QUALITY ACCOUNT

2019 - 20

Safe | Personal | Effective

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EAST LANCASHIRE HOSPITALS NHS TRUST – QUALITY ACCOUNT REPORT 2019-2020

1.0 PART ONE – INTRODUCTION TO OUR QUALITY ACCOUNT

1.1 Our Trust

East Lancashire Hospitals NHS Trust (ELHT) was established in 2003 and is a large integrated healthcare organisation providing acute, secondary 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 over 9,000 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.

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:

Safe | Personal | Effective

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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.

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 on our Quality Improvement Register including a Harms Reduction Programme, Clinical Effectiveness 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 foundation doctors (FY2's), medical students (SSC4's) and Trainee Advanced Clinical Practitioners take part in and lead quality improvement projects. In addition, the Trust has an Improvement Practice Office which sits within the Director of Finance's portfolio and supports the work streams devised as part of the NHSI Vital Signs Programme.

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. Support for projects is agreed within Divisions, approved through Divisional Clinical Effectiveness Committee and reported through to Clinical Effectiveness Committee. The Quality Improvement Triage group, also reporting into Clinical Effectiveness Committee, provides support and guidance for cross-divisional or Trust-wide quality improvement projects.

Dr Jawad Husain 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 2019-20. Regular 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 Divisional Serious Incident Reporting Groups (SIRG) and presented at a monthly Trust Serious Incident Requiring Investigation (SIRI) Panel. Quality and Safety reports are submitted to one of the bi-monthly subcommittees of the Quality Committee and then to the Trust Board. Following these meetings, validated reports and data are shared with the 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 continues to be used this year to facilitate monitoring against a range of quality indicators.

1.5 Our Quality Account

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

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

- The Trust's priorities for quality improvement in 2019-20;
- 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 2019-20 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

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

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

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

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

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

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

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

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

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 are being addressed through an action plan and are monitored through the appropriate assurance committee structure and the Trust and CQC have regular engagement meetings.

1.7 Our Chief Executive's Statement on Quality

I am delighted to introduce the Quality Account 2019/20 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. The challenges the Trust faced during this reporting year, including a global pandemic, has renewed my pride for the professionalism, resilience and dedication of the staff who work at ELHT. While the challenges we face may be shared with other partner organisations, we are able to meet the unprecedented demands due to a strong focus on quality and improvement. The high quality care our staff deliver is driven by an organisational culture that embraces the Trust's values – patients first, respect the individual, act with integrity, serve the community and promote positive change - all of which are embedded within the Trust's appraisal system.

Working with our health and social care partners, third sector organisations, volunteers and other external stakeholders, we endeavour to join up care and improve health outcomes for our local communities. The focus we place on improving quality will continue to ensure we are able to deliver improvements across organisational boundaries, across Pennine Lancashire.

This work has been carried out through the NHS Vital Signs National Improvement Programme, to deliver Improvement Practice across the health economy. This important work enables a standardised approach to a range of existing health pathways. Great strides have been taken particularly in how we care for our elderly and frail patients. Improvement work has also been carried out with our Older Peoples' Rapid Assessment unit, the Pendle East, Hyndburn Centre Neighbourhood Networks and on the safe transfer or discharge of patients.

There have been a number of measurable quality improvements made, here are just a few:

- A 10% reduction in patient cancellations on the day of their operation
- The whole time equivalent of a nurse has been released back into care through the implementation of a new electronic referral system from ward to district nursing.
- 70% of wards/areas at Royal Blackburn Teaching Hospital have established a standard laundry replenishment system
- 40% reduction in on the day cancellation in endoscopy
- A reduction of 1.5 days to the average length of stay for respiratory patients

While it is clear that our Trust continues to improve, we will take nothing for granted and will build on our successes. Our overarching principle remains, and that is to continue to provide **Safe**, **Personal** and **Effective** care to every patient, every time. What you will read in this report should demonstrate our commitment to this in all that we do. I would also like to give thanks to all our staff who, despite the additional pressures that COVID-19 has brought, continued to seek out opportunities for improvement and to raise the quality of care our patients received.

