NHS 70 YEARS OF THE NHS 1948 - 2018

East Lancashire Hospitals NHS Trust

Quality Account

2018/19

Safe | Personal | Effective

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Part One
Introduction to our Quality Account

1.1 Our Trust

East Lancashire Hospitals NHS Trust (ELHT) was established in 2003 and is a large integrated healthcare organisation providing acute, secondary and community healthcare for the people of East Lancashire and Blackburn with Darwen. Our population includes patients who live in several of the most socially-deprived areas of England.

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

We employ almost 8,000 staff, some of whom are internationally-renowned and have won awards for their work and achievements. Our staff provide care across five hospital sites, and various community locations, using state-of-the-art facilities. We have a total of 1,041 beds and treat over 700,000 patients a year from the most serious of emergencies to planned operations and procedures.

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

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

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

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1.2 Our Vision and Values

Our vision is to be widely recognised for the delivery of Safe, Personal and Effective care to the local population.

We are committed to ensuring the future of our organisation and services by continually improving our productivity and efficiency. This core focus has enabled demonstrable improvement in our key access, quality and performance indicators.

The strategic framework which guides all our activities is shown in the diagram below:

1.3 Our Future

The Trust is working hard on closer integration with providers of health and care across Pennine Lancashire through the Pennine Lancashire Transformation programmes and across all of Lancashire as part of the Integrated Care System (ICS) of Lancashire and South Cumbria.

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

Across Pennine Lancashire we now integrate more closely with providers in the primary, community, voluntary and third sectors. We undertake co-design with Commissioners, creating an Integrated Care Partnership (ICP) in Pennine Lancashire. Trust clinicians increasingly work with their professional colleagues from other organisations to provide Lancashire-based sustainable networks which determine the standards of care, the governance and the delivery of care pathways.

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

These themes are:

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

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

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

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1.4 Our Approach to Quality Improvement

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

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

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

Our quality improvement methodology is the '7 Steps to Safe Personal Effective Care'. This is based on the model for improvement and also incorporates Lean and other tools. We have a small and developing Quality Improvement Team of facilitators as part of the Quality and Safety Unit, linking with the Quality Committee structure. All junior foundation doctors take part in and lead quality improvement projects.

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

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

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

The Trust continues to build on its relationships and communication with lead CCGs over 2018-19. Monthly quality review meetings are held, chaired by CCG, with quality leads from all organisations. The focus of these meetings is around clinical effectiveness, risk and safety, quality improvement and the patient, family and carer experience. This communication is enhanced by weekly teleconferences between the lead CCG, CSU and the Trust.

The escalation process for incidents, risks and events of concern are triaged daily to ensure timely and appropriate communication to all relevant parties. This allows the Trust to identify and nominate appropriate staff to investigate incidents and where appropriate a family liaison officer to support, provide information and feedback to the patient, family and/or carer. Evidence is collated from divisions and presented to one of the bi-monthly subcommittees of the Quality Committee and then to the Trust Board. Following these meetings, validated reports and data are shared with the CCGs and CSU to provide assurance and to support health economy decision making. Reports include:

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

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

1.5 Our Quality Account

Quality Accounts are annual reports from providers of NHS services which provide information about the quality of the services they deliver.

Our Quality Account demonstrates our commitment to continuous evidence-based service quality improvement and to explaining our progress in this area to patients, the public and interested parties.

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

- The Trust's priorities for quality improvement in 2018-19;
- Performance during the last year against quality priorities set by the Trust;
- Performance during the last year against a range of nationally set quality indicators, initiatives and processes; and
- Performance during the last year against a range of other quality indicators, initiatives and processes.

Our Quality Account has been developed over the course of 2018-19 as we have continually monitored and reported against our quality priorities and indicators both within the organisation and externally to the public, commissioners and regulators and at a national level.

We have also invited a variety of representatives of local people to comment on what they think of this Quality Account and what is says about our Trust; their comments and contributions can be found in Part 3 of this report.

We also want you to provide us with feedback about this report, or about our services. If you wish to take up this opportunity please contact:

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East Lancashire Hospitals NHS Trust
Park View Offices
Royal Blackburn Teaching Hospital
Haslingden Road
BLACKBURN
BB2 3HH

Email: qualityandsafetyunit@elht.nhs.uk

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

From 28 August to 27 September 2018, the Care Quality Commission (CQC) visited the Trust to conduct a series of inspections concluding with a 'Well-Led' review.

Following their review the report was published on 12th February 2019 and the Trust was rated as being Good overall. The CQC scores for each of the main hospital sites and overall are as follows:

Ratings for a Combined Trust	
Acute	Good
Community	Good
Mental Health	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

The report presents the findings of the inspection and highlighted areas of outstanding and good practice. Areas which must have further improvement were also identified as follows;

- Trust to ensure that fridges and room temperature are monitored in areas where medicines are stored and appropriate actions taken if the temperature is outside a safe range
- Ensure all records are stored confidentially and in line with the trust's record policy
- Ensure that fluid and food thickening powder is stored safely and in line with national guidance

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

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1.7 Our Chief Executive's Statement on Quality

I am delighted to introduce the Quality Account 2018/19 for East Lancashire Hospitals NHS Trust (ELHT), which provides us with the opportunity to reflect on our quality achievements and successes over the last 12 months, as well as identify areas where enhancements to quality can be made.

Our agreed quality priorities for the coming year show a real commitment to provide Safe, Personal and Effective care for our patients. I am forever proud of the professionalism, resilience and dedication of the staff who work at ELHT. While the challenges we face may be in line with national trends, the Trust continues to see unprecedented demand on its services as people live longer and become frailer with increasingly complex health needs.

This is why the launch and implementation of the Pennine Lancashire Plan, through the Together Healthier Future programme, is so important. The six partnership organisations* carrying out the plan have come together to work towards a shared vision: to improve our health and care system in Pennine Lancashire.

In September 2018 we were again pleased to welcome the CQC inspection team, who recognised the sustained quality and care improvements made throughout the Trust. The rating of 'Good' overall was enhanced by two 'Outstanding' areas; community end of life care and specialist mental health for children and young people. This underlines how ELHT and our partners across Pennine Lancashire work together to deliver fully integrated health and social care services, which massively benefits our patients and communities.

While it is clear that our Trust continues to improve, we take nothing for granted and remain committed to making further improvements in order to provide the best possible care for the community we serve.

I hope you find our latest annual Quality Account informative. I believe it is an accurate reflection of the Trust's performance against our quality indicators. To the best of my knowledge all the data and information presented in this 2018/19 Quality Account is true and accurate and the Quality Account has been approved by the Trust Board.

Kevin McGee

Chief Executive

Mr Kevin McGee, Chief Executive

Part Two
Quality Improvement

2.1 Our Strategic Approach to Quality

Following the publication of the East Lancashire Hospitals NHS Trust's (ELHT) first Quality Strategy in 2014 there have been significant developments within ELHT and the local health economy.

Introduction

The Trust has been re-inspected three times by the CQC; the first inspection culminating in the lifting of special measures and the second leading to both main hospital sites being assessed as 'Good', the third visit strengthening the 'Good' outcome with areas of 'Outstanding'. This demonstrates the strength of the initial strategy's approach to quality and the adoption of the Trust's vision to be widely recognised for the delivery of Safe, Personal and Effective care. As a result of up-dating the Trust Quality Strategy (2017-19) those three core elements remain its focus, whilst further strengthening governance and reporting arrangements, to provide a clear reporting system from 'Floor to Board'.

Safe Care

The initial strategy in 2014 focused upon the specific Harms Reduction Strategy with clear emphasis upon the strengthening of awareness, reporting and acting upon findings. Whilst this successful approach is to be maintained and strengthened the approach from 2017-2019 will have a focus upon the safety of systems and the culture of safety both across the organisation as a whole and in specific teams.

Harms Reduction Programme/Sign up to Safety

To utilise resources effectively a review of the Trust's harms reduction programme and Sign up to Safety pledges has been undertaken in order that these are merged to deliver a reduction in accidents causing harm to patients receiving care at ELHT and contributing to the Sign up to Safety national programme target (reducing incidents causing harm by 50,000 in the five year cycle).

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

Safety Culture Survey

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

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

c. The Prompt to Protect campaign has been launched to promote a culture of openness around infection control issues and encourage staff to step in when they feel it is not right and needs challenging.

Mortality Reduction Programme

Whilst ELHT is no longer an outlier for mortality ratios we are continuing to develop the Mortality Reduction Programme. Since the 1st December 2017 the Trust has been using the Structured Judgement Review (SJR) methodology and introduced an electronic review process that is part of our patient safety risk management software system (Datix).

The new review process is in line with the most recent NHS England guidance: Learning from Deaths and includes an overall score. Any score of 1 or 2 triggers a secondary review process to determine whether or not poor care contributed to the death of a patient. The number of avoidable deaths and the outcomes of any Learning Disability/Mental Health death investigations will be reported to the Quality Committee.

Personal Care

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

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

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

b. Patient and Carer Stories are collected for presentation at Trust Board and divisional meetings and as part of quality improvement work to facilitate learning.

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

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

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

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

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

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

i. The Trust has established a Public Participation Panel which will support the Trust in helping our services reflect the needs of and view of the people using them. The panel will be involved in supporting patient led change throughout the Trust, with a particular emphasis on ensuring that the views of patients and carers are considered.

Clinical Effectiveness

There is a continued evolution to the approach of ensuring clinical directorates are delivering effective, evidence-based care in a reliable manner. Over the past year the Clinical Effectiveness and Quality Improvement Teams have two main functions – to provide assurance of delivery of best practice and to oversee quality improvement activity to improve areas where practice falls below the expected level. To ensure that directorates are delivering best practice and are aware of the standards expected of them each directorate now has a 'portfolio' of standards against which they monitor their performance.

This portfolio includes:

a. National audits as mandated by the national contract

b. Regional and Local audits as determined by commissioners or regional bodies

c. Local Quality audits (e.g. compliance with local care bundles)

d. Relevant National Institute for Health and Social Care Excellence (NICE) guidance

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

f. Getting It Right First Time (GIRFT) data

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

Quality Improvement QI Triage Group

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

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

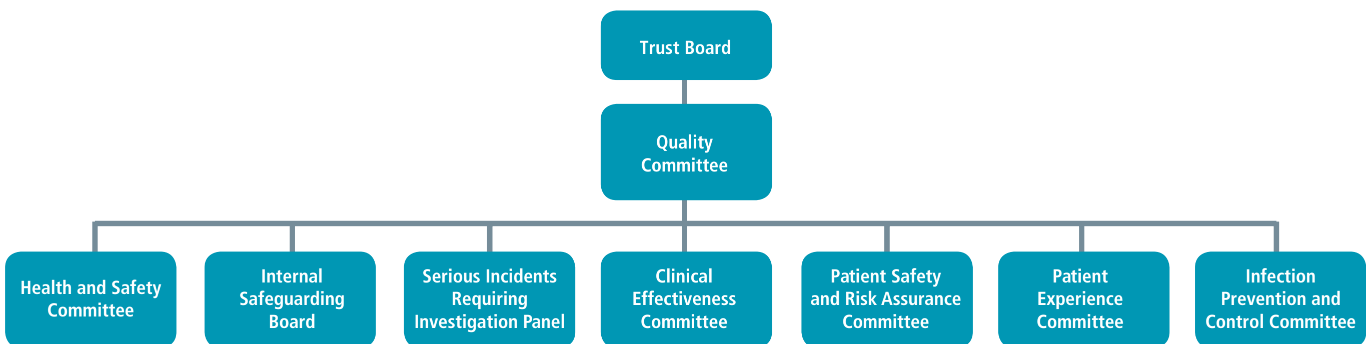
- All new Quality Improvement Projects submitted;
- Quality Improvement Projects deemed to apply to single division;
- Why this decision was made;
- Assurance that impact monitoring plans are in place;
- Quality Improvement Projects deemed to require further review;
- Which Group(s) undertaking further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

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

Governance Arrangements for Quality

Improving quality is the Board's top priority. It also represents the single most important aspect of the Trust's vision to be widely recognised for providing Safe, Personal and Effective care. The Trust places quality and safety at the heart of everything we do. Ensuring that our activities offer best quality and high safety levels is becoming our minimum standard rather than an aspiration. This continual drive for quality means our patients, their families and all our stakeholders can have greater confidence in the Trust as we move forward. The Trust has established the governance and committee structure shown in figure 1 to ensure the Board receives assurance in relation to the delivery of the Trust's objectives and that risk to the delivery of Safe, Personal and Effective care is appropriately managed.

Figure 1: Trust Governance Structures for Quality and Safety



2.2 Quality Monitoring and Assurance

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

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

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

The Trust Board is ultimately accountable for the delivery of quality outcomes and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality and Safety Unit, comprising three specific portfolios of patient safety/clinical risk, patient experience and clinical effectiveness, which includes the Quality Improvement Team. Similarly, Divisional Directors and Divisional General Managers are responsible for the delivery of quality outcomes within their divisions and the Trust Board holds Divisional Senior Management Teams to account for delivering quality outcomes within their respective divisions. This principle of accountability and responsibility is reflected from Board to Floor and supports the delivery of our quality objectives.

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

During 2018-19 ELHT provided and/or sub-contracted 8 NHS services. These services have been identified using the CQC's definition of regulated activities. The services provided during the year were:

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

The Trust has reviewed all the data available on the quality of care in all of these NHS services. The Trust uses its integrated quality, safety and performance scorecard to facilitate this. Reports to the Trust Board, the Quality Committee, Patient Experience Committee, Clinical Effectiveness Committee, Patient Safety and Risk Assurance Committee and Operational Delivery Board all include data and information relating to quality of services. Progress against last year's priorities for quality improvement, as set out in our Quality Account 2018-19, has been managed by way of these reporting functions.

The income generated by the NHS services reviewed in 2018-19 represents 93% of the total income generated from the provision of NHS services by the ELHT for 2018-19 (2017-18 90%).

2.3 Priorities for Quality Improvement 2019-20

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

Subject	Quality Aim	How achievement will be measured	How achievement will be monitored
Discharge	Implementation of a Trust-wide approach to support for safe discharge to continuing care	Quality Improvement Collaborative through Model Ward	Report to the Patient Safety & Risk Assurance Committee
Safe Transfer of Care	Implementation of a Trust-wide approach to improve staff and patient handover between care areas and organisations	Quality Improvement Collaborative through Model Ward	Report to the Patient Safety & Risk Assurance Committee
Deteriorating Patient – continuing work from last year	Implementation of a Trust-wide approach to improve the recognition of and response to the deteriorating patient	Use of the Mortality/Cardiac Arrest/Deteriorating Patient score card	Monthly Deteriorating Patient Steering Group reports to Patient Safety & Risk Assurance Committee
Falls	To reduce the number of inpatient falls by 20% by 2020	Monthly Falls Dashboard circulated to all wards	Monthly Falls Steering Group reports to Patient Safety and Risk Assurance Committee

2.4 Mandated Statements on the Quality of our Services

2.4.1 Clinical Audit and Confidential Enquiries

Clinical Audit involves improving the quality of patient care by reviewing current practice and modifying it where necessary. The Trust takes part in Regional and National Clinical Audits, and we also carry out local audits.

Sometimes there are also National Confidential Enquiries which investigate an area of health care and recommend ways of improving it. The Trust also takes part in these Confidential Enquiries.

