

A dedicated team has been set up at the Trust to provide pastoral support. They take care of everything from travel arrangements and providing accommodation during their first two months, practical help with finding schools or opening a UK bank account through to support with local information about transport and places to eat.

Part of this unique support also helps them prepare for professional assessments in the UK that simulate clinical environments and patient scenarios which all registered nurses and midwives are likely to encounter. All recruits are expected to be able to assess, plan, implement and evaluate care for the different scenarios and each international recruit receives a personalised plan to support them in their learning and development.

The in-depth support is a key reason why the Trust attracts around 600 overseas nurse applicants every year, with 20 recruited every month.

3.4.10 Hospital hosts Olympic-style games

Hospital colleagues caring for patients recovering from a stroke devised a creative way of supporting rehabilitation, inspired by the Invictus Games.

Marsden Ward at Pendle Community Hospital in Nelson have recently hosted their own version of the Olympic Games, as a way of reminding patients anything is possible and encouraging exercise to support their recovery.

In true Olympic style, an opening ceremony had also been held, featuring patients actively participating in their own Olympic torch relay, with Linda Readfearn, a former patient on Marsden Ward, on hand at the end of the relay to officially declare the event open.

From paper plate discus to help coordination and core stability through to bowls to support visual scanning and upper limb activity, a range of fun activities were put together by the team.

3.4.11 East Lancashire Hospitals NHS Trust's culinary stars shine at NHS Chef 2023

Chefs at East Lancashire Hospitals NHS Trust (ELHT) have been crowned winners in the annual national NHS Chef competition for the second time in just three years.

Darby Hayhurst and Dylan Lucas, who are based at Royal Blackburn Teaching Hospital, were named Chefs of the Year 2023 after impressing judges with a winning menu that featured cauliflower prepared in three delectable ways, Moroccan spiced cakes, pan-fried duck and a choc, rock and pop crumble dessert.

They also emerged victorious in another two categories of the competition after scooping the top prize for the best regional plant-based dish and the best national plant-based dish.

The competition was not only about delighting the taste buds but also showcased exceptional culinary skills and the highest quality of healthcare cuisine – all within an NHS budget.

Dylan and Darby beat off stiff competition in knock-out rounds ahead of the prestigious final. Along the journey they took part in 24 different challenges and created 72 dishes.

The NHS Chef 2023 competition saw talented chefs from NHS Trusts across the country vying to create the most sumptuous and nutritious dishes. The restaurant-quality of food produced during the final round reflected the dedication, expertise, and enthusiasm required to serve tasty and wholesome meals to patients.

Now in its third year, the competition continues to gain prominence as it spotlights the invaluable contributions of chefs in the healthcare system.

3.4.12 Hospital’s head and neck team crowned East Lancashire’s Public Health Hero

A team from East Lancashire Hospitals NHS Trust has been crowned Public Health Heroes after showing compassionate care during a family’s difficult time.

The Head and Neck Team, based at Royal Blackburn Teaching Hospital, were recognised following a public appeal designed to encourage patients or their families to share examples of outstanding care as part of the Trust’s annual Star Awards.

The Public Health Hero category attracted more than 65 nominations but the judges were overwhelmed by the nomination submitted by Jane Devanney after her mum Pauline was

given the devastating diagnosis of mouth cancer just days after her husband of 48 years had died.

The annual Star Awards recognise the fantastic work and achievements of colleagues and volunteers at the Trust.

There were 15 coveted categories, including Clinical Team of the Year, Unsung Hero and Rising Star.

A particular highlight was the Public Health Hero as nominations for this award are from patients or their relatives and carers and recognises those who have made a significant and memorable difference to the lives and experiences of patients and their families.

3.4.13 Burnley General Teaching Hospital awarded for commitment to patient safety by the National Joint Registry

Burnley General Teaching Hospital is celebrating after being named as a Quality Data Provider after successfully completing a national programme of local data audits run by the National Joint Registry (NJR).

Burnley General Teaching Hospital is one of five sites within East Lancashire Hospitals Trust (ELHT).

The NJR monitors the performance and effectiveness of different types of joint replacement surgery – such as hip, knee, ankle, elbow and shoulder operations – in a bid to improve clinical outcomes for patients and standards of care across hospital Trusts.

It launched the 'NJR Quality Data Provider' certificate scheme to encourage best practice and offer hospitals a blueprint for reaching high quality standards relating to patient safety.