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 2019/20 Quality Account is true and accurate and the Quality Account has been approved by the Trust Board.

Kevin McGee, Chief Executive

2.0 PART TWO – QUALITY IMPROVEMENT

2.1 Our Strategic Approach to Quality

Introduction

East Lancashire Hospitals NHS Trust's (ELHT) first Quality Strategy completed in 2019. This Quality Strategy enabled us to focus on practice improvements in key clinical areas and in the embedding of clear assurance systems to govern our quality monitoring. Our improved performance in this area has led to ELHT being asked to represent the North West as an early adopter of the Patient Safety Incident Response Framework (PSIRF) during 2020. PSIRF will support us to strengthen the links between patient safety, patient experience and clinical effectiveness; further developing our approach to organisational learning. PSIRF will underpin a review of our Quality priorities for the year ahead, enabling improved triangulation of quality information across the organisation to maximise learning.

We continue to be rated by the CQC as a Trust that is 'Good' outcome with areas of 'Outstanding'. Demonstrating 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. Our commitment to providing high quality care for the people of East Lancashire has seen the embedding of our Public Participation Panel as a monthly meeting directly supported by our Chief Nurse. The PPP are actively engaged in the development and review of services, providing a patient/carer perspective to our quality improvement plans.

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

Safe Care

The organisation response to safety is being influenced by the new National Patient Safety Incident Response Framework (PSIFR) which will be replacing the National Serious Incident Framework (SIF). The Trust was invited to part of the early adopters programme for the draft framework in January 2020 by NHE England and NHS Improvement. With the introduction of the PSIRF the Trust main areas of focus for 2020 – 21 will be:

- Enhancing capabilities in being open when things go wrong
- Developing and promoting robust support mechanisms for patients, staff and investigators affected by or involved in patient safety incidents;
- Developing our Patient Safety Incident Response Plan (PSIRP) in consultation with stakeholders and getting agreement for this plan with our commissioner(s);
- Enhancing knowledge, understanding, application and monitoring of patient safety improvement as the key output in response to incidents; and
- Sharing our experience of this with NHS England and NHS Improvement and with other early adopters to influence the final national version of the PSIRF.

Clinical Effectiveness

There is a continued evolution to the approach of ensuring clinical directorates are delivering effective, evidence-based care in a reliable manner. The Clinical Effectiveness Team's function is to provide assurance against standards and ensure the organisation is delivering best practice according to national guidance. To ensure that directorates are delivering best practice and are aware of the standards expected of them each directorate has a 'portfolio' of 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 guidance (e.g. NICE)
e) Relevant National Confidential Enquiry (NCE) 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 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 has in place a Clinical Effectiveness Lead supported by a Quality and Safety Lead. They are responsible for developing the divisional portfolio of evidence and ensuring all relevant national guidance is captured. This process is supported corporately by the Clinical Effectiveness Team.

Quality Improvement

The Quality Improvements Team supports the organisation by coaching and facilitating on defined improvement programmes and projects linked to Trust and divisional priorities. A scientific improvement methodology is used to diagnose the current state (problem), use data to establish a baseline, identify potential interventions, monitor the impact through series of PDSA cycles then embed, sustain and (where applicable) spread improvements.

Each division has a governance route (e.g. Divisional Clinical Effectiveness Committees) for assurance that plans are in place for reviewing and discussing their Quality Improvements projects, alignment of projects to their priority areas and monitoring the impact of projects. Each division reports their Quality Improvement activity through to Clinical Effectiveness Committee. Projects agreed by a senior divisional lead through this forum are added to the Trust Quality Improvement Projects Register. In addition, a corporate Quality Improvements Triage Group formally reports to the Clinical Effectiveness Committee. This group brings together the divisional and Quality Improvement Teams with a purpose to examine the detail of cross-divisional and/or Trust-wide quality improvement projects, those with the potential for spread and those which require organisational sign off.