During 2018-19 63 national clinical audits and 9 national confidential enquiries covered services that ELHT provides. During that period East Lancashire Hospitals NHS Trust participated in 60 (95%) 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 2018-19 also appears in the table below alongside the percentage of cases required by the terms of that audit or enquiry.

National Audits

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Acute Myocardial Infarction (MINAP)	NICOR	Continuous	Yes	100%
Adult Asthma Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Bullous Pemphigoid – National Clinical Audit	BSMD	Intermittent	Yes	100%
Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NACAP)	RCP	Continuous	Yes	100%
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	NICOR	Continuous	Yes	100%
Cystectomy	BAUS	Continuous	Yes	100%
Elective Surgery (National PROMs Programme)	NHS Digital	Continuous	Yes	100%
Endocrine & Thyroid National Audit (BAETS)	BAETS	Continuous	Yes	100%
Female Stress Urinary Incontinence Audit	BAUS	Continuous	Yes	100%
Feverish Children (care in emergency departments)	RCEM	Intermittent	Yes	100%
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Head & Neck Cancer Audit (HANA)	Saving Faces	Continuous	Yes	100%

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
Inflammatory Bowel Disease (IBD) programme / IBD Registry	IBD Registry	Continuous	No	NA
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	Continuous	Yes	100%
Major Trauma Audit (TARN)	TARN	Continuous	Yes	100%
Management of Massive Haemorrhage	NHSBT	Intermittent	Yes	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	PHE	Continuous	Yes	100%
NaDIA-Harms – reporting on diabetic inpatient harms in England – Adult (NDA)	NHS Digital	Intermittent	No	100%
National Adult Community Acquired Pneumonia (CAP) Audit	BTS	Intermittent	Yes	100%
National Adult Non-Invasive Ventilation (NIV) Audit	BTS	Intermittent	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	RCS	Continuous	Yes	100%
National Audit of Cardiac Rehabilitation	University of York	Continuous	Yes	100%
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Intermittent	Yes	100%
National Audit of Dementia (care in general hospitals)	RCPsych	Intermittent	Yes	100%
National Audit of Intermediate Care	NHS Digital	Intermittent	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	RCPCH	Intermittent	Yes	100%
National Bowel Cancer Audit (NBOCA)	NHS Digital	Continuous	Yes	100%
National CAMHS Benchmarking Audit	NHS Benchmarking Network	Intermittent	Yes	100%
National Cardiac Arrest Audit (NCAA)	ICNARC	Continuous	Yes	100%
National Cervical Cancer Audit	NHSCSP	Continuous	Yes	100%
National Core Diabetes Audit –Adults (NDA)	NHS Digital	Intermittent	Yes	100%
National Diabetes Foot Care Audit –Adults (NDA)	NHS Digital	Continuous	Yes	100%
National Diabetes Inpatient Audit	NHS Digital	Intermittent	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	BSR	Continuous	Yes	100%
National Emergency Laparotomy Audit (NELA)	RCA	Continuous	Yes	100%

Audit Topic	Coordinator	Frequency	Participation	Required Sample Submission
National Heart Failure Audit	NICOR	Continuous	Yes	100%
National Hip Fracture Database (FFFAP)	RCP	Continuous	Yes	100%
National Inpatient Falls Audit (FFFAP)	RCP	Intermittent	Yes	100%
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 Oesophago-Gastric Cancer Audit (NOGCA)	NHS Digital	Continuous	Yes	100%
National Ophthalmology Database (NOD) Adult Cataract Surgery Audit	RCOphth	Continuous	No	100%
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	RCS	Continuous	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Nephrectomy audit	BAUS	Continuous	Yes	100%
Percutaneous Nephrolithotomy (PCNL)	BAUS	Continuous	Yes	100%
Pulmonary Rehabilitation Audit	RCP	Intermittent	Yes	100%
Radical Prostatectomy Audit	BAUS	Continuous	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic Consumption	PHE	Intermittent	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antimicrobial Stewardship	PHE	Intermittent	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%
Seven Day Hospital Services Self-Assessment Survey	NHSE	Bi-annual	Yes	100%
Surgical Site Infection Surveillance Service	PHE	Continuous	Yes	100%
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	NHSBT	Intermittent	Yes	100%
Vital Signs in Adults (care in emergency departments)	RCEM	Intermittent	Yes	100%
VTE risk in lower limb immobilisation	RCEM	Intermittent	Yes	100%

Key to Audit Coordinator abbreviations	
BAETS	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BTS	British Thoracic Society
BSMD	British Society for Medical Dermatology
FFFAP	Falls and Fragility Fractures Audit Programme
HQIP	Health Quality Improvement Partnership
ICNARC	Intensive Care Audit & Research Centre
MINAP	Myocardial Infarction National Audit Project
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
NBOCAP	National Bowel Cancer Audit Project
NDA	National Diabetes Audit
NHSBT	NHS Blood & Transplant
NHSCSP	NHS Cervical Screening Programme
NHSE	NHS England
NICOR	National Institute for Cardiovascular Outcomes Research
NPDA	National Paediatric Diabetes Audit
PHE	Public health England
RCA	Royal College of Anaesthetists
RCEM	Royal College of Emergency Medicine
RCOG	Royal College of Obstetricians and Gynaecologists
RCOphth	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPsych	Royal College of Psychiatrists
RCS	Royal College of Surgeons
PROMs	Patient Recorded Outcome Measures
TARN	Trauma Audit Research Network

National Confidential Enquiries (NCEs)

Audit Title	Coordinator	Frequency	ELHT Participated	Data collection completed 2018-19	Required Sample Submission
Medical and Surgical Clinical Outcome Review Programme: Cancer in Children, Teens and Young Adults	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Peri-operative Diabetes	NCEPOD	Intermittent	Yes	Yes	64%
Medical and Surgical Clinical Outcome Review Programme: Pulmonary Embolism	NCEPOD	Intermittent	Yes	Yes	100%
Child Health Clinical Outcome Review Programme: Long term Ventilation in Children & Young Adults	NCEPOD	Intermittent	Yes	On-going	On-going
Medical and Surgical Clinical Outcome Review Programme: Acute Bowel Obstruction	NCEPOD	Intermittent	Yes	On-going	On-going
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 Morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	MBRRACE-UK, NPEU, University of Oxford	Continuous	Yes	Yes	100%

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

The results of 44 national clinical audit reports and 5 national Confidential Enquiry reports were received and reviewed by the Trust in 2018-19. Following the review of National Clinical Audit reports, East Lancashire Hospitals NHS Trust intends to continue to implement the following actions to improve the quality of healthcare provided:

- National Audit reports will continue to be presented at specialty/ multi-specialty effectiveness meetings or other appropriate forums where lessons learnt, subsequent recommendations and action will be agreed so that practice and quality of care can be improved
- A list of all National Audit Reports received will be collated and shared with the medical Director, Divisional / Directorate Leads, this will be monitored via Trust Clinical Effectiveness Committee to provide assurance that these reports are being reviewed and lessons learnt, subsequent recommendations and action captured
- National audit activity which highlights the need for improvement will be reviewed for inclusion in subsequent quality improvement activity plans
- The Clinical Audit and Effectiveness Team annual report which will continue to focus on lessons learnt to be presented to the Clinical Effectiveness Committee for on-going assurance and monitoring

268 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2018-19. 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 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 Committee

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

2.4.2 Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust during 2018-19 that were recruited up to the 26th March 2019 to participate in research approved by a research ethics committee was 1,907.

2.4.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of East Lancashire Hospital Trust's income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between East Lancashire Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment framework.

Unlike previous years when the goals were a combination of national and local commissioner agreed CQUIN schemes, the schemes were all National Schemes the majority of which are two year schemes. The following table sets out brief details of the Trust's CQUIN scheme for 2018-19:

ELHT CQUIN Programme Summary

Commissioned by	Scheme	Indicators
National	Improvement of staff health and wellbeing	Improvement of health and wellbeing of NHS staff 2017/18 – 5% improvement (on 2015) in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress 2018/19 – 5% improvement (on 2016) in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress
		Healthy Food for NHS Staff, visitors and patients 1. Maintain the 4 changes required in the 2016/17 CQUIN in both 2017/18 and 2018/19 a. ban price promotions on foods high in fat, sugar or salt (HFSS) b. ban advertisements on NHS premises of HFSS c. ban sugary drinks and HFSS from checkouts d. Ensure healthy options are available to staff including night shifts. 2. Introduce 3 new changes to food and drink provision
		2018/19 a. 80% of drink lines stocked to have <5g of added sugar/100ml b. 80% of confectionary and sweets do not exceed 250 kcal c. at least 75% of pre-packed sandwiches and other savoury pre-packed foods contain 400 kcal or less and do not exceed 5g saturated fat per 100g
		Improving uptake of flu vaccinations for frontline clinical staff 2018/19 – achieve flu vaccination uptake of 75%
National	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Timely identification and screening of patients with sepsis in emergency departments and acute inpatient settings
		Timely treatment of patients with sepsis in emergency departments and acute inpatient settings
		Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours
		Reduction in antibiotic consumption per 1,000 admissions: i) Total antibiotic usage (for both inpatients and outpatients) per 1000 admissions ii) Total usage of carbapenem per 1,000 admissions iii) Total usage of piperacillin-tazobactam per 1,000 admissions

Commissioned by	Scheme	Indicators
National	Improving services for people with mental health needs who present to A&E	2017/18 Reduce by 20% the number of attendances to A & E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable
		2018/19 1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions 2. Reduce total number of attendances to A&E by 10% for all people with primary mental health needs
National	Personalised care and support planning	Embed personalised care and support planning for people with long-term conditions. In 2017/18 agree/put in place systems and processes to ensure that the relevant patient population can be identified, workforce trained and that personalised care and support planning conversations can be incorporated into consultations with patients and carers
National	Preventing ill health by risk behaviours	Tobacco screening Percentage of admitted adult patients who are screened for smoking status AND whose results are recorded
		Tobacco brief advice Percentage of admitted adult patients who smoke AND are given very brief advice
		Tobacco referral and medication offer Percentage of admitted adult patients who are smokers AND are referred to stop smoking services AND offered stop smoking medication
		Alcohol screening Percentage of admitted adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems
		Alcohol brief advice or referral Percentage of admitted patients who drink alcohol above low-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent
NHSE LAT	Breast screening	Strengthening patient and public participation
NHS Spec Comm	Hospital pharmacy transformation and medicine optimisation	Trigger 1 – Faster adoption of prioritised best value medicines as they become available
		Trigger 2 – Improving drugs MDS data quality
		Trigger 3 – Cost effective dispensing routes
		Trigger 4 – Improving data quality associated with outcome databases (SACT and IVIg)
		Trigger 5 – 2018/19 – Reviewing and switching existing patients to treatments in line with nationally agreed policy/concensus guidelines. Existing patients reviewed and moved to appropriate regimen as per guidelines (further detail to be provided prior to 18/19)

Commissioned by	Scheme	Indicators
NHS Spec Comm	Nationally standardised dose banding adult intravenous SACT	Trigger 1 – 2017/18 and 2018/19 – Collection of baseline-data for the range of drug doses that are to be standardised as agreed with the commissioner
		Trigger 2 – 2017/18 and 2018/19 – Local Drugs and Therapeutics committee have agreed and approved principles of dose standardisation and dose adjustments required
		Trigger 3 – 2017/18 and 2018/19 – Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug (number of SACT doses given of selected drugs that match to the standardised doses / number of SACT doses given of selected drug); including confirmation of transition from local previously agreed QIPP arrangements (if any) such as legacy gain share
		Trigger 4 – 2017/18 Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs
NHS Spec Comm	Neonatal community outreach team – To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for critical care beds and to enable reduction in occupancy levels.	Trigger 1 – 2017/18 All units to present their 2016/17 average occupancy rates for their funded cots and patient flow data. National Definitions on discharge criteria for outreach care, to be developed by neonatal intensive care CRG. All Units to present to their ODNs their current discharge definitions and criteria for outreach support. (ODNs will assess and analyse the difference between their current state definitions and criteria and the National Definitions for babies that fall into the criteria for outreach support
		Trigger 1 – 2018/19 Outreach teams to be fully functional at full capacity by September 2018
		Trigger 2 – 2017/18 Providers that have presented information to their ODNs outlining the number of babies that would have been discharged (linked to the new criteria) and the impact that this would have had on occupancy rates. ODNs to work with NICU to scope the additional support required to provide an outreach service in line with the National Definitions and discharge criteria. Plan adopted to create outreach units and target reduction in occupancy levels agreed.
		Trigger 2 – 2018/19 Fall in occupancy rates by Quarter 4 relative to projection (as per Trigger 2, year one)
		Trigger 3 – 2017/18 Providers (with support from ODNs) to recruit outreach teams to support all parts of the network to comply with national occupancy rate standards
NHS Spec Comm	Improving HCV treatment pathways through ODN's	Supports the infrastructure, governance and partnership-working across healthcare providers working in HCV networks in their second and third years of operation to achieve the following outcomes: • Improvements in engagement of patients • The planned rollout, aligned to NICE guidance, of new clinical and cost effective treatments guidance to improve outcomes through Multi-disciplinary team treatment plans • Improved participation in clinical trials • Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments

*Where two years data is recorded, this is to reflect full duration of the CQUIN scheme.

Further details of the agreed goals for 2018/19 and the following 12 months are available on the NHS England website www.england.nhs.uk/publication/cquin-indicator-specification/

2.4.4 Care Quality Commission Compliance

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

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

2.4.5 Data Quality Assurance

East Lancashire Hospitals NHS Trust submitted the following records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 18 to Dec 18 (most recent figures):	
Admitted Patient Care	123,502
Outpatient Care	457,630
Accident & Emergency Care	135,154

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

Performance for Apr 18 to Mar 19 (most recent figures):	
Admitted Patient Care	99.8%
Outpatient Care	99.9%
Accident and Emergency Care	99.0%

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

Performance for Apr 18 to Mar 19 (most recent figures):	
Admitted Care	100%
Outpatient Care	100%
Accident and Emergency Care	100%

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 care of our patients and their support relies on timely and secure information sharing as well as strong data security. Organisations that have access to NHS patient data and systems, each must publish the Data Security Protection Toolkit (DSPT) self-assessment to provide assurance that they are practicing good data security and that personal information is handled correctly.

East Lancashire Hospitals NHS Trust submitted the toolkit assessment at the end of March 2019. This toolkit replaces the previous Information Governance Toolkit in which organisations were required to submit a minimum level 2 compliance. These levels have been removed from the new DSPT and to meet the new standard organisations must respond and confirm the associated assertions. All assertions have been responded to and the Trust remains compliant in its handling of data.

The Trust will prepare for the DSPT submission for 2019-20 and will aim to maintain an upward trajectory of improvements in Information Management and Security.

2.4.7 Clinical Coding Audit

The following external clinical coding audits were carried out in 2018/19:

- ELHT General Medicine, Trauma Orthopaedic and Obstetric Clinical Coding Review June 2018 – Mersey Internal Audit Agency (MIAA)
- East Lancashire Clinical Commissioning Group (ELCCG) ELHT Stroke Coding Audit December 2018 – MIAA
- Data Security and Protection Toolkit Audit 2018-19 – Lancashire Coding Collaborative

2.5 Complaints Management

Feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, individually and for the wider NHS, as well as contributing to a culture of learning from experience.