To achieve the award, colleagues at Burnley General Teaching Hospital had to achieve six ambitious targets during the NJR's mandatory national audit period for 2022-23, including compliance with the NJR's mandatory national audit aimed at assessing data completeness and quality within the registry.

The audit ensures that the NJR is collecting and reporting upon the most complete, accurate data possible across all hospitals performing joint replacement operations.

3.5 Statements from Stakeholders

3.5.1 Healthwatch Blackburn with Darwen and Healthwatch Lancashire

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 Account for 2023-24.

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 colleagues 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.

We agree with the areas for improvement via collaboration with partner organisations of out of hospital health care, ageing well, mental health, and improvements in elective and emergency care and aware of a number of initiatives currently underway by the Trust to deliver on these improvements.

Part 2: Quality Improvement:

We are pleased to see the implementation of the Quality Strategy and monitoring structures.

We actively support the engagement of the Public and Patient Panel as part of the quality improvement work of the Trust and are aware of new structures in place to develop the ongoing implementation of PSIRF. We note the issues identified as 3 local priorities for this work as areas of complaints to Healthwatch and appreciate the Trust's focus on addressing these - namely medication errors, discharge planning and safeguarding patients with learning difficulties.

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 2023/24 and 2024/25

We note the initiatives listed in 2.3 which have received specific focus for 2023/24 and the Improvement Hub Team Priorities 2024/25. The Improvement Hub priorities are all areas of work we recognise and are glad to state that the Public and Patient Panel are involved in several of these initiatives.

We very much appreciate the continuous open working relationship with ourselves as a local Healthwatch as a valuable source of patient feedback and involves us as a partner in reviewing the Trust's complaints handling process.

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.

Part 3 Quality Achievements and Statutory Statements

We would single out the key actions which have already been taken in respect of i) improving the quality of mortality data and the learning from deaths programme and ii) reducing the readmission rate of 0-15 year olds.

We also note the continued focus on ensuring that learning from Never Events is embedded within the organisation and from our own engagement in the Community Diagnostic Centres, we know the impact these are having on the numbers of people being scanned and the positive response received from patients about this offer**.**

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 Carney

Manager
Healthwatch Lancashire

3.5.2 Lancashire and South Cumbria Integrated Care Board (LSCICB)

Throughout 2023/24, the Trust has demonstrated its commitment to delivering safe, personalised, and effective care to its patients, with a strong emphasis on collaboration with external healthcare providers across Pennine Lancashire.

The Lancashire and South Cumbria Integrated Care Board (LSCICB) is pleased with the progress made on key priorities identified in 2023/2024, recognising the Trust's ongoing efforts in continuous learning and improvement to fulfil quality commitments.

The Trust remains proactive in soliciting patient feedback through various methods, including surveys, Friends and Family Tests, patient forums, patient stories presented to the board, and complaints. The Trust adheres to the principles of "Getting it right," "Being customer focused," "Being open and accountable," "Acting fairly and proportionately," "Putting things right," and "Seeking continuous improvement" to ensure patients receive safe, effective, and personal care.

The Trust has implemented a new Electronic Patient Record system (EPR) which, over the past nine months, has yielded notable benefits for both colleagues and patients, as well as their families. We are pleased to note that colleagues now have access to decision support tools and enhanced information, facilitating more informed decision-making. Additionally, the hospital's efforts have led to a reduction in duplicated work and have contributed to the NHS Green plan and Waste Reduction Program. While acknowledging the significant achievements of the new EPR system (CERNER), Over the last nine months, LSCICB has been made aware of the limitations of CERNER and its impact on primary care services, patients, colleagues and other partner organisations such as nursing homes. While CERNER has provided efficiencies in various areas, LSCICB will closely monitor how the Trust resolves these known issues.

We acknowledge the commendable efforts of the Maternity service for attaining a "Good" rating from the CQC in November 2022. While recognising that no other formal inspection has taken place since. We will closely monitor how Urgent and Emergency services manage

the newly awarded regulated activity “assessment or medical treatment for individuals detained under the Mental Health Act 1983 when the primary need for assessment or treatment is directly related to an eating disorder”.

LSCICB is pleased to report that the Trust has successfully completed investigations into all five local priorities initiated in 2021 as part of the Patient Safety Incident Framework (PSIRF). The insights gained from each case have significantly contributed to the development of organisational improvement plans for each respective area. We are particularly interested in the new local priorities set by the Trust in November 2023 and look forward to understanding the lessons and improvements that will emerge from these initiatives in the coming year. The continuous commitment to learning and improvement is essential for advancing patient safety and service quality.