The Clinical Effectiveness Committee receives a regular report and update from each division 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.

Harms Reduction Programme

To utilise resources effectively a review of the Trust's Harms Reduction Programme has been undertaken in order that these deliver a reduction in incidents causing harm to patients receiving care at ELHT. Each project within the Harms Reduction Programme has a working group with designated Quality Improvement support. These projects are run using the Trust's Quality Improvement methodology. Progress against the Harms Reduction Programme is reported through to Patient Safety & Risk Assurance Committee.

Safety Culture Survey

a) We are working in collaboration with AQuA to roll out their Safety Culture survey in a number of services across the Trust 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 the introduction of the PSIRF which supports:

- Developing and promoting robust support mechanisms for our patients, staff and investigators affected by or involved in patient safety incidents;

- In addition the reliability of systems is being improved with use of Human Factors training for areas identified as being the highest risk and further development of our serious incident investigation training.

- Enhancing staff knowledge, understanding, application and monitoring of patient safety improvement as the key output in response to incidents

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 are reported to the Quality Committee.

The trust has appointed 6 medical examiners and a lead medical examiner ahead of the mandatory implementation of the medical examiner role. Whilst plans for the roll out of the medical examiner role were suspended nationally as part of the coronavirus act, the trust

opted to retain these roles through the pandemic response to provide added scrutiny and support to the certification of death process which was significantly altered as part of the pandemic response nationally.

The trust has also funded 2 medical examiner officer posts which are currently in the process of being appointed to. These roles will provide pivotal support to the medical examiners and allow the new process to be fully effective.

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.

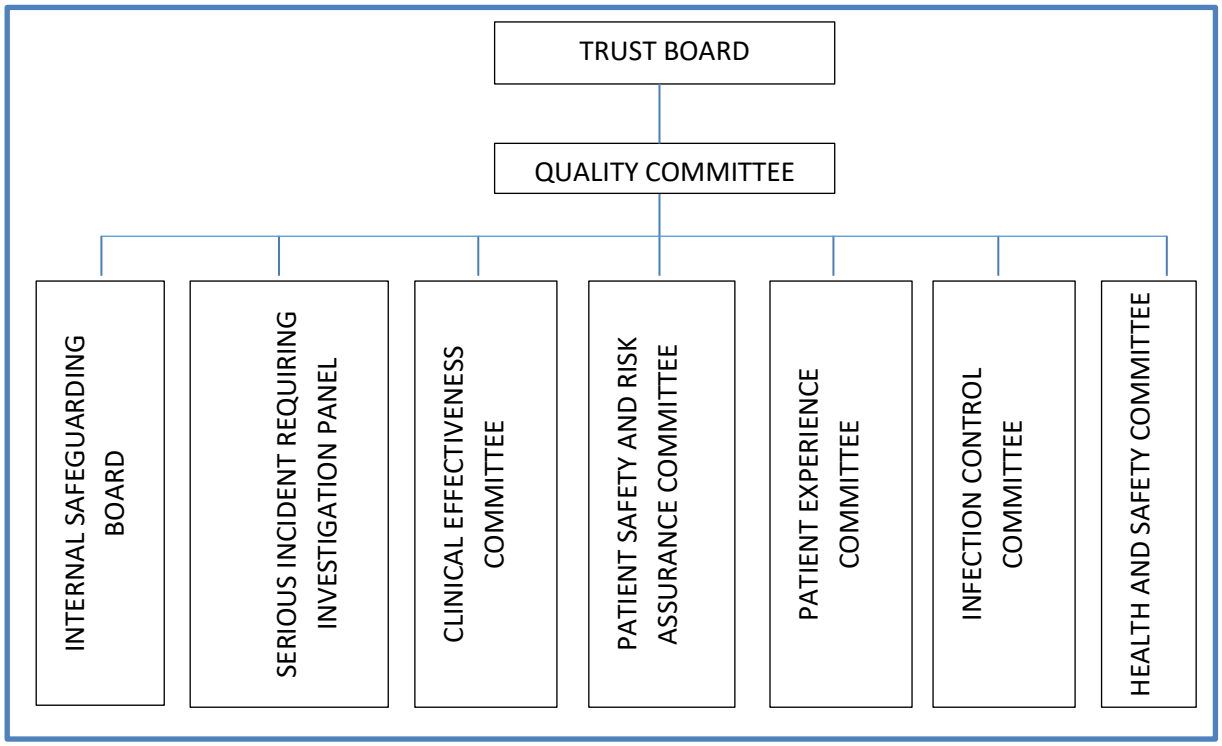
h) Implementation of our Patient, Carer and Family Experience Strategy 2018-21.