Patients, relatives and carers are encouraged to communicate any concerns to staff with the aim of addressing those concerns immediately. The Trust has adopted the principles of good complaints handling, as set out by the Parliamentary and Health Service Ombudsman and which reflect the Trust's own vision and values as follows:

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

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

The Trust Board acknowledges the importance of listening to patients' stories directly. As a result, these are now presented at Trust Board meetings.

Complaints Review Panels are held quarterly – this is an in depth review of a randomly chosen complaint to ensure that a robust complaints process has resulted in a thorough and complete investigation, an open and honest response, appropriate action and monitored learning. The outcome of the meetings is reported to the Patient Experience Group and provides assurance regarding the Trust Complaints Procedure and has led to improvements in the process.

The Customer Relations Team deals with concerns raised formally and informally, ensuring that individual concerns are addressed effectively and lessons are learnt from the issues raised. During 2018-19, 11352 Patient Advice Liaison Services (PALS) enquiries were received from a variety of sources. The team reports key performance indicators to Executive and Divisional leads to closely monitor concerns raised and to ensure a timely response is provided. The Trust received 348 formal complaints during this period. Complainants are contacted as soon as possibly following raising their concerns.

The current policy ensures that complainants are kept informed and updated and that greater compassion is evident within responses. Further training is being planned to raise awareness of complaints requirements and correct procedures to ensure that complaints are dealt with in a timely and appropriately manner, providing assurance that lessons are learned from complaints across the Trust and themes have been identified. Bi-monthly reports now include more detail of these. The Trust has a Share 2 Care news bulletin ensuring that learning is disseminated to all staff and shared within teams. Complainants have the right to take their complaint to the Parliamentary and Health Service Ombudsman if they remain dissatisfied with the Trust's response. During the financial year 2018-2019, 8 complaints were referred to the Ombudsman, 2 have been partly upheld, 1 was not accepted for investigation, 2 had actions agreed for early resolution (no investigation/report provided) and 3 are currently being reviewed by the Ombudsman.

2.6 Duty of Candour

The Duty of Candour requirement has been implemented within the Trust by the development of a Standard Operating Procedure for the daily tracking and monitoring of the delivery of duty of candour.

A report is published daily and made available to the divisional Quality and Safety Leads, to support clinical teams to deliver the duty of candour regulation requirements to patients in a timely manner. An escalation report is forwarded to the Executive Medical Directorate Team to support a resolution of issues and the delivery of duty of candour. Oversight of the effectiveness of this procedure is vested in the Medical Director and the Associate Director for Quality and Safety with assurance reports to the Trust's quality committee. An e-learning training package for Duty of Candour has now been developed and available on our Trust's learning hub for all staff to access.

2.7 NHS Staff Survey Results

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

Indicator	Question	% Result
KF21 (Q14)	Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Workforce Race Equality Standard 1	85.2%
KF26 (Q13c)	In the past 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	17.6%

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

3.1 Achievements against Trust Quality Priorities

No	Quality Priority Aim	How achievement will be measured	How achievement will be monitored	Achievement at year end
1	Implementation of a Trust wide approach to improve the recognition and the response to the deteriorating patient	Mortality/ Cardiac Arrest/ Deteriorating Patient score card	Monthly Deteriorating Patient Steering Group reports to bi-monthly Patient Safety & Risk Assurance Committee	Sepsis • Maternity sepsis bundle in use in maternity with monitoring of compliance in place • Neutropenic sepsis bundle has been revised and in use • Click the clock is now available and has been promoted for both adult and paediatric inpatient areas and ED. • Sepsis edition of Share to Care published in December 2018
				Early Warning Score (EWS) • Maternity EWS (MEOWS) in use • E-EWS planned for 2020 as part of the Cerner project • New Clinical observation policy agreed and approved
				Acute Kidney Injury (AKI) • AKI bundle revised and in use across the Trust • AKI bundle data collection has reviewed and supported by the Acute Care team AKI lead. AKI 3's being collected to look at reasons for deterioration and bundle compliance • Support from Acute Care Team (ACT) HCA's is now in place to action AKI 3's earlier • Overall AKI Care Bundle usage has increased by 6% from November 2017 – November 2018 (63%). There was an overall improvement in October 2018 when the revised AKI Care Bundle was initially launched • AKI Patient Information Leaflet launched in January 2019 • AKI Share to Care published in May 2018
				Fluid balance • The fluid balance change package is now available on the Learning Hub (communicated to all Matrons) • IV Fluids – Pilot under review to look into using the ward based pharmacists to educate and continually improve IV fluid management • Fluid Balance Share to Care published in May 2018 • Establishing a Fluid Stewardship group to look at whole process of management, prescribing and procurement of fluid balance to continue to drive improvements

No	Quality Priority Aim	How achievement will be measured	How achievement will be monitored	Achievement at year end
2	Discharge	Implement a Trust-wide approach to support safe discharge to continuing care	Regular assurance report to the Model Ward Steering Group	• Much of this work is developed and coordinated as part of the Pathways & Process Sub-Group of the Model Ward programme • The Trust has introduced the SAFER patient flow bundle and the concept of the 'Golden Patient'. A scoping exercise provided baseline evidence of the effectiveness estimated date of discharge (EDD) at admission. A key focus of SAFER on the need to effectively use EDD in planning and delivering patient activity, and managing timely discharge. Golden Patients are identified on a daily basis as those applicable for early discharge. This has resulted in reduced Length of Stay, fewer patient transfers/bed moves, better recovery for the patient and improved flow • A programme of work focusing on the transfer of patients from wards to their destination commenced in Q3 2018/19. This seeks to reduce the number of substantiated safeguarding alerts particularly related to unsafe discharge
3	Safe Transfers of Care	Implement a Trust-wide approach to improve staff and patient handover between care areas and organisations	Regular assurance report to the Model Ward Steering Group	• This work is developed and coordinated as part of the Pathways & Process Sub-Group of the Model Ward programme • Launch of programme based on improving the Admission pathway. Diagnostic phase identified that handover from AMU to wards can, at times; take between 5 to 60 minutes of staff time over the telephone. Test of change to work closely with system support for EPTS and others to develop an electronic hand over only, for 80% of patients, by the end of March 2019
4	Falls	To reduce the number of inpatient falls by 20% by 2020	Falls Dashboard; Monthly Falls Steering Group reports to Patient Safety and Risk Assurance Committee	• Previous aim has been accomplished • A new aim has been agreed – reduction of falls by 20% by year 2020 • Bi-monthly Strategy Falls Group Meeting continuing to meet, scrutinise the data and provide challenge/support to areas • New Falls Lead Nurse in post • Compliance results from the 2018 Falls Change Package audit distributed to all wards, along with action plans for the wards to complete as a QI project

3.2 Sign Up to Safety

Sign up to Safety is a national patient safety campaign announced by the Secretary of State for Health and launched in June 2014.

Its mission is to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Trust signed up to the campaign at its inception and the following tables show the progress that has been made so far and the Trust's plan for its future implementation.

Achievements

Aim	Key Achievements to 31 March 2019
Falls Reduction To reduce the number of inpatient falls across all inpatient areas at East Lancs Hospitals NHS Trust by 20% by year 2020	• New aim has been agreed – reduction of falls by 20% by year 2020 • All project documentation in place • Bi-monthly Strategy Falls Group Meeting continuously review and act on incidents relating to slips, trips and falls • Revised 'Falls Dashboard' produced and shared with wards on a monthly basis, including metrics such as number of falls, time/ frequency of falls, time between falls • Falls incident rates continue to be used to track improvement • Change package now at full spread in ELHT, monitored via Ward Assurance Checklists, Nursing Assessment Performance Framework (NAPFs) and the Falls Prevention Steering Group • Compliance results from Falls Change Package audit conducted in June/July 2018 have now been distributed to all wards, along with action plans for the wards to complete as a QI project • Falls collaboration outcome video produced which shares a patient and family story and provides guidance for wards and departments • Direct training and guidance is provided for wards and departments
Deteriorating Patient Improve the recognition and response to acutely deteriorating patients with a resultant decrease in unexpected cardiac arrests by 50% by January 2018 To improve the recognition and timely management of sepsis in the emergency department and acute admissions unit Improve the recognition and management of AKI and reducing avoidable harm by decreasing the % of patients who develop AKI 2 and 3 during their Hospital stay after 48 hours	Sepsis • Maternity sepsis bundle in use in maternity with monitoring of compliance in place • Neutropenic sepsis bundle has been revised and in use • Click the clock is now available and has been promoted for both adult and paediatric inpatient areas and ED • Sepsis edition of Share to Care published in December 2018 EWS • Maternity EWS (MEOWS) in use • E-EWS planned for 2020 as part of the Cerner project • New Clinical observation policy agreed and approved

Aim	Key Achievements to 31 March 2018
	AKI • AKI bundle revised and in use across the Trust • AKI bundle data collection has reviewed and supported by the Acute Care team AKI lead. AKI 3's being collected to look at reasons for deterioration and bundle compliance • Support from Acute Care Team HCA's is now in place to action AKI 3's earlier • Overall AKI Care Bundle usage has increased by 6% from November 2017 – November 2018 (63%). There was an overall improvement in October 2018 when the revised AKI Care Bundle was initially launched • AKI Patient Information Leaflet launched in January 2019 • AKI Share to Care published in May 2018
	Fluid balance • The fluid balance change package is now available on the Learning Hub (communicated to all Matrons) • IV Fluids – Pilot under review to look into using the ward based pharmacists to educate and continually improve IV fluid management • Fluid Balance Share to Care published in May 2018
Safer Surgery To improve the safety culture in theatres through the use of the '5 Steps to safer surgery' for all planned/ elective operating lists and all patients to have a quality brief/debrief and a compliant WHO checklist completed	• Surgical Team Leadership Programme rolled out to support the required cultural changes • Scenario based learning sessions, following any incidents and round table events, help embed the safety culture into everyday practice/ situations • A '5 steps to safer surgery' training programme has been developed for all staff who are involved or take part in the WHO checklist • Brief/Debrief forms have now been standardised across all sites • Quality checks of the Brief, Debrief and WHO Safety Checklist • Standardisation of Swab count boards in all theatres • Brief Boards are in situ and used in all theatres • Loop TV screens are now operational. These share any policy updates, leaning from incidents and other safety related information

Aim	Key Achievements to 31 March 2018
Still Births Reducing stillbirths forms part of the 'Saving Babies Lives: Care Bundle for Reducing Stillbirth and Neonatal Death' CQUIN.	In 2018, there was an overall reduction in the number of stillbirths at ELHT – 31, compared to 32 stillbirths in 2017 and 40 in 2016 All stillbirths within ELHT continue to be subject to: - A Primary Review which is undertaken within the first 24-48 hours by an Obstetric Consultant and Senior Midwife, to identify any immediate issues with care or service delivery - Reporting via the Datix system - Further review by the Perinatal Lead Consultant and Bereavement Midwife - National reporting via the MBRRACE database - Reporting through Mortality Steering Group - Presentation and multidisciplinary review at the monthly multidisciplinary perinatal mortality meetings - All term stillbirths (over 37weeks gestation) are also reportable to the Health Safety Investigation Board (HSIB) who will undertake an independent investigation • Continued development and growth of the 'Placenta Clinic', with a second consultant now trained in undertaking a 'placenta screen' • ELHT Maternity Services Clinical Guideline 68 version 2.0: Detection and Management of Fetal Growth Restriction (2017) has been reviewed and revised to help identify women at risk of fetal growth restriction at the beginning of pregnancy and provide further clarity for midwives • Funding has been secured to train two additional Midwife Sonographers, increasing the support available for women with a suspected fetal growth concern during pregnancy
Hospital Acquired Infections Prompt To Protect – To improve the rates of hand hygiene across the Trust (all areas) by 20%	• Prompt to Protect uses a wide approach of promoting no blame culture, prompting colleagues to quickly identify actions/patients who might need isolation/intervention, monitoring lines & promoting safety • The testing stages for Prompt to Protect have been very successful with some strong tried and tested interventions being formed as part of it • Change package developed and being undertaken by Emergency Department, C3 and C10 • AMU A, C2, C5, C9, C11, C14A/B, C18 and Rakehead have all completed the programme – all made improvements in hand hygiene, environment and safety culture on the ward
Nutrition & Hydration Reduce risk of patients becoming malnourished: 1) 95% of adults to be screened for malnutrition within 24 hours of admission 2) 95% patients re-screened for Malnutrition every 7 days	• NHSI led Nutrition Collaborative commenced • MUST training e-learning package now available on the Learning Hub • New MUST form created for use within Extramed (EPTS) system, a go live date expected in early 2019

Aim	Key Achievements to 31 March 2018
Medication Errors Reduction of Medicines Omissions especially for critical medicines Reduction in dosing errors with Insulins	• A reporting dashboard to monitor and track medicines omissions through incident reporting has been developed • QI plan for reduction of Parkinson's drugs omissions is in progress • Peri-operative medicines management guidelines have been prepared and expanded to include wider issues such as anticoagulation following review in Anaesthetics • Guidance on managing red Flag drugs when the oral route is unavailable has been published and disseminated • Datix incident report for medicines incidents has been expanded to record medicine name and Red Flag status • Extension of Dedicated Ward Pharmacy system has demonstrated increasing performance in the Trust in for Medicines Reconciliation of all eligible admissions clinically checked by Pharmacist • The QI project looking at reducing insulin medication errors through introduction of a comprehensive insulin prescribing booklet is being piloted • Medicines Safety Share 2 Care published in July 2018 Extension of Dedicated Ward Pharmacy system is demonstrating increasing performance in the Trust in for Medicines Reconciliation – 66% of all eligible admissions clinically checked by Pharmacist in Oct 2018

The Future

Priority	Future Plan
Falls	✓ Aim to reduce the number of inpatient falls across all inpatient areas at East Lancs Hospitals NHS Trust by 20% by year 2020 ✓ Building on the achievements following the original Sign up to Safety Plan and having met the aim of 15% reduction, the updated aim will focus on falls reductions across the whole Organisation and will also focus on falls in general (not just falls with harm) Rationale ✓ Identified as an improvement priority in our Quality Strategy ✓ Part of our Harms Reduction Programmes ✓ In line with NICE clinical guidance 161 falls are the most common & serious problem ✓ Most expensive cost to the NHS (approximately £2.3 billion per year) ✓ One of the highest reported patient safety incidents at East Lancashire NHS Trust ✓ Common Complication: The risk of falling is greater in hospital than in the community setting due to acute illness, increased levels of chronic disease and different environments
Deteriorating Patients	✓ The Deteriorating Patient Project document has been revised to realign the aims and goals of the project over the next 2 years, incorporating Early Warning Scores, Sepsis, AKI, Fluid balance, IV fluids and Bedside handovers ✓ Improve the recognition and response to acutely deteriorating patients with a resultant decrease in unexpected cardiac arrests ✓ Improve the recognition and subsequent timely management of sepsis in the emergency department and acute admissions units so that standardised mortality for sepsis is within the expected range ✓ Improve the recognition and management of AKI and reducing avoidable harm by decreasing the amount of patients who develop AKI 2 and 3 during their Hospital stay after 48 hours Rationale ✓ Failure to act or recognise patient deterioration was identified as the most frequently occurring type of incident in thematic reviews of NRLS data (NRLS 2014) ✓ Recognising and responding to deteriorating patients is one of the Trusts main Quality Improvement priorities for the Harm free Care programme ✓ Failure to recognise patient deterioration is a common cause of patient harm (NHS England) ✓ Over 123,000 people in England suffered from sepsis, and estimates suggest that there are around 37,000 deaths per year associated with it (NHS England 2015) ✓ Sepsis costs the NHS £2 billion per year (Gov.uk 2015) ✓ 100,000 deaths in secondary care are associated with AKI & 1/4 to 1/3 have potential to be prevented

Aim	Key Achievements to 31 March 2018
Reducing Stillbirths	✓ Reducing stillbirths forms part of the 'Saving Babies Lives: Care Bundle for Reducing Stillbirth and Neonatal Death' Rationale ✓ Fetal growth restriction is associated with stillbirth, neonatal death and perinatal morbidity ✓ Part of our Harms Reduction Programmes ✓ NHS set out a national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020 ✓ MBBRACE perinatal enquiry showed how undetected poor fetal growth is a factor in stillbirth ✓ Evidence and experience tells us more must be done to tackle stillbirths in England
Safer Surgery	✓ To continue to improve the safety culture in Theatres through the use of the '5 Steps to safer surgery' for all planned/ elective operating lists and all patients to have a quality brief/debrief and a compliant WHO checklist completed Rationale ✓ Over 9 million surgical related incidents per year ✓ Part of our Harms Reduction Programmes ✓ Forms part of never event guidance (NHS England) ✓ WHO checklist forms part of national requirements ✓ New national safety standards for invasive procedures

Each of the aims outlined above have common improvement drivers:

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

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

3.3 Achievement against National Quality Indicators

3.3.1 Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) was introduced by the Department of Health in 2011-12 and reports on risk adjusted ratios of deaths that occur in hospitals and up to thirty days after discharge, divided by the number of deaths that were expected given the size of the Trust and other factors such as the patient's age, method of admission and underlying medical conditions.