LSCICB acknowledges the diverse approaches the Trust has employed to deliver effective evidence-based care and disseminate learning across the organisation, thereby supporting improvements and promoting safety. We appreciate the comprehensive information received during 2022-2023, which highlights the Trust's commitment to patient safety and the effectiveness of the service to the community.

We will continue to seek assurance regarding mortality data. The issues related to the reliability of this data since the introduction of Cerner have been well-documented across various forums. LSCICB recognises that further work is necessary to ensure the accuracy of coding, recording, and data input by clinical users, enabling reliable conclusions about mortality outcomes.

Additionally, we are keen to understand the Trust's learning outcomes from maternal deaths and Maternity and Neonatal investigations in the forthcoming year.

We acknowledge the Trust's efforts to gather feedback from patients, carers, and the public. Attending the trust’s Patient Experience meetings offers valuable insights into the various engagement opportunities utilised to capture a diverse perspective on the services delivered by ELHT.

LSCICB notes that the Trust aims to launch its Patient, Carer, and Family Experience Strategy 2024–2027 in May 2024. The progress of this strategy will be monitored by LSCICB so that any ongoing support can be provided.

During 2023/24, the Trust participated in 88% of national clinical audits and 100% of eligible national confidential enquiries. The did not participate in the remaining 12% because they were not eligible. LSCICB is pleased to note the continued monitoring of compliance, with associated improvement actions and learning to inform improvement programs. Over this period, the Trust completed 255 local clinical audits, the results of which have contributed to improvements across the Trust. The Trust will continue to report the outcomes of their audits through Clinical Effectiveness meetings and monitor the implementation of identified actions to enhance service delivery.

LSCICB would like to commend the Trust for its significant contribution to research and development. Notably, 6,029 participants were recruited for 85 studies in 2023/24, including the recruitment of global patients for two studies. ELHT was the first Trust in the world to achieve this milestone.

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 100% of records included a valid NHS Number for admitted patients, 99.9% for outpatient care and 97% for accident and emergency care. The compliance rate for records documenting a valid GP Code decreased from 100% last year, to 98.7% for admitted patient care, 99.4% for outpatient care, records and 98.9% for accident and emergency care.

In the Care Quality Commission's Adult Inpatient survey, the trust improved its scores on five questions. These questions pertained to receiving enough drink, having sufficient privacy during examinations or treatments, being treated with dignity and respect while in the hospital, confidence in the nurse providing care, and colleagues efforts to manage pain effectively. However, in the upcoming year, the LSCICB will focus on understanding how the trust plans to address the five lowest-scoring questions. These include patients being asked for their views on the quality of care received as inpatients, receiving information about medications taken home, getting food outside set mealtimes, and waiting for a bed.

During 2023/24, the Trust consistently reported high scores on the Friends and Family Test, with an average of 96% of inpatients rating their overall experience as either very good or good. However, scores have declined for patients attending the Emergency Department and Urgent Care Centres. The Trust attributes this decline to increased footfall, high acuity levels, and staffing shortages, which have impacted the quality-of-care patients expect. Ongoing efforts are being made to address patient feedback, utilising Friends and Family Test reports to guide service improvements. Progress in enhancing response rates and patient satisfaction is reviewed at the Patient Experience Group meetings, which are attended by the LSCICB.

LSCICB have noted a decline in scores for question 15 and Q14c since last year staff survey. Q14c relates to career progression regardless of gender, age and ethnic background, and Q15 relates to colleagues experiencing harassment, bullying or abuse at work from other colleagues. The Trust has engaged with colleagues following publication of the survey results and developed an action plan to address feedback and further improve performance. LSCICB will be monitoring this in the forthcoming year, ensuring the trust is held accountable for demonstrating how they are improving in both these areas.

Staffing pressures have been observed in both administrative and medical/nursing roles. The LSCICB has identified specific staffing challenges within the microbiology, clinical coding, Structured Judgement Review (SJR) and medical examiners teams. Numerous reports indicate that while ELHT is actively working to expand its workforce, increased patient volume and acuity present significant challenges.