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

Governance Arrangements for Quality

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

Figure 1: Trust Governance Structures for Quality and Safety



2.2 Quality Monitoring and Assurance

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

The Board Assurance Framework (BAF) and the Corporate Risk Register provide assurance to the Board that risks to patient safety, reputation and quality are appropriately managed in a timely way. The risk management process is designed to ensure current and

potential future risks to quality are identified and included on the risk register, for example new technologies and changes in policy and funding. There are clear directorate and divisional reporting structures with specific triggers and processes by which risk and mitigating actions are reported and escalated. There is a clear and dynamic process for the management of risk in the organisation and both the BAF and the Corporate Risk Register are regularly reviewed to ensure appropriate, preventative and corrective actions have been taken.

The Trust Board is ultimately accountable for the delivery of quality outcomes and they are held to account by our regulators. Oversight of the Quality and Safety Framework is supported by a Quality 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 2019-20 the East Lancashire Hospitals NHS Trust continued to provide and / or subcontracted 8 NHS Services. These services have been identified using the CQC's definition of regulated activities. The services provided during the year were:

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

The Trust has reviewed all the data available on the quality of care in all of these NHS services. The Trust continues to use its integrated quality, safety and performance scorecard to facilitate this and has begun using a Quality Dashboard to support triangulation. Reports to the Trust Board, the Quality Committee, 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 2019-20; have been managed by way of these reporting functions.

The income generated by the NHS Services reviewed in 2019-20 represents 97% of the total income generated from the provision of NHS services by the East Lancashire Hospitals NHS Trust for 2019-20. (2018-19 93%).

2.3 Priorities for Quality Improvement 2020-21

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

Subject	Quality Aim	How achievement will be measured	How achievement will be monitored
Deteriorating Patient	Implementation of a Trust-wide approach to improve the recognition of and response to the deteriorating patient. Various aims relating to cardiac arrests, sepsis, Acute Kidney Injury, Early Warning Scores and Fluid Balance	Use of the Mortality/Cardiac Arrest/Deteriorating Patient score card; HSMR/SHMI; monthly ward audits; care bundle audit data; national audit.	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
Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	To reduce the rates of stillbirths, neonatal death and brain injury occurring during or soon after birth by 20% by 2020	Data from Athena Post Delivery System	Reporting through Mortality Steering Group and Harm Reduction Report to Patient Safety and Risk Assurance Committee
Safer Surgery	To improve safety culture within theatres through compliance with '5 steps to safer surgery' by March 2021	Incident reporting through Datix; analysis of brief-debrief forms; culture survey; e-learning compliance	Harm Reduction Report to Patient Safety and Risk Assurance Committee

The organisations' improvement priorities have been identified through a number or routes, including areas of safety concerns, Never Events, audit and performance data, and system-wide priorities.