The latest published SHMI trend data up to September 2018 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	Rolling 12 months to Sep-18
East Lancashire NHS Trust SHMI Value	1.069
East Lancashire NHS Trust % of deaths with palliative care coding	31.4
East Lancashire NHS Trust SHMI banding	2 (as expected)
National SHMI	100
Best performing Trust SHMI	0.692
Worst performing Trust SHMI	1.268
Trust with highest % of deaths with palliative care coding	59.5
Trust with lowest % of deaths with palliative care coding	14.3

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

Our process requires that all deaths in alerting diagnostic groups, low risk deaths and a proportion of deaths following readmission are subject to a structured judgement mortality review, followed by a secondary review where appropriate.

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

- Increasing awareness of mortality ratios across the Trust
- Improving reliability of care by introducing further care bundles and improving compliance rates
- Improving the current mortality review process, to ensure risks identified are investigated and key themes are identified and acted on
- Reducing health care acquired infections
- Improving the response to the deteriorating patient
- Alerting conditions are identified and subject to internal audit. Where cause is not identified, external review is requested.

In 2017-18 these actions will be consolidated and fully embedded within the Trust. This will be supported by the introduction of systematic audit and performance management.

3.3.2 Percentage of Patient Deaths with Palliative Care Coding

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator.

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

East Lancashire Hospitals NHS Trust percentage of deaths with palliative care coding	31.4%
National percentage of deaths with palliative care coding	33.6%
Trust with highest percentage of deaths with palliative care coding	59.5%
Trust with lowest percentage of deaths with palliative care coding	14.3%

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

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

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

- Increasing awareness of mortality ratios across the Trust
- Improving reliability of care by introducing further care bundles and improving compliance rates
- Introduction of the new Structured Judgement Review (SJR) methodology to review clinical care of patients who have died, to ensure risks identified, recorded, investigated, and key themes are identified and acted on in line with National guidance on Learning from Deaths
- Reducing health care acquired infections
- Improving the response to the deteriorating patient
- Alerting conditions are identified and subject to internal audit. Where cause is not identified, external review is requested.

3.3.3 Patient Recorded Outcome Measures

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

The two procedures are:

- Hip Replacement
- Knee Replacement

PROMs measures a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected pre-op and 6 months after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients; this data has been collected by all providers of NHS funded care since April 2009.

The following tables set out the percentage of ELHT patients identified as achieving an 'improved post-operative adjusted average health gain' in comparison with the national figures for both of the PROMs procedures using the EQ-5D measure of health gain. The 'EQ-5D Index' scores are a combination of five key criteria concerning patients' self-reported general health: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

3.3.3.1 Hip Replacement Surgery

Hip Replacement Surgery	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19*
ELHT	87.4%	94.0%	92.0%	91.5%	92.4%	*Insufficient Data
National Average	89.4%	89.5%	89.6%	89.1%	90%	*Insufficient Data

3.3.3.2 Knee Replacement Surgery

Knee Replacement Surgery	2013-14	2014-15	2015-16	2016-17	2017-18*	2018-19*
ELHT	78.6%	84.5%	85.3%	83.4%	82.9%	*Insufficient Data
National Average	81.4%	81.0%	81.6%	81.1%	82.6%	*Insufficient Data

**PROMs outcome data for 2018-19 is not currently available on NHS Digital by Hospital/Provider and there is insufficient data both at a local level to chart improvement rates for these procedures and measures.*

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

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

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

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

- A verbal request sheet has been scripted to ensure standardisation of information given to maintain and improve participation rates.
- Ensuring the process at pre-assessment is checked on a weekly basis to maintain and improve on current figures where required.
- Random spot checks to be continued to prevent a decline in participation rates, feedback will be given on a weekly basis to the Pre-op assessment coordinator via email.
- If a questionnaire is not completed at pre-op assessment then the Surgical Day Unit (SADU) will aim to complete.

3.3.4 Readmissions within 28 Days of Discharge

The following table sets out the Trust's performance during 2018-19 for emergency admissions within twenty-eight days of discharge.

We have used Dr Foster data which provides national benchmarking from the National Hospital Episodes Statistics data. The Health and Social Care Information Centre (HSCIC) do not provide data on readmissions at the level of detail required. Figures shown are as at 11 Apr 19.

All Ages	2013-14	2014-15	2015-16	2016-17	2017-18	2018/19 (Apr-Sept)
Readmission Rate	8.40%	8.74%	8.79%	8.44%	8.30%	8.16%
Age Band	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018/19 (Apr-Sept)**
0-15	11.15%	11.22%	12.06%	12.21%	11.75%	10.79%
16+	7.80%	8.19%	8.05%	7.64%	7.54%	7.63%

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 8.16% which is below the Dr. Foster risk adjusted expected rate of 8.7% and has reduced on last year. Compared to local acute hospitals, the Trust is middle of the group and the rate is lower than the national rate of 8.7%.

- For the 0-15 age group, the rate is 10.79% which is higher than the expected rate of 9.93% and the national rate of 8.9%.
- For the 16+ age group the rate is 7.63% which is below the expected rate of 8.50% and better than the national rate of 8.6% 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:

Key actions taken to date to manage readmission rate:

1. Introduction of 'common childhood illnesses' guides, to support parents manage illness and reduce parental anxiety and hence need for support. This is now used by all agencies in East Lancashire so that the same messages are shared and has recently been set up as a mobile phone App.
2. Hot clinics have been set up and are working very successfully, for urgent paediatric consultant input – as an alternative to admission or readmission. Slots are accessed directly from GPs.
3. Telephone advice line for GPs directly accessing a consultant paediatrician – to help GPs manage care in practice rather than referring back to hospital. This is in addition to Advice & Guidance processes.
4. Service QI reviews and subsequent investment in diabetes multi-professional team, respiratory nurse specialists, and epilepsy nurse specialists– to reduce readmissions for specific sub specialist areas.
5. The Community Children's Nursing (CCN) service has been extended so that GPs can refer directly to the CCN rather than hospital for care.
6. 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.
7. Consultant presence in COAU extended until 10pm Monday - Friday – to support more senior decision making.
8. Extended Community Children's Nursing service to a longer day / 7 day service (was previously Mon-Fri 8am-6pm service).
9. Discharge process tightened so that all discharges are reviewed at Consultant level.

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

1. A pilot of a Children's Hub – which is a multi-disciplinary community hub is on-going – which has shown initial reduction in admissions and need for secondary care interventions.
2. Development of a new Assistant/Advance Practitioner for self-management of key chronic conditions where children and parents can get advice and support and directly contact the specialist team for advice. This is being piloted in diabetes services and includes guidance on managing acute episodes, sick day rules etc. for parents to avoid admissions and readmissions.
3. A review of the top 5 reasons for admission and comprehensive review of 5 clinical pathways to improve flow and support discharge, thus reducing readmission. Care pathways for croup, bronchiolitis, fever in under 5's and gastroenteritis established across primary and secondary care. An asthma pathway has also been developed in Emergency Department. The new pathways are being launched across GPs, primary and community services and the hospital in April 2019.
4. A further epilepsy nurse specialist starts in May 2019, 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.
5. Investment in Allergy specialist nursing is planned for Spring 2019, so that children and families with severe allergies can be managed safely at home and avoid admission and readmission for acute episodes.
6. Development of Advanced Paediatric Nurse Practitioners and joint workforce with Emergency Department so that children re-attending hospital after admission are supported on arrival and do not need further admission.
7. Establishment of 'Patient Trigger Reviews' so that parents can contact the department directly for an outpatient consultation after admission/last appointment. This allows parents control on required further help and advice and offers a more suitable alternative to readmission.

3.3.5 Responsiveness to Personal Needs of Patients

Quality Health was commissioned by East Lancashire Hospitals NHS Trust to undertake the Inpatient Survey 2018.

A total of 1250 patients from East Lancashire Hospitals NHS Trust were sent a questionnaire. 449 returned a completed questionnaire, giving a response rate of 38%. This is an increase on the response rate for the 2017 survey which was 33%.

Overall, feedback is consistent with the findings of the 2017 survey. However, Quality Health has identified the following issues for the Trust to consider:

The Accident and Emergency Department:

- Provision of regular and updated information given to patients about their condition and/or treatment in A&E.
- Privacy for patients when being examined or treated.

Waiting list or Planned Admission:

- Changes of admission dates by the hospital.

All types of admission:

- Long waits to get a bed on a ward.

The Hospital and Ward:

- Food rated as only fair or poor.
- High levels of noise from other patients at night.

Doctors:

- Communication between doctors and patients; patients not fully understanding answers to questions given by doctors.
- Acknowledge and included patients in all conversations which are around them and their care.

Nurses:

- Acknowledge and included patients in all conversations which are around them and their care.

Care and Treatment:

- Conflicting information given to patients.
- Involvement of patients in decisions about their care and treatment.
- Quality and simplicity of written information available to patients regarding their condition or treatment.
- Privacy when discussing condition or treatment with patients.
- Poor pain control on wards.

Operations and Procedures:

- Information and explanations to patients about what surgery entails, before, during and after, including anaesthesia and its effects.

Leaving Hospital:

- Discussions with patients about any additional equipment or adaptations they may need at home after leaving hospital.
- Involvement of patients in decisions about their discharge from hospital.
- Care plan on discharge which includes: the name of the person coordinating the care plan, when and how often support will be provided, who will be responsible for providing support and how to contact them.
- Information about danger signals to watch for after discharge and what to do if patients are concerned or worried.

Overall:

- Patient feedback methods and information about how to complain.
- Information to patients about suitable research studies.

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

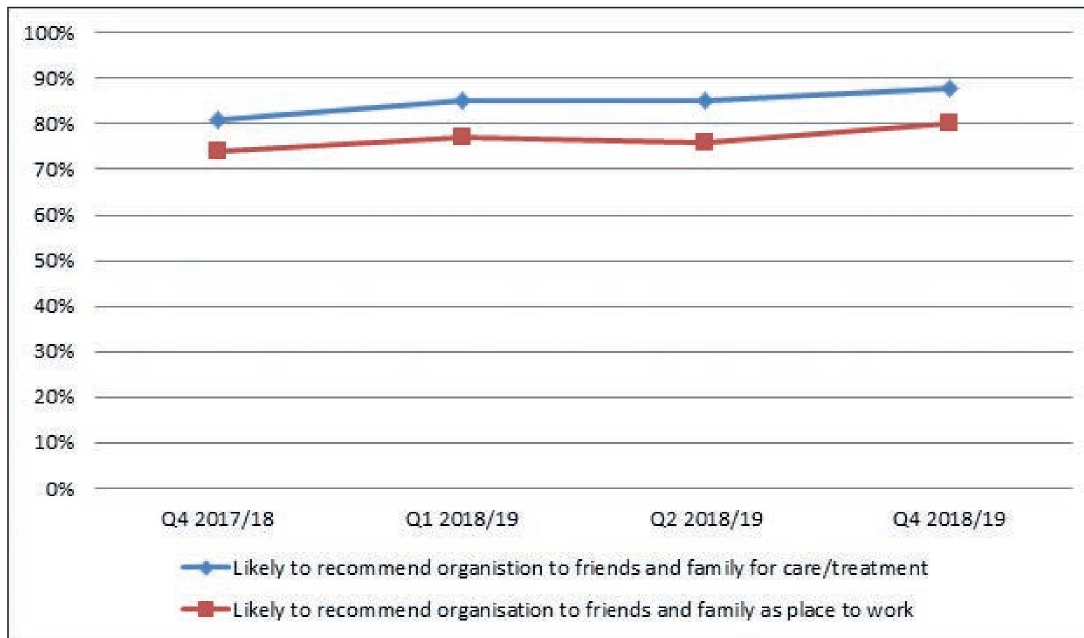
- Continued effort is required to engage and listen to the care experience of patients, their carers and families and to respond to this feedback.
- National challenge around the increase in numbers of patients attending Emergency Departments and requiring admission.

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

- ELHT is using continuous improvement practice, in delivering the model ward programme; striving to provide standardised quality in-patient care which is valued by patients, carers and the community we serve.
- The development of a new single Acute Medical Unit system of care which will improve timely access to Senior Medical Staff for patients, reduce unnecessary admissions, shorten length of stay and provide a more positive staff and patient experience.
- The ongoing development of 'Always Events' within the Trust based on feedback from patients about 'what matters' to them.
- Continue to engage and work with our patients, their families and carers around our provision of services to maintain the quality delivered.
- The establishment of a Public Participation Panel which will support the Trust in helping our services reflect the needs of and view of the people using them. The panel will be involved in supporting patient led change throughout the Trust, with a particular emphasis on ensuring that the views of patients and carers are considered.
- Development of a Trust-wide and Divisional action plan to address the issues raised and which will be monitored by the Patient Experience Group.

3.3.6 Recommendation from Staff as a Provider of Care

The data made available to the East Lancashire Hospitals NHS Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This provides an indication of whether our staff feel the Trust provides a positive experience of care for our patients.



The quarter 4 results of the staff friends and family test reflect that 88% of staff respondents would recommend the Trust as a place to receive care during the reporting period. The quarter 4 results of the staff friends and family test reflect that 80% of staff respondents would recommend the Trust as a place to work during the reporting period.

The Trust scored 3.93 for the overall staff engagement score on the 2018 national staff survey which is significantly above the national average of 3.80 for UK acute Trusts in 2018. The national staff survey also highlighted that ELHT remains in the best 20% for staff satisfaction with the quality of work and care they are able to deliver outlined in the key themes of the National Staff Survey.