The trust has conducted an audit of annual leave and sickness absence in collaboration with the Mersey Internal Audit Agency. The LSCICB looks forward to reviewing the outcomes and understanding how changes to the annual leave policy and sickness management process has enhanced workforce efficiency.

We acknowledge that staffing shortages are a national issue affecting all hospitals, including ELHT. Nonetheless, we are pleased to note that the trust has received the NHS Pastoral Care Quality Award for its exemplary support of international nurses and midwives.

Patient Reported Outcome Measures (PROMs) have improved since last year, the trust has reported improvements in both Hip and Knee replacement surgery. In 2022-2023, the trust reported 100% of patients who had a hip replaced reported an improved health gain compared to 88.5% in 2021-22. This was also 10% above the national average.

Readmissions within 28 days of discharge has decreased from the previous year, however, remains above the national average. We note that there has been an increase in the 0-15 age group, rising to 13.87% from last year's 13.09%. This rate exceeds the expected 10.71% and the national average of 9.2%. Although these figures appear high, LSCICB recognises that this is due to assessment units being coded as inpatient admissions. The Trust believes this pathway is appropriate to ensure children receive adequate support. We are pleased to learn of the key actions the trust has taken to manage readmission rates in the 0–15-year-old age band. These actions provide a safe and responsive service that supports children and their families.

The number of Clostridium difficile (C. diff) cases has significantly increased since last year, with the Trust reporting 101 positive cases compared to the projected 53 for 2023/24. The LSCICB infection control team will continue to monitor the Trust's efforts to enhance compliance.

The number of Never Events has risen compared to the previous year, with the Trust reporting 3 Never Events in 2023/24. Investigations have been completed, leading to several key changes in systems and processes. The ICB will continue to review the investigative outcomes of any significant reported Never Events, with a particular focus on the Trust's application of learning, training, and scrutiny.

LSCICB recognises that the Trust utilises SJR methodology to evaluate the clinical care of deceased patients. We will persist in examining the areas for improvement identified by the SJRs, as well as the progress of actions already initiated in 23/24. These actions include commencing End of Life and Advance Care Planning at the earliest opportunity and addressing gaps in paediatric bereavement and palliative care.

Additionally, the Trust has reported 27 deaths of individuals with learning disabilities or autism and 2 referrals to the coroner. We are pleased to note the collaborative efforts between the palliative care team and the learning disabilities and autism nursing team. The LSCICB will monitor areas for improvement in the coming year and review the Trust's progress on enhancing documentation regarding DNACPR, end-of-care planning, and best interest decision-making. This includes addressing the lack of capacity assessments, insufficient referrals to the learning disabilities nurse, and inadequate documentation of recommendations made by the learning disabilities nurse.

LSCICB congratulate ELHT for securing 2 million pounds of funding from the National Institute for Health Research, for research into the use of antibiotics following surgery, for mandible fractures and for successfully opening their new urology unit at Burnley and two new community diagnostic centres. We are pleased to read that the trust has delivered 1,678 non-pregnancy related ultrasounds between April 2023 and July 2023, this being 194% increase against planned activity at their Burnley site and 4,479 MRI scans and non-pregnancy related ultrasound in the same period, which equates to 11% over the predicted number.

LSCICB would like to thank the individual teams deployed by ELHT to better patient experience and support people in the community by delivering patient centred care such as the veteran team.

Throughout 2023/24, ELHT demonstrated a strong commitment to quality by delivering safe, personalised, and effective care to every patient using their services. LSCICB will continue to support ELHT's colleagues, processes, pathways, and strategies to achieve the key

priorities identified for 2024/25, ensuring that patients and their families remain at the centre of our collective efforts.

Yours sincerely

Professor Sarah O'Brien Chief Nursing Officer

3.5.3 Lancashire County Council

This year the Lancashire County Council Health Scrutiny Committee have provided a comprehensive response to four of the eight Quality Accounts received (Blackpool, Lancashire and South Cumbria NHS Foundation Trust, NWAS and University Hospitals Morecambe Bay) due to the priorities in the Health Scrutiny work plan and this will be reviewed again next year.

Although we are unable to comment on this year's Quality Account, we are keen to engage and maintain an ongoing dialogue throughout 2024/25.

3.6 Statement of Directors' Responsibilities (to be signed on completion and approval)

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: *M. S. Sarwar (signed electronically)*

Chief Executive: *M. A. Hodgson (Signed electronically)*

Date: 27 June 2024

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 colleagues
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