In 2018, ELHT were successful in applying for the NHS Improvement Vital Signs Programme so there has been a change in dynamic of improvement priorities going forward. Being members of this prestigious programme means in 2020/21 the focus will be on aligning the existing approach and methodology, and programmes of work, to the improvement principles utilised through Vital Signs. This approach seeks to maximise impact across Pennine Lancashire by creating improvement capability (e.g. Specialist Practice Coaches; Kata Coaches), thereby supporting the

system in both meeting today's pressures and creating sustainable improvements for future **Safe**, **Personal** and **Effective** care.

The areas of focus that have been identified are as follows:

- Deteriorating Patient
- Falls
- Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
- Safer Surgery
- Nutrition and Hydration
- Infection Prevention
- Medication Errors
- Frailty
- SAFER Discharge
- Transfers of Care
- Clinical Flow
- Theatres
- Endoscopy
- Radiology

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 2019-20 63 national clinical audits and 8 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
Adult Asthma Secondary Care (NACAP)	RCP	Intermittent	Yes	100%
Breast and Cosmetic Implant Registry (BCIR) BCIR operate a continuous data collection model.	BCIR	Continuous	Yes	100%
Cardiac Rhythm Management (CRM)	NICOR	Continuous	Yes	100%
Care of Children (Care in Emergency Departments)	RCEM	Intermittent	Yes	100%
Case Mix Programme (CMP)	ICNARC	Continuous	Yes	100%
Chronic Obstructive Pulmonary Disease (COPD) Secondary Care (NACAP)	RCP	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%
Assessing Cognitive Impairment in Older People	RCEM	Intermittent	Yes	100%
Fracture Liaison Service Database (FLSD) (FFFAP)	RCP	Continuous	Yes	100%
Head & Neck Cancer Audit (HANA)	Saving Faces	Continuous	Yes	100%
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	>90%
Myocardial Ischaemia National Audit Project (MINAP) - National Cardiac Audit Programme (NCAP)	NICOR	Continuous	Yes	100%

Mandatory Surveillance of bloodstream infections and clostridium difficile infection	PHE	Continuous	Yes	100%
Mental Health (Care in Emergency Departments)	RCEM	Intermittent	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%
Perioperative Quality Improvement Programme Audit operates continuous data collection	RCA	Continuous	Yes	100%
National Audit of Dementia (Spotlight Audit – Antipsychotic Drugs	RCPsych	Intermittent	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) - National Cardiac Audit Programme (NCAP)	RCP	Continuous	Yes	100%
National Audit of Seizure Management in Hospitals (NASH) round 3	University of Liverpool	Intermittent	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	RCPCH	Intermittent	Yes	TBC
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%
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 (Project closed August 2019)	RCOphth	Continuous	No	NA
National Paediatric Diabetes Audit (NPDA)	RCPCH	Continuous	Yes	100%

National Pregnancy in Diabetes Audit - Adults (NDA)	NHS Digital	Continuous	Yes	100%
National Prostate Cancer Audit	RCS	Continuous	Yes	100%
National Smoking Cessation Audit	BTS	Intermittent	Yes	100%
National Vascular Registry	RCS	Continuous	Yes	100%
Nephrectomy audit	BAUS	Continuous	Yes	100%
Paediatric Asthma (NACAP)	RCP	Continuous	Yes	100%
Percutaneous Nephrolithotomy (PCNL)	BAUS	Continuous	Yes	100%
Pulmonary Rehabilitation Audit	RCP	Intermittent	Yes	100%
Radical Prostatectomy Audit	BAUS	Continuous	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	RCP	Continuous	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	SHOT	Continuous	Yes	100%
Seven Day Hospital Services Self-Assessment Survey	NHSE	Bi-annual	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAMBA	Intermittent	Yes	100%
UK Parkinson's Audit	Parkinson's UK	Intermittent	Yes	100%