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

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

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

- Continuing to deploy the Employee Engagement Strategy to drive further improvements in staff experience and engagement.
- Continuing focused work on the ten key enablers which have been identified to enhance levels of employee engagement together with the additional three behavioral indicators used to demonstrate high employee engagement levels.
- Continuing to promote, gather, analyse and action staff suggestions, involvement and feedback from employees within the organisation.
- Continue to progress the discovery, design and delivery phases of the ELHT Compassionate and Inclusive Culture and Leadership Programme to further enhance the organisation as a great place to work and provider of high quality compassionate care.
- Continuing to monitor and review our approach to employee engagement and culture and leadership through the employee engagement sponsor group chaired by the Chief Executive to ensure the Trust is an exemplar of best practice in this field.

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

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

The question that is asked is: 'How likely are you to recommend our service to your friends and family if they needed similar care or treatment'? Patients are invited to respond to the question by choosing one of six options ranging from extremely likely to extremely unlikely. Currently inpatients, including surgical day case attenders, accident and emergency attenders, maternity, outpatient attenders and community service users are asked this question.

The following table sets out the East Lancashire Hospitals NHS Trust's response rates for inpatients and accident and emergency attenders, and also how these results compare with other Trust's nationally for the period April 2018 to March 2019.

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Inpatient % patient response rate												
ELHT	49	36	42	49	50	48	54	47	43	46	45	45
Nat Ave	24.9	25.6	25.2	25.2	25	24.7	24.9	24.6	22.2	24	24.6	24.6
A&E % patient response rate												
ELHT	49	36	42	49	50	48	54	47	43	46	45	45
Nat Ave	24.9	25.6	25.2	25.2	25	24.7	24.9	24.6	22.2	24	24.6	24.6
Combined inpatient and A&E patient response rate												
ELHT	33	24	29	30	31	32	33	31	28	30	29	29
Nat Ave	Not available											

The following table sets out the percentage of Inpatients and Emergency Department attenders who would recommend the service and how these compare with other Trusts nationally for the period April 2018 to March 2019.

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Inpatient % recommend												
ELHT	98	97	99	97	96	91	95	97	97	97	98	98
Nat Ave	96	96	96	96	96	96	96	96	96	96	96	96
A&E % recommend												
ELHT	84	80	82	81	83	84	84	85	83	84	86	86
Nat Ave	87	87	87	87	88	86	87	87	86	86	85	86
Combined inpatient and A&E recommend												
ELHT	92	90	91	90	90	88	91	92	90	92	93	93
Nat Ave	Not available											

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

Our inpatient response rates regularly exceed the national average as we consider the collection of feedback from our patients to be a high priority; therefore staff are encouraged to collect information from patients.

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

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

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

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

3.3.8 Venous Thromboembolism (VTE) Assessments

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

VTE assessments (2018-19) Data submitted from Trust to NHS UNIFY system. Data access available at: https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201819/ VTE data collection responsibility has moved to NHS Improvement from April 2018		**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Year to Date**
East Lancashire NHS Trust	Number of VTE assessed admissions*	31,749	31,528	32,627	33,527	129,431
	Total admissions	31,945	31,776	32,909	33,789	130,419
	% of admitted patients risk assessed for VTE (rounded to nearest decimal)	99.39%	99.22%	99.14%	99.22%	99.24%
National	Number of VTE assessed admissions	3,576,416	3,664,364	3,714,779	3,687,183	14,642,742
	Total admissions	3,739,865	3,837,335	3,883,669	3,851,296	15,312,165
	% of admitted patients risk assessed for VTE (rounded to nearest decimal)	95.63%	95.49%	95.65%	95.74%	95.6%
Best performing Trust	(The Trusts reporting 100% all have small numbers of admissions)	2 NHS Trusts at 100% ELHT ranked 8th	2 NHS Trusts at 100% ELHT ranked 9th	2 NHS Trusts at 100% ELHT ranked 6th	2 NHS Trusts at 100% ELHT ranked 8th	2 NHS Trusts at 100%
Worst performing Trust		76.26%	74.32 %	74.2%	74.03%	74.2%

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

- Systems and processes are in place at ELHT for risk assessing all appropriate patients utilizing the national VTE risk assessment tool on admission.
- The Trust monitors quarterly VTE performance figures routinely using an electronic system with real time capture of data on admission from Patient Administration System (PAS) and Electronic Patient Tracking System (EPTS).
- Trust VTE performance has consistently improved from just above 95% in 2012, to above 97% since July 2013, above 97.5% since July 2014, above 98% since July 2016 and currently above 98.5% across the first three quarters of 2017/18 and currently above 99% in 2018/19.

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

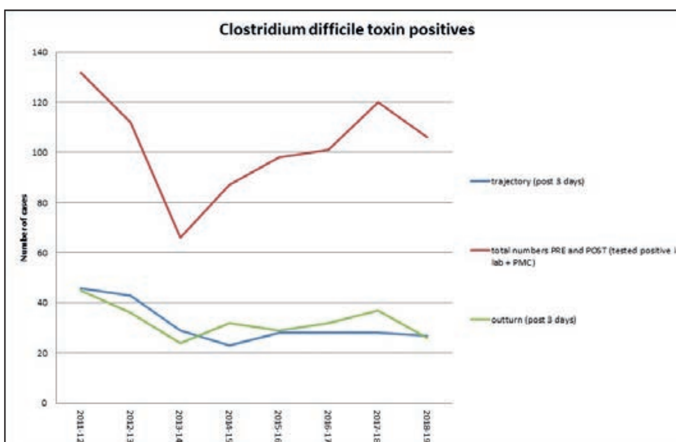
- Monitoring of VTE risk assessment through formal bi-monthly reporting by all divisions through the Trust VTE committee which functions as a sub-committee of the Trust Patient Safety and Risk Assurance Committee (PSRA).
- Each of the Trusts divisions participates in cross organisational clinical audit to ensure effective compliance with VTE assessment.
- VTE Quality Improvement Faculty developed in 2016 leads on focused quality improvement projects to enhance the robustness of the VTE risk assessment on admission.
- Trust has invested in developing an electronic VTE risk assessment tool through Hospedia system based on the National Tool and this development phase is now complete with further initial testing phase completed in April 2018. Pilot phase of implementation of the electronic VTE tool was completed in June 2018 and full trust wide implementation commenced from 22/3/2019.
- Trust VTE prevention Information leaflet for patients has been updated again to enhance patient awareness regarding VTE and prevention and patient involvement in VTE prevention strategies including Risk assessment on admission and made available from April 2019 in three languages namely English, Polish and Urdu.

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 26 clostridium difficile positive which is under trajectory set at 27.

Clostridium difficile toxin positive results 2011/12 – 2018/19



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

Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level. Each case both pre and post 3 days of admission is discussed at the C. difficile multidisciplinary CCG meeting to determine lapses in care.

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

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

3.3.10 Patient Safety Incidents

NHS Trusts are required to submit the details of incidents which involve patients to the National Reporting and Learning System (NRLS) on a regular basis.

The Trust uploads data via the NRLS on a weekly basis. The NRLS publishes Patient Safety Incident Reports by organisation biannually showing comparative data with other large acute Trusts. East Lancashire Hospitals NHS Teaching Trust is able to use this information to understand its reporting culture; higher reporting Trusts usually have a strong safety culture and as such the Trust continues to actively encourage the reporting of incidents and near misses. The information set out in the table below has been extracted from NRLS reports and sets out the Trust's performance over the last six reporting periods. The table also compares the Trust's performance against similar large acute organisations in the cluster data.

	April 2014 to Sept 2014	Oct 2014 to Mar 2015	April 2015 to Sept 2015	Oct 2015 to March 2016	April 2016 to Sept 2016	Oct 2016 to March 2017	April 2017 to Sept 2017	Oct 2017 to March 2018	April 2018 to Sept 2018
Patient safety incidents per 100 admissions									
ELHT number reported	8,190	7,563	6,732	6,579	7,010	7,122	7,032	7,401	6,426
ELHT reporting rate	55.7	48.2	44.18	42.05	44.9	44.8	45.5	46.4	42.0
Cluster average number	4,196	5,458	4,647	4,818	4,995	5,122	5,226	5,449	5,583
Cluster average reporting rate	35.9	31.2	39	39.6	40.7	41.1	43	43	44.5
Minimum value for cluster	35	443	1,559	1,499	1,485	1,301	1,133	1,311	566
Maximum value for cluster	12,020	12,784	12,080	11,998	13,485	14,506	15,228	19,897	23,692
Patient safety incidents resulting in severe harm									
ELHT number reported	29	28	18	16	13	8	14	9	6
ELHT % of incidents	0.4	0.4	0.3	0.2	0.2	0.1	0.2	0.1	0.1
Cluster average number	15.5	17.3	15	13.7	13.4	13.8	13	13.5	13.5
Cluster average reporting rate	0.9	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3
Minimum value for cluster	0	1	1	0	0	0	0	0	0
Maximum value for cluster	74	128	89	85	75	67	92	78	74
Total incidents across cluster	2,168	2,373	2,052	1,862	1,826	1,872	1,821	1,810	1,771
Cluster % of incidents	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.2	0.2
Patient safety incidents resulting in death									
ELHT number reported	3	6	8	8	6	8	2	2	1
ELHT % of incidents	0	0.1	0.1	0.1	0.1	0.1	0	0	0
Cluster average number	4.9	5.2	5	5.7	5	5.5	5	5.3	5.1
Cluster average reporting rate	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Minimum value for cluster	0	0	0	0	0	0	0	0	0
Maximum value for cluster	27	24	22	37	36	31	29	24	22
Total incidents across cluster	683	716	665	780	690	751	661	712	706
Cluster % of incidents	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1

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

The overall number of incidents reported by the Trust over the last three reporting periods has reduced from the previous 3 years. Staff are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared.

The Trust has a comprehensive harms reduction programme supported by Quality Improvement Team and Quality and Safety Unit which from the data shown provides assurance of the reduction in harm. The Trust does however consistently report higher numbers of incidents compared with similar Trusts in the cluster, this demonstrates an open and honest culture within the Trust.

Serious Incident Requiring Investigation (SIRI) Panel has focused on the identification of lessons learned and actions taken following review of serious incident investigations to ensure services are improved and harm is reduced. The Trust is not an outlier in terms of severe harms and deaths due to patient safety incident.

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

- Embedding the new 1 day Introduction to Human Factors Training across the Trust and linking with simulation training
- Further investment in incident reporting training to new and existing employees
- The availability of an electronic Duty of Candour training package available to all staff
- Linking root cause analysis training and Human Factors Training to ensure accurate and effective outcomes from investigations
- Linking of the complaints process to incidents process to ensure a combined approach to the investigation of harm
- Linking of incidents with inquests to ensure appropriate escalation and investigation is carried out
- Daily triage of incidents that are reported to review the grading and to ensure an appropriate level of investigation is carried out.

3.3.11 Never Events

A Never Event is a serious incident that is recognised as being entirely preventable if all the correct guidance is followed and all our systems work to create a safe situation for patients and staff.

Over 2018/2019 the Trust has reported 2 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Overdose of insulin due to abbreviations or incorrect device	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	1

Each incident above has been investigated and in all incidents we found important learning that has been shared with staff across the Trust, with our commissioners and the patient and/or family.

- Detailed action plan for each incident own by divisions, updated and assurance provided to Executive Management Team on a weekly basis
- Outcome of investigation is shared with the patient and/or family members
- NHS/PSA/D/2016/009 – Medical Air Flow Meters revisited and assurance provide to Trust Board that all patient safety alert actions completed

Learning from Never Event Incidents

On seven occasions within 2018-19 the Trust has not met the expectations of Safe, Personal and Effective care in regards to Never Events. The Trust has identified a number of key changes in systems and processes within teams and across the organisation. These include:

- A new and more robust process has been introduced (including updating Trust Policy) to ensure that National Patient Safety Alerts (NPSA) are communicated and actioned in full and assurance provided and monitored at Patient Safety and Risk Committee which reports to the Trust Board.
- The Trust has introduced second checks in insulin dosing and the Medicines Policy / SOP updated and communicated with staff.
- Patient Safety Alert (NHS/PSA/W/2016/011) 'Risk of severe harm and death due to withdrawing insulin from pen devices' reviewed and circulated to all divisions. The alert has also been highlighted within the Trust Share2Care leaflet on Human Factors to help communicate the importance of following the actions within the safety alert.

3.3.12 Learning from Deaths

Throughout 2018/19 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 (based on SJR methodology) is triggered to determine whether or not this poor care contributed to the patient's death. If this is felt to be the case a full Root Cause Analysis (RCA) of the case is undertaken and presented to the Trust's Serious Incident Requiring Investigation (SIRI) Panel.

The number of trained SJR reviewers has increased throughout the year and as a result the review of deaths in the targeted groups has become more timely. The identification of cases to be reviewed follows the processes identified within 'Learning from Deaths'.

Not every death is subjected to an SJR; the primary reasons for triggering an SJR are listed in the trusts learning from deaths policy. In 2019 it was noted that 69% of SJR's were triggered because of a readmission. Of these only 4 out of 368 were scored as a 1 or 2 at SJR 2, which provided assurance to the trust that re admission was not a risk for poor care and death. Subsequently it was decided to remove this category from the reasons to trigger an SJR in order to focus more on alerting groups such as sepsis.

Breakdown of deaths in 2018-19 and number of completed SJRs for this time period.

	Completed	2018-19	
Total number of deaths 2018-2019	Q1	461	
	Q2	443	
	Q3	466	
	Q4	505	
Total		**1,370**	
Number of SJR Stage 1 & 2s completed by the quarter the SJR was completed		**SJR 1**	**SJR 2**
	Q1	2	0
	Q2	23	1
	Q3	48	5
	Q4	130	8
Total		**203**	**14**
Number of SJR Stage 2 cases where issues with care may have contributed to death (SJR Stage 2 score 1 or 2) completed 2018-2019		**SJR 2**	
	Q1	0	
	Q2	1	
	Q3	1	
	Q4	5	
Total		**7**	

Breakdown of SJRs completed in 2018-19 for the deaths in 2017-18.

	Completed	2018-19	2018-19
Number of 2017-18 SJR Stage 1 & 2s completed in 2018-19		SJR 1	SJR 2
	Q1	55	8
	Q2	66	6
	Q3	31	5
	Q4	27	1
Total		179	20

	Completed	2017-18
Number of 2017-18 SJR Stage 2 cases where issues with care may have contributed to death (SJR Stage 2 score 1 or 2) completed in 2018-19		SJR 2
	Q1	4
	Q2	3
	Q3	0
	Q4	0
Total		7

- 179 case record reviews and 20 investigations completed after 17/18 which related to deaths which took place before the start of the reporting period.
- 2 representing 0.10% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been calculated by counting the number of SJR's which led to full RCA investigations whereby the outcome was deemed to have contributed to the patient's death.

- 2 representing 0.15% of the patient deaths during 18/19 are potentially judged to be more likely than not to have been due to problems in the care provided to the patient, due to RCA investigations outstanding.

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

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

i. Fluid balance

ii. Management of Acute Kidney Injury

iii. Timeliness of antibiotic administration (sepsis patients)

iv. Recognition and response to the deteriorating patient

v. Decision making at the end of life

These themes are collated with learning from other clinical governance functions/claims, complaints, incident reviews) and help to inform the Harms Reduction and Quality Improvement Projects. Section 3.1.2 and 3.1.1 of the Quality Account describes what achievements have been made against areas of learning and what future improvement plans the Trust will be focusing on in 2019/20.

3.3.13 Seven Day Service Meeting the Clinical standards

East Lancashire Hospitals self-assessment of care in line with the NHS 7 day priority standards shows:

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

- For February 2019 within Medicine 76% of acutely admitted patients are seen by a consultant within 14 hours of admission, with 81% on weekdays and 65.5% at weekends.
- The target of 90% is met for all patients admitted between 8pm and midday, 7 days a week. Whilst this is a reduction from 88% achieved in April 2018, we have increased consultant delivered ambulatory emergency medical care with 20 additional patients per day being discharged within 14 hours, 7 days a week.
- In Surgery on average 73% of patients had consultant review during weekdays and 66.5% at weekends, an improvement from 47% overall in April 2018.
- In Paediatrics 65% of children had consultant review with 14 hours (66% in April 2018), this was 60% at weekends and 66.5% on weekdays.
- The standard of 90% is fully met for vascular surgery.
- Stroke services have continued to improve from October to December 2018 81.5% of patients had consultant review within 14 hours of presentation, including 43.5% before admission, This has improved from 64.1% in in Q2 2018. as demonstrated by SSNAP data.

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

- East Lancashire Hospitals is fully compliant with this standard.

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

- East Lancashire Hospitals is fully compliant with this standard.

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

- On weekdays 98.4% of in patients have daily consultant review. This falls to 44.5% at weekends.
- Numbers of patients designated by consultants as not needing review at weekends is 24% on Saturdays and 41% on Sundays.
- For patients requiring twice daily review that meet level 2 or 3 criteria, this is achieved 80% of the time on weekdays and 50% of the time at weekends
- Additional consultant appointments have been made in Surgery and would be required in Paediatrics to meet standard 2. Extended consultant shift hours would be required in Medicine.

Significant increases in weekend multi-professional working has been delivered within Medicine during the winter period, increasing weekend discharges.

3.3.14 Staff can speak up

ELHT is committed to ensuring the highest standards of service and the highest ethical standards in delivering this service.

The Freedom to Speak up (Whistleblowing) policy (HR20) is in place to support and assist staff in raising concerns without fear of discrimination or reprisal. ELHT will deal with all disclosures consistently, fairly and confidentially. Anyone who works (or has worked) in for East Lancashire Hospitals NHS Trust can raise concerns under this policy. This includes agency workers, temporary workers, students, volunteers and governors.

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

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

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

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 high level information about all concerns raised by our staff and what actions are being taken to address any problems.

3.4 Other Quality Achievements

3.4.1 Refer to Pharmacy reduces unnecessary prescriptions, saves time and reduces errors

Refer-to-Pharmacy is business as usual in Pennine Lancashire. It's now in its 4th year of use.

It allows the hospital pharmacy team to refer patients directly to their community pharmacist or the medicines support team for post-discharge pharmaceutical support. Hospital Admission Notifications are sent to prevent unnecessary dispensing activity whilst a patient is in hospital. We refer 700-800 people/month.

In the last year from the outcome reporting tool:

- over 200 safety incidents have occurred where pharmacists have prevented unintentional GP prescribing errors making it through to patients
- over 1,000 items have not been dispensed i.e. prescriptions saved
- over 350 hours have been saved by community pharmacies not dispensing whilst their patients were in hospital

referto pharmacy
Get the best from your medicines and stay healthy at home

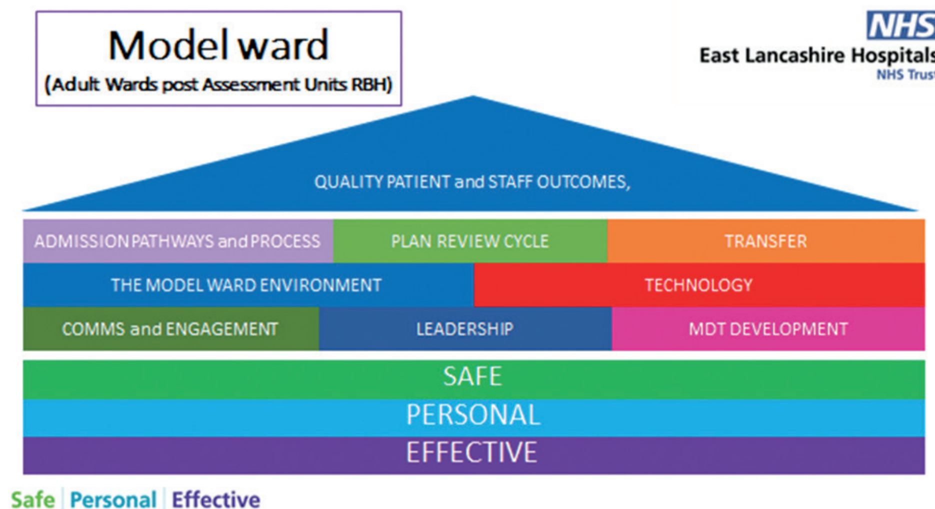
This is the April 2019-March 2019 referral type pattern.

Care Home	Home Visit	Information	MDS (Blister Park)	Medicines Use Review	New Medicines Service	Total
1,597	247	542	3,740	2,328	614	9,068

3.4.2 Model Ward Programme

The Model Ward Programme aims to reduce unnecessary variation in clinical pathways & process and the ward environment; seeking to standardise and streamline in-patient care, where appropriate, allowing staff to work across clinical areas.

It also aims to further develop patient centred team based care; recognising that good leadership, mechanisms for patient and family involvement, excellent communication and clarity of roles will enhance the delivery of that care. It is closely aligned to the SAFER programme.



Recent alignment of the Model Ward Programme with the Vital Signs NHS Improvement Practice has presented opportunity to coordinate activity and contribute to improvement for the Elderly and Frail Pathway, across Pennine Lancashire; with specific focus on specialty care for those patients suffering fracture neck of femur and for all in-patients in making safe transition from ward / unit to destination.

Improvement project plans have been developed and multi-disciplinary cross agency groups established. Improvement events have facilitated a greater level of understanding with regard to the current state, and identified the root cause to a number of issues. A future state is agreed and a solutions plan aims to deliver measured improvement. A ward based measurement dashboard is being developed.

3.4.3 Trust Introduces a Malnutrition Prevent/Screening

The Trust is committed to preventing malnutrition and dehydration of patients in our care. When people are acutely unwell it can be difficult to meet their nutritional requirements as appetite is often affected, combined with the body's need for more nutrients as part of the healing process.

A 12 month quality improvement project commenced in October 2018. With involvement from nursing, dietetics and catering, monthly audits are underway measuring both the quality of malnutrition screening and the volume of food waste – two factors that are important in ensuring we identify patients at risk of malnutrition and provide appropriate support to help people to eat and drink.

There are many variables that can prevent people from eating when they are in hospital and we understand that there is no one-size-fits-all solution; therefore, this project will test and evaluate a variety of service changes across various wards to help ensure that we provide optimal nutritional care.

3.4.4 Trust receives a favourable response to Dedicated Ward Pharmacists

This workforce transformation centres around each ward having their own dedicated pharmacist with the right amount of pharmacy technician support.

The key intervention is that the pharmacist takes part in the consultant-led MDT ward round to ensure safe and effective prescribing occurs and discharge planning is a reality. The pharmacy technicians build the medicines sections of the Transfer of Care discharge letters (saving junior doctors time).

The roll out of the service has been funded in three phases from Autumn 2016, and we are in the final phase of recruitment with all vacancies expected to be filled by late summer. Currently around three quarters of our wards receive the service (the remainder have the traditional pharmacy service with pharmacists and technicians shared between two or more wards).

Many quality improvement sub-projects and (Plan, Do Study, Act) PDSA cycles have taken place around Dedicated Ward Pharmacy. The University of Manchester has just completed a favourable service evaluation of the project; this was funded by Health Education England (HEE) and we are working with them to see how the service model can be spread to other Trusts.

Dedicated Ward Pharmacy
Delivering World-class Pharmacy

3.4.5 Endoscopy Services awarded Join Advisory Group (JAG) Accreditation 2019

The three endoscopy units at ELHT (Royal Blackburn Hospital, Burnley General Hospital and Rossendale Primary Health Care Centre) all successfully achieved continued Joint Advisory Group (JAG) accreditation for 2019.

JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

The JAG accreditation scheme is a patient-centred and workforce-focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

JAG accreditation aims to...

- stimulate continuous improvement in processes and patient outcomes
- strengthen endoscopy services
- provide a knowledge base of best practices
- increase patient confidence in services
- improve the management and efficiency of services
- provide education on better/best practices
- provide comparison with self and others
- enhance the workforce, retention and satisfaction
- increase chances to add to and grow services

To achieve JAG accreditation an endoscopy service must provide clear evidence that they have met all of the JAG standards.

3.4.6 Fetal Medicine Unit supporting other Trusts

On 5 October 2018 antenatal outpatients expanded to create a new Antenatal Wellbeing Unit. This area accommodates the Fetal Medicine Unit, midwife sonography service, antenatal screening and antenatal day assessment unit.

This area allows thorough, prompt assessment of complex pregnancies. Such pregnancies include those at suspicion of growth problems, those with identified abnormalities and assessment of pregnancies complicated by maternal medical conditions. Prior to the estates reconfiguration, these services were limited due to availability of space and resources. The establishment of the new area has brought about a much better patient experience, allowing for timely assessment in a conducive environment. The developing Fetal Medicine Unit has started to take referrals from other Trusts for complex pregnancy problems.

ELHT has been at the forefront of developing a midwife sonography service. Over the past year two further midwives have completed university modules in third trimester ultrasound assessment and working clinically within the new antenatal wellbeing unit. This development has allowed ELHT to offer a 5-day service, meaning babies with suspected growth problems can be assessed very promptly. The midwife sonographers work well within the multi-disciplinary team, integrating with the work of the established placenta clinic. More recently, ELHT has become a training centre for other Trusts in the region wishing to develop a midwife sonography service.

Since March 2018, ELHT have offered fetal genotyping to establish the babies' blood group in pregnant women who are identified as being rhesus negative. Traditionally, all rhesus negative women would have received a prophylactic injection of anti-D (a blood product) to prevent sensitizing the baby, in the event that the babies blood group is different to the mothers. Although we know that 40% of babies will have the same blood group as mother, all rhesus negative women received the injection as previously the blood group of baby could not be established. This meant that almost 350 women per year received unnecessary anti-D injections. In March 2018, fetal genotyping was introduced to tackle this problem. This is a simple blood test from the mother that analyses the babies' blood group from fragments of DNA in the sample. Over a 6 month period, 436 tests were conducted and it was identified that 38% of babies were the same blood group as mothers, meaning unnecessary blood products were avoided in these women. Testing of cord blood after birth has shown no wrong antenatal results. As well as a much improved patient experience, the project has also led to a moderate cost saving for the Trust.

3.4.7 Sentinel Stroke National Audit Programme (SSNAP)

Stroke service provision within ELHT is delivered by a multidisciplinary integrated stroke specialist workforce across the whole pathway, which includes a 23 bedded acute stroke unit (ASU), 24 bedded rehabilitation stroke unit, and the East Lancashire community.

Up until the end of 2015, the trust was consistently at level E on SSNAP (RCP Sentinel Stroke National Audit Programme). During 2016 a multi-disciplinary stroke improvement programme was developed which included:

- Cross divisional bi-monthly operational meetings
- Monthly executive-led commissioner and provider board meetings
- Detailed data analysis to scrutinise performance and reasons for poor results
- Dedicated data inputting support
- Development of a multidisciplinary stroke booklet following the patient's journey from ED, detailing clinical and activity recording guided by SSNAP domains and standards
- Increased staff awareness of SSNAP
- 0-4 hours stroke pathway.

These actions led to a capture of more robust data reporting and a detailed understanding of the quality of service provided. It further identified therapy and nursing workforce issues which impacted on the service delivery and subsequent SSNAP outcomes. The robustness of the data collected and the impact of an internal improvement plan, including a range of QI initiatives especially around the 0-4 hour target and responsiveness of therapies, led to successful business case for a workforce review:

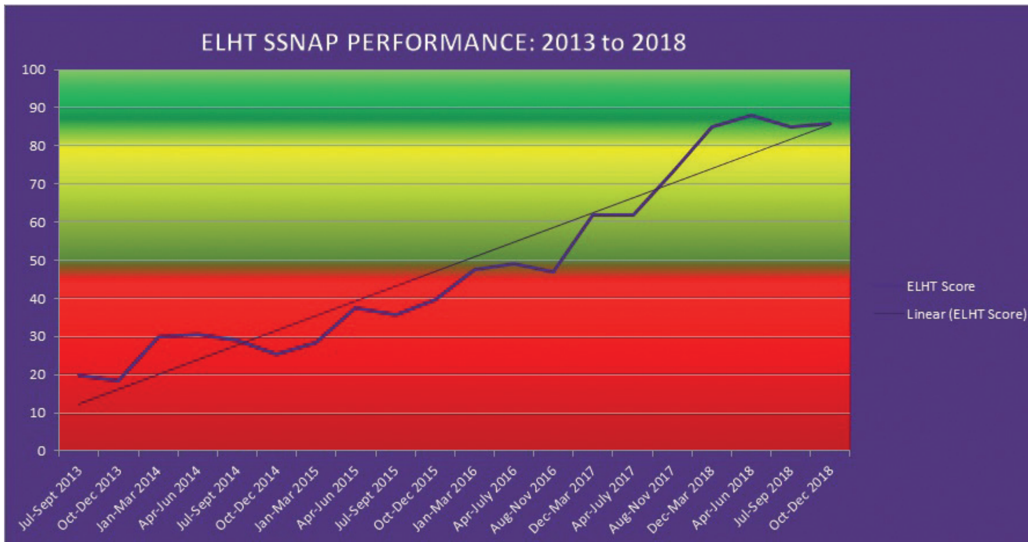
- Specialty stroke doctor and 2 stroke nurse consultants appointed in addition to existing medical workforce enabling improved medical support throughout the pathway with reduced median times for specialist stroke review
- Weekly sessions provided by stroke nurse consultants for training on stroke care and mortality reviews
- Stroke Nurse Consultant identified as dedicated Clinical Lead for stroke resulting in increased clinical support to all areas within the stroke pathway (ED, acute stroke unit, stroke rehabilitation unit)
- Strengthened process for RCA's where KPI's are not met for individual patients to ensure immediate improvements to pathway can be made
- Recruitment of 5.5 whole time equivalent (WTE) Stroke Nurse Practitioners working 24/7 to support first 0-4 hours of the stroke pathway
- Increases in therapy workforce to provide 6 day/bank holiday physiotherapy, occupational therapy and speech and language therapy, supported by stroke therapy assistant practitioners, to improve referral to assessment times to below 18hours, and to increase the amount and duration of therapeutic input.

A continuous improvement plan spanning the acute stroke unit, rehabilitation stroke unit, and East Lancashire community, supported by the Lancashire and South Cumbria ICS Stroke Programme Board, is under constant review and development.

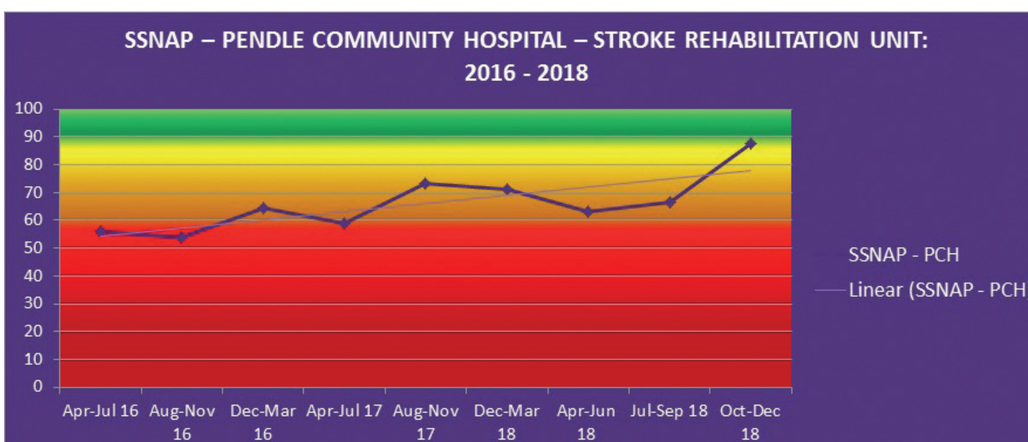
Crucial to the success of the improvement programme is how we work together as a team:

- Monthly Stroke Improvement Group meeting attended by all multidisciplinary team (MDT) members and management team
- Weekly breach meetings using real time data
- Daily MDT meetings on the ward with extended meetings twice a week and an MDT meeting on the Rehab ward at Pendle
- Work together to support any changes – e.g. recent Stroke Ambulatory Care Unit pilot
- Aware and a respect of the challenges each team face
- Communication – All team members have a voice.

Acute Stroke pathway



Stroke Rehabilitation Pathway



3.4.8 Older Peoples Rapid Assessment (OPRA) improving patient experience

In mid-January 2019 the OPRA unit opened with the purpose to provide specialist geriatric assessments and treatment of frail patients. The Frailty team will admit patients into the assessment area of the unit from the Emergency Department.

The qualitative benefits of admitting frail and elderly patients to the unit are:

- Better Patient and carer experience
- Greater patient autonomy
- Currently Pennine Lancashire has the highest burden score for prescribing in the North West for Anticholinergic
- Reduced re-attendances to ED
- Patients more likely to retain independence
- Reduced risk of Psychological harm
- Reduced time in ED

The Unit will completes a Comprehensive Geriatric Assessment on all patients admitted to the unit with the aim of reducing re-admissions for this cohort of patients, a reduction in length of stay for this criteria patients aiming for same day discharge or up to 48 hour length of stay and for patients with a Clinical Frailty Score of 8 or above to be included on the palliative care register and commencement of advanced care planning discussions.

3.4.9 Enhanced Recovery: Hip & Knee School reported as 'Outstanding'

The Hip and Knee School was set up within the Orthopaedic Directorate back in December 2016. The aim of the school is to educate our patients on what to expect in terms of their responsibilities prior to joint replacement surgery, manage expectations, and creating the mind-set required to motivate patients to actively participate in their recovery with the aim to improve outcomes and reduce length of stay.

The Advanced Nurse Practitioner is the Clinical Lead and the school is run daily by the Assistant Practitioner, Occupational Therapist and Physiotherapist, with support where needed from the Enhanced Recovery Team, two Orthopaedic Consultants and Stryker, maintaining a holistic approach to health care.

Since starting the school there have been 1844 patients that have attended and given valuable feedback. We as a team are continually working towards improving the Hip/Knee School. We have been commended for excellent PROMS outcomes on the recent GiRFT visit by Professor Tim Briggs. We were shortlisted for a Nursing Times award 2017. **In the 2019 CQC report the School gained 'Outstanding status'.**

Patient Feedback
'I cannot praise the team enough.'
'It has given me more confidence and has helped me deal with any lingering fears I had.'
'Absolutely brilliant idea to run these schools.'
'This is my second operation and I wish I'd had this information the first time in this form.'
'It's such a good idea to really prepare people and be clear about what is expected of them to aid their recovery.'

'Better informed patients are better recovering patients.'

3.4.10 Prompt to Protect

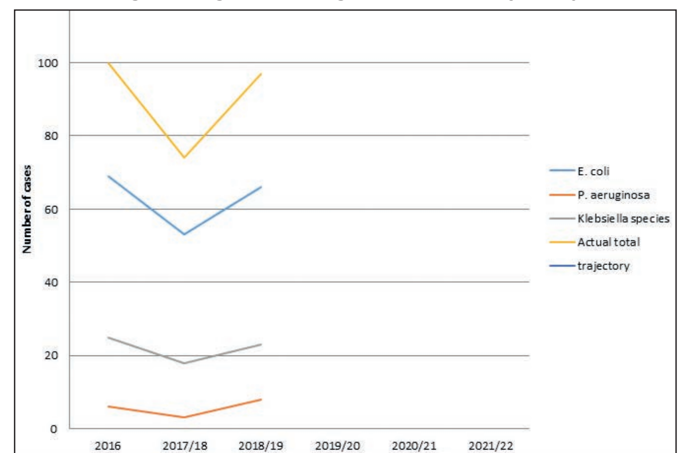
In November 2016 the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021.

This ambition has been reviewed in light of further research being required and now the plan is to continue the work to halve the health care associated Gram negative BSIs by adopting a systematic approach to preventing infection and delivering a 25% reduction by 2021-22 with the full 50% by 2023-2023.

The initial focus was on reducing Escherichia coli bloodstream infections because they represent 55% of all Gram-negative bloodstream infections. In the first year the aim was to reduce these by 10%, which ELHT achieved. Going forward reduction on gram negative bloodstream infections include E. coli, Klebsiella species and P. aeruginosa blood stream infections. Most cases are community onset and therefore reduction requires a whole health economy approach.

Unfortunately we have been unable to achieve our internal 2018/19 trajectory and have seen an increase in Gram-negative bloodstream infections both pre and post two days of admission. This has been recognised nationally and the government initiative has been revised.

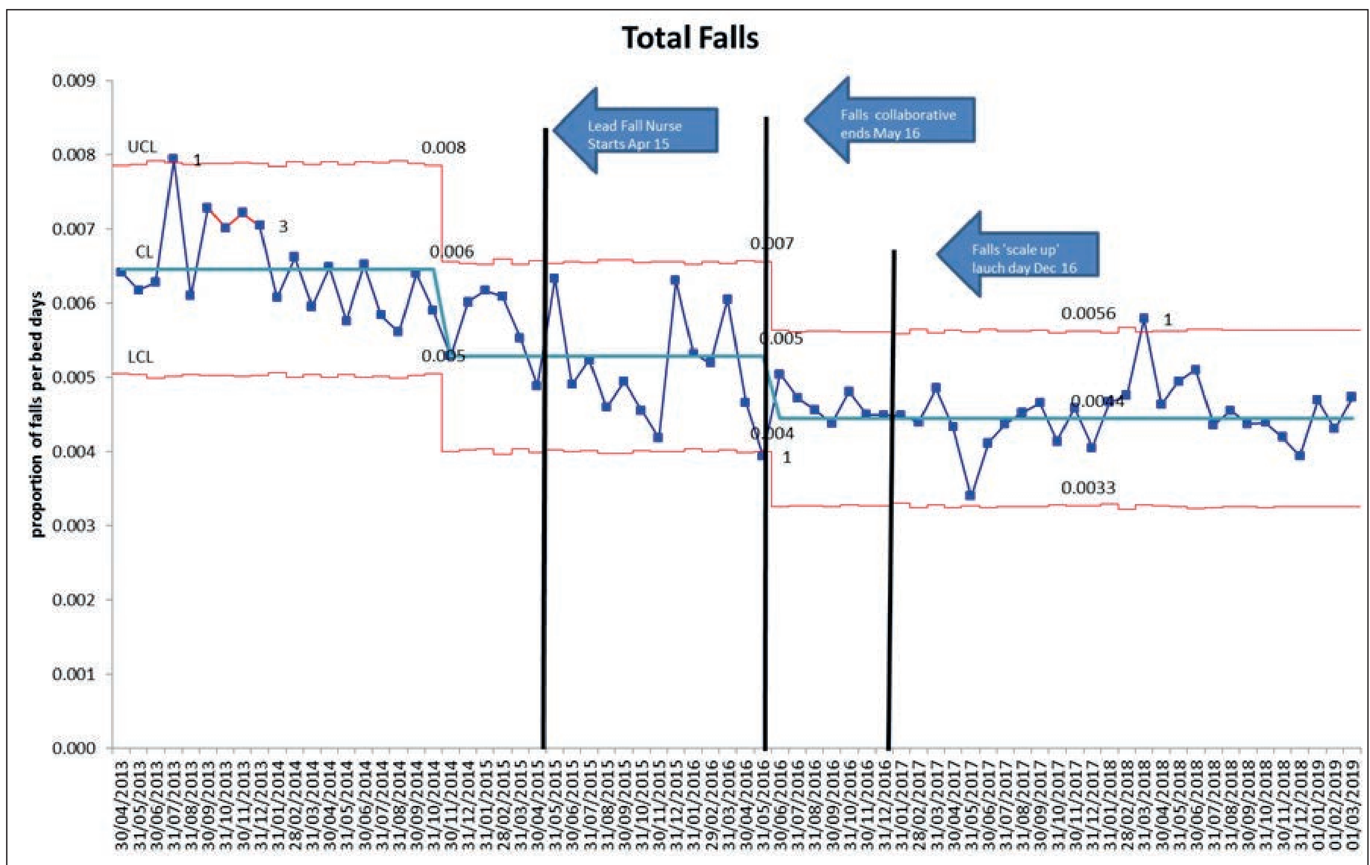
Number of gram negative BSI against annual trajectory



3.4.11 Trust on target for 20% reduction of patient falls by 2020

Inpatient falls continue to be on the decline across the organisation and we are currently on track to meet our target of a further reduction of 20% less falls by 2020 compared to 2017 data.

The number of falls per month is constantly being reviewed by the falls specialist nurse and targeted support is given to any wards that show a rise in any particular month. A new audit has been designed to provide assurance that wards are complaint with the principles of the falls change package and the results will be available monthly. In addition a post falls integrated care pathway has been designed to assist nursing and medical staff manage in patient falls in line with best practice.



3.4.12 National Emergency Laparotomy Audit (NELA)

The Trust is now into year six of NELA and with continued commitment to improvement our results in the latest annual report reflects this.

The report confirms that we continue to achieve 85% and over in 7 out of 10 standards and in those fields we remain above the national mean. Our case ascertainment was reported at 100% which indicates that our clinicians are identifying patients promptly and can then implement the standards of care aligned with those set by NELA.

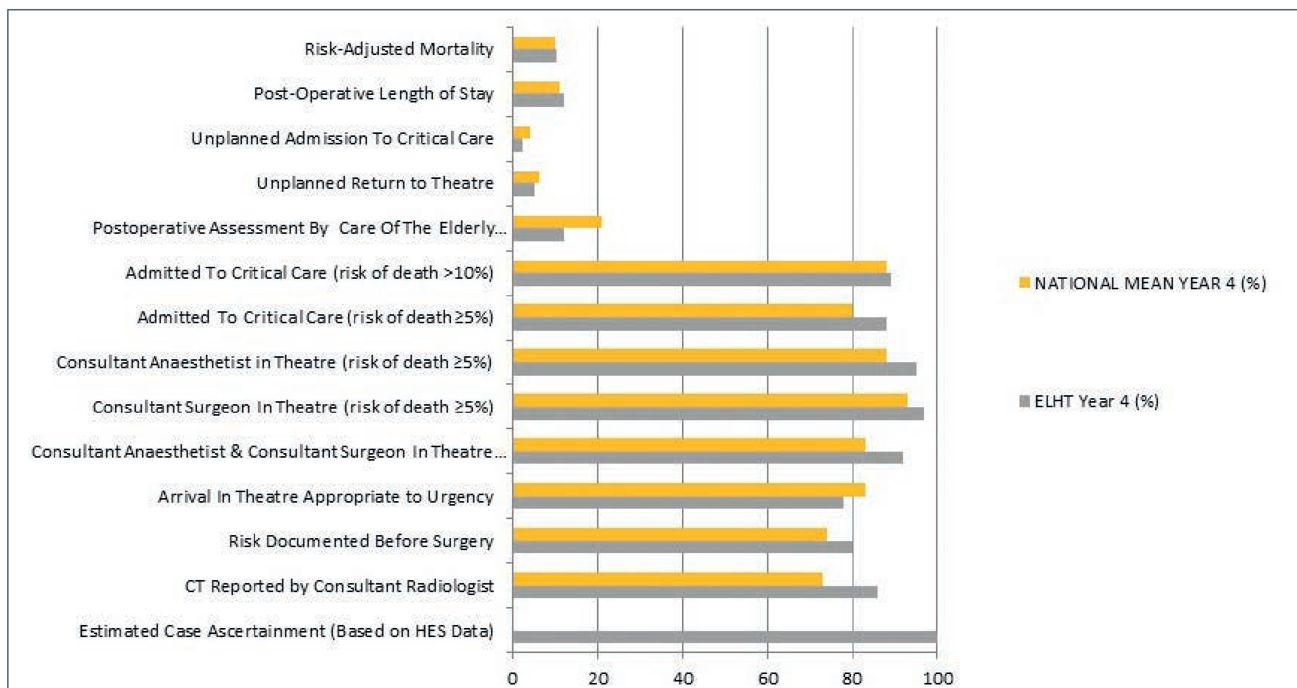
Our quality improvement team have been working on how we can make the pathway of these patients safe, timely, but still individualised. This year we introduced a red folder system where everything the team will need for the emergency laparotomy patients can be accessed altogether. It includes documentation which prompts the pre-operative assessment of patients including NELA risk score and frailty scores which both influence the patient's care and can affect outcomes. There is also a patient information pack which is given to the patient before their operation and gives them an opportunity to understand what is ahead of them and outlines how they can help themselves in this process. We want our patients and those who matter to them to be involved in their care planning and decisions being made about them.

Our emergency laparotomy patients follow an enhanced recovery pathway, we believe our patients will benefit from this evidence based programme and it will aid in getting them back to normal function as soon and as safe as possible. The year 4 NELA report indicates our length of stay has reduced from 14 days to 12 days within a year, with multidisciplinary team working these patient receive an approach that encourages early mobilising, appropriate nutrition, good pain relief and patient independence.

This year we are continuing our improvement work in:

- Finalising our pre-printed consent form
- Ensuring all patients are risk assessed pre-operatively using the NELA risk score and that this is documented and discussed with the patient
- Promoting how important the Frailty score is, how care is adapted and its impact on patient outcomes
- Introducing an Acute Abdomen Pathway which will be commenced in the emergency department and ensures all referrals, diagnostic procedures and reports are completed within the allocated time to ensure patients get to theatre within the appropriate time.

Nela Standards (Year 4 Nela Report)



3.4.13 Trust working hard to improve and better support Mental Health Patients

The quality improvement project was developed out of research conducted by one of our chaplains and counsellors, David Anderson and published in Nursing Times in 2018.

The project seeks to improve the experience of mental health patients within our care through staff training and links with the third sector. Over 800 staff (10% of the workforce) have now attended training where they learn how they can better support patients affected by feelings of self-harm and suicide. At the heart of the training, is the listening to the patient stories and hearing their voice about their experience of our care – what helps and what makes things harder for them. The feedback from staff attending has been 99.8% extremely positive with staff feeling better equipped and having less fear when working with this patient group. The training has also been adopted as essential for all staff on our AMU's and Critical Care. Interest in this training has been expressed by other Trusts in the North West and NHS England have met with David about extending it across the ICG.

All patients now have free access to the Samaritans helpline via a fast dial button on their bedside phone – another initiative that has been taken up by other Trusts in the North West and in Kent. Patients are now visited by David on the wards and offered a leaflet giving details of charities that they can contact for support in addition to services in the NHS. Many of the patients value the opportunity to talk.

The challenge ahead is for suicide prevention training to become embedded within ELHT and for funding for the leaflet to be granted by the Trust.

3.4.14 Achievement of Sepsis CQUIN target for 2018/19

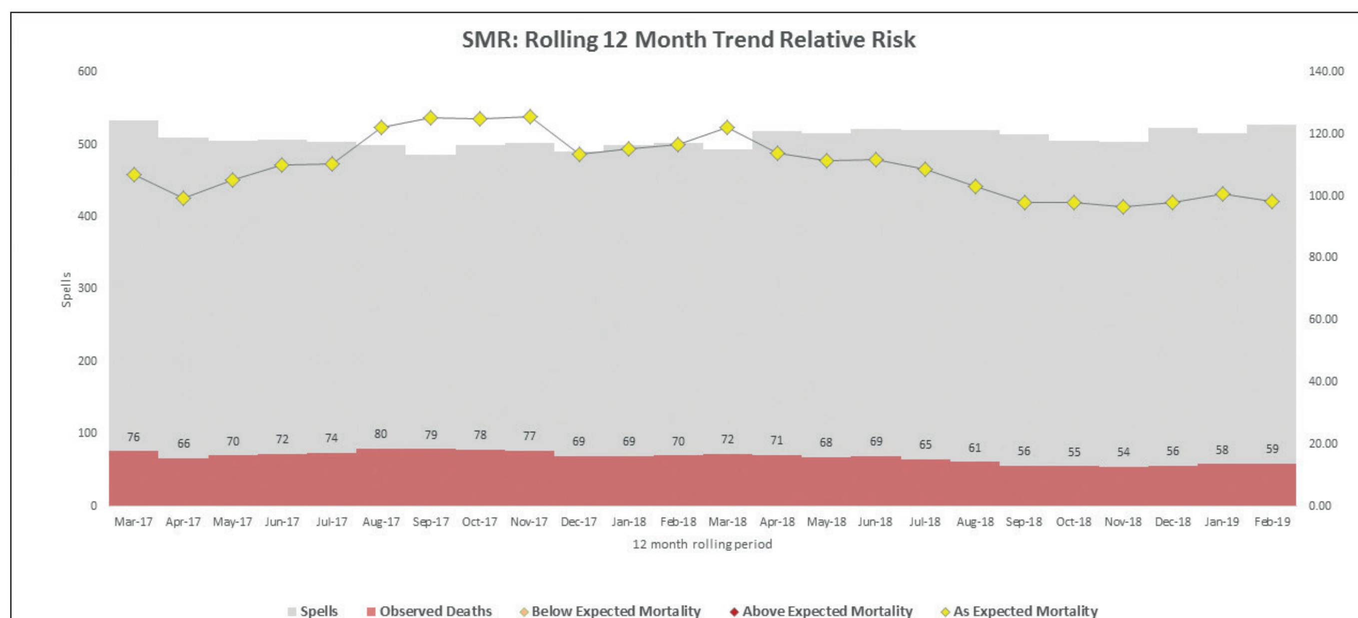
East Lancashire Hospitals NHS Trust continues to deliver high quality care in relation to the identification and management of Sepsis. We have delivered on our CQUIN targets for 2018/19, screening all our patients and delivering antibiotics within an hour where clinically necessary.

Compliance with the delivery of elements of the care bundle continues to remain high.

Sepsis Compliance	April 2019 (n=50)		
	Num	Den	%
Early warning Score within 60 mins.	50	50	100.00
Oxygen Commenced within 60 mins.	16	16	100.00
Blood Cultures Obtained within 60 mins.	46	50	92.00
Broad spectrum antibiotics given within 60 mins. (High Risk)	36	39	92.31
Antibiotics reviewed within 72 hours	49	50	98.00
IV Fluids Commenced within 60 mins. (High Risk)	30	39	76.92
Initial Lactate Obtained within 60 mins.	45	50	90.00
Fluid balance commenced where Sepsis was diagnosed			
(NEW MEASURE from JANUARY 2018) 3	36	50	72.00
Composite process Score	**308**	**344**	**89.53**

3.4.15 Improvement work leads to a fall in Mortality for Acute Kidney Injury

With the education of staff, redesign of the AKI bundle, awareness raising with the publication of the AKI Share to Care bulletin in May 2018, data provision and monitoring across divisions this has led to continued improvements in care which has resulted in a fall in the mortality associated with acute kidney injury.



3.5 Statements from Stakeholders

3.5.1 Healthwatch Lancashire (Chief Operating Officer)

Healthwatch Lancashire is pleased to be able to submit the following considered response to East Lancashire Hospitals NHS Trust's Quality Accounts Report for 2018-19.

Part 1 including Statement on Quality from the Chief Executive:

A concise description of the Trust, the demography in which it operates, the range of services and the relationships with academic partners and the closer integration with other providers of health and care services within the Lancashire and South Cumbria Integrated Care System.

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

Part 2: Quality Improvement:

We are impressed by the strategic approach being taken to develop a robust quality improvement programme to not only improve CQC outcomes but also patient experience as supported by the establishment of a Public Participation Panel and the continuous relationship with local Healthwatch as a valuable source of patient feedback.

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 2019-20

We note the initiatives listed in 2.3 which will receive specific focus during 2019-20 and would agree with the priorities as described.

Mandated Statements

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

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

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

Part 3 Quality Achievements and Statutory Statements

We would single out the comprehensive key actions taken by the Trust in respect of reducing readmissions for the 0-15 age group as being particularly praiseworthy. The key further actions being implemented over the next 12 months to support further reductions are very positive and we are fully supportive of these.

It is gratifying to read of the commitment to the principles of the Freedom to Speak Up review in line with the report by Sir Robert Francis QC.

We would congratulate the Trust for the work done to improve the support available for Mental Health Patients and the development of a staff training programme which has attracted interest from other Trusts in the North West and NHS England.

Summary

Overall, we would say that this is a well-balanced document in that it acknowledges areas of improvement needed and details comprehensive actions being taken to further improve patient treatment and care. We welcome these, and would like to find ways of supporting the Trust to achieve its aims.

3.5.2 East Lancashire Clinical Commissioning Group and Blackburn with Darwen Clinical Commissioning Group – Interim Director of Quality and Chief Nurse Associate

East Lancashire Clinical Commissioning Group (EL CCG) and Blackburn with Darwen Clinical Commissioning Group (BwD CCG) welcome the opportunity to comment on the 2018/19 Quality Account for East Lancashire Hospitals Trust (ELHT).

Throughout 2018/19, the Trust has continued to demonstrate their commitment to providing safe, personal and effective care for patients and the Quality Account details the vast range of initiatives and innovation to improve the quality and safety of services.

The CCGs were extremely pleased with the Trust's recent CQC overall rating of 'Good' with two services achieving a rating of 'Outstanding' and are proud of the joint work between all partner organisations to improve the health and care system in Pennine Lancashire.

Progress has been made against the 4 quality improvement priorities identified in the 2017/18 Quality Account, with clear reporting and governance arrangements in place to ensure that improvements are continual. The CCGs monitor progress through monthly Contract Quality Review Meetings and Trust Internal Meetings which the CCGs have been invited to be a member of.

ELHT has achieved 15 of the 24 applicable national and operational standards included within their contract. 2018/19 has continued to be a challenging year nationally, with the NHS experiencing exceptional operational pressures.

The Trust performed well against the referral to treatment incomplete standard with performance of 92.22% against a 92% target.

Performance against the 4 hour A&E target has been challenging with the position remaining below the 95% target at 82.3%, there has also been an increase in the number of 12 hour breaches reported in year. The CCG welcomes the work the Trust is undertaking in relation to the wider system to improve pathways overseen by the A&E Delivery Board.

It is positive that the readmission rate within 28 days has further reduced in 2018-19 to 8.16% and remains below the Dr Foster risk adjusted rate of 8.7%, which provides assurance of effective discharge planning.

There have been pressures for the national cancer targets and the Trust has worked closely with the CCGs and Cancer Alliance to improve cancer pathways and on the communication campaign 'Let's Talk Cancer'.

At the time of writing the Trust has achieved the full requirements of four of the five 2018/19 national Commissioning for Quality and Innovation (CQUIN) schemes, with submission of the Antimicrobial Resistance and Sepsis indicator awaited.

The Trust has participated in 95% of national clinical audits, 100% of national enquiries and completed 268 local clinical audits, demonstrating their continued commitment to the delivery of evidence based safe care.

Friends and Family response and recommendation rates remain high at the Trust. Through quality walkarounds the CCG are able to triangulate comments with actions taken and have the opportunity to speak to patients about their experience of care.

The Patient Voice is important to the Trust and the CCGs are happy that this is an area that the Trust continue to develop with continued engagement with patients, their families and carers. The introduction of 'Always Events' will enable optimal patient experience and improved outcomes for patients.

The rate of complaints remains low with the Trust committed to resolve issues as they arise. It is positive that the Trust Board continue to hear patient stories and that lessons learned are being disseminated via the Share 2 Care bulletins.

The Trust has reported two Never Events in 2018/19. Root cause analysis has identified lessons learned and actions which the Trust has implemented. In addition the Trust have completed an organisational Never Event action plan, which identified the themes and trends through the Never Events reported in 2017/18 and provided assurance of the areas of improvement that have been made over the last 12 months. This work had a focus on culture, leadership and human factors.

The Trust has taken a pro-active approach to the training of staff in Human Factors, with 4 staff members trained as trainers and becoming associate members of the Advancing Quality Alliance (AQUA) to deliver training across the North West. The Trust have supplemented this training locally to link Human Factors training and Simulation Training.

The CCG continue to sit on the Trust's Mortality Steering Group and are assured of the Trust's continued focus to reduce mortality rates through the introduction and care bundles and improved compliance rates. The Trusts Structured Judgement Review (SJR) process has been strengthened in 2018/19 leading to thorough review and learning from deaths.

The CCG were pleased with the annual NHS Staff Survey results for the Trust which demonstrated a positive staff culture and improvement on the previous year. The Trust has shared an action plan with the CCG of areas of work to further improve performance.

The CCGs support East Lancashire Hospitals approach to quality improvement and look forward to continuing to work with the Trust and wider health and social care economy throughout 2019/20 to ensure that the services commissioned for our patients are of a high quality.

3.6 Statement of Directors' Responsibilities

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

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

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

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

Signed By Order of the Board:

Chairman:

Chief Executive

Date:

Glossary

Term	Explanation
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.
Always Event	Always Events refer to aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time.
Antimicrobial	An agent that kills microorganisms or inhibits their growth.
Board Assurance Framework (BAF)	The BAF is a key framework which supports the Chief Executive in completing the Statement on Internal Control, which forms part of the statutory accounts and annual report, by demonstrating that the Board has been properly informed through assurances about the totality of the risks faced by the Trust.
Care Bundle	A group of interventions which are proven to treat a particular condition.
Care Quality Commission (CQC)	The independent regulator for health and social care in England.
Clinical Audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.
Clinical Commissioning Group (CCG)	Clinical Commission Groups are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Clostridium Difficile Infection (CDI)	A type of infection.
Commissioning for Quality and Innovation (CQUIN)	A payment framework linking a proportion of a Trust's income to the achievement of quality improvement goals.
Commissioning Support Unit (CSU)	Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners, for example by providing business intelligence services and clinical procurement services.
COPD	Chronic Obstructive Pulmonary disease – This is the name used to describe a number of conditions including emphysema and chronic bronchitis.
Datix	An electronic system that supports the management of risk and safety involving patients and staff.
Dr Foster Guide	A national report that provides data on patient outcomes in hospitals in the UK.
Duty of Candour	The Duty of Candour is a legal duty on hospital Trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.
EQ-5D	Instrument for measuring quality of life.
Family Liaison Officer (FLO)	Acts as a single point of contact for the relevant person, patient, next of kin in regards to liaise with on the investigation of a serious incident.

Get It Right First Time (GIRFT)	A programme to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improvement patient outcomes.
Healthwatch	Healthwatch England is the national consumer champion in health and care and has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.
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.
Lean	Lean is a system of continuous process improvement, which is increasingly being applied to health services in the UK and overseas to: improve the quality of patient care; improve safety; eliminate delays; and reduce length of stay.
Mersey Internal Audit Agency (MIAA)	The Trust's uses this internal audit firm who support improved outcomes through audit, assurance, challenge and solutions.
Morbidity	The disease state of an individual, or the incidence of illness in a population.
Mortality	The state of being mortal, or the incidence of death (number of deaths) in a population.
MBBRACE	Mothers and babies: reducing risk through audits and confidential enquires across the UK.
National Confidential Enquiries (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.
Quality Impact Risk Assessment Process (QIRA)	A robust process to ensure that our Safely Releasing Costs Programme ensures the Trust continues to maintain Safe, Personal and Effective care as it works to reduce its cost base.
Quality and Safety Framework	The means by which quality and safety is managed within the Trust including reporting and assurance mechanisms.
Red Flag Drugs	Within ELHT specific drugs/drug classes are identified as those where timeliness of dosing is crucial and these are known as RED Flag drugs. Healthcare professionals involved in the medication administration process must make every effort to secure the timely availability of these drugs for dosing.
Research Ethics Committee	A committee that approves medical research involving people in the UK, whether in the NHS or the private sector.
Secondary Uses Service	A national NHS database of activity in Trusts, used for performance monitoring, reconciliation and payments.
Share 2 Care	A process to facilitate sharing of best practice and lessons learned.
Structured Judgement Review (SJR)	A methodology for reviewing case records of adult patients who have died in acute general hospitals. The primary goal is to improve quality through qualitative analysis of mortality data.
Summary Hospital Mortality Indicator (SHMI)	The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die.
Systemic Anticancer Therapy	Systemic Anti-Cancer Therapy (SACT) encompasses both biological therapy (therapies which use the body's immune system to fight cancer or to lessen the side effects that may be caused by some cancer treatments) and cytotoxic chemotherapy (a group of medicines containing chemicals directly toxic to cells preventing their replication or growth, and so active against cancer).
Venous Thromboembolism (VTE)	A blood clot forming within a vein.
WHO Checklist	A checklist that identified three phases of an operation, before induction of anaesthesia, time out, sign out that helps minimize the most common and avoidable risks endangering the lives and well-being of surgical patients.
10,000 Feet	'Ten Thousand Feet' is a staff-led service improvement initiative that is now in use in theatres cross ELHT to reduce the noise level and increase concentration if staff feel safety is potentially being compromised.

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