Key to Audit Coordinator abbreviations

BAETS	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BTS	British Thoracic Society
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 2019 - 20	Sample Submission
Child Health Clinical Outcome Review Programme: Long term Ventilation in Children & Young Adults	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Acute Bowel Obstruction	NCEPOD	Intermittent	Yes	Yes	50%
Medical and Surgical Clinical Outcome Review Programme: Dysphagia in Parkinson's Disease	NCEPOD	Intermittent	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: In-hospital management of out-of-hospital cardiac arrest	NCEPOD	Intermittent	Yes	Yes	100%
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 78 national clinical audit reports and 5 national Confidential Enquiry reports were received and reviewed by the Trust in 2019-20. 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

244 local clinical audits were completed by East Lancashire Hospitals NHS Trust in 2019-20. 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 2019-20 that were recruited up to the 31st March to participate in research approved by a research ethics committee was 1717

2.4.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of ELHT's income in 2019-20 was conditional on achieving quality improvement and innovation goals agreed between East Lancashire Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment framework.

The following table sets out brief details of the Trust's CQUIN schemes for 2019-20:

ELHT CQUINs Programme Summary		
Commissioned By:	**Scheme:**	**Indicators:**
National	CCG1: Antimicrobial Resistance	a. Adherence to national antibiotic guidance in treatment of Lower Urinary Tract Infections in older people (CCG1a)
		b. Antibiotic prophylaxis in elective colorectal surgery
National	CCG2: Staff flu vaccinations	Uptake of flu vaccinations by frontline clinical staff

National	CCG3: Tobacco and alcohol screening and advice	Screening for tobacco and alcohol use in inpatient settings.
		Brief advice for tobacco use in inpatient settings.
		Brief advice for alcohol use in inpatient settings.
National	CCG7: Three High Impact interventions to prevent Hospital Falls	Implementation of three high impact interventions to prevent Hospital Falls: - Lying and standing blood pressure to be recorded - No hypnotics or anxiolytics to be given during stay or rationale documented - Mobility assessment and walking aid to be provided (if required).
National	CCG11: Same Day Emergency Care: Eligible patients to be managed in a same day setting	a. Eligible patients to be managed in a same day setting for Pulmonary Embolus
		b. Eligible patients to be managed in a same day setting for Tachycardia
		c. Eligible patients to be managed in a same day setting for Community Acquired Pneumonia (CAP)
Spec Comm	PSS1: Medicines Optimisation and Stewardship	**Trigger 1:** Improving efficiency in the IV chemotherapy pathway from pharmacy to patient – reducing chemotherapy waste. **Trigger 3:** Supporting national treatment criteria through accurate completion of prior approval **Trigger 4:** Faster adoption of prioritised best value medicines and treatment – improving the rate of adoption at a local level.
Spec Comm	PSS2: Towards Hepatitis C Virus (HVC) Elimination	Increase focus on improving treatment of diagnosed patients and increasing rates of testing and diagnosis.

Further details of the agreed goals for 2019/20 and the following 12 months are available on the NHS England website https://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 2019-20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Records submitted from Apr 19 to Mar 20 (most recent figures):

- Admitted Patient Care 174,965
- Outpatient Care 661,942
- Accident & Emergency Care 184,160

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

Performance for Apr 19 to Mar 20 (most recent figures):

- Admitted Patient Care 99.8%
- Outpatient Care 99.9%
- Accident and Emergency Care 98.4%

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

Performance for Apr 19 to Mar 20 (most recent figures):

- Admitted Care 100%
- Outpatient Care 100%
- Accident and Emergency Care 99.5%

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 2020. This is the second version of the DSPT with updates to the 2019-20 version increasing the number of standards from 100 to 117 mandatory evidence items for NHS trusts. All assertions have been responded to and the Trust has again secured 'Standards Met' for the 19/20 publication as well as reaching 'substantial assurance' following an audit through the Trust external auditors.

The Trust will prepare for the DSPT submission for 2020-21 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 2019/20:

- Data Security and Protection Toolkit Audit 2019-20 (200 episodes) – Lancashire Coding Collaborative
- Specialty Audit – Gynaecology (50 episodes) – Lancashire Coding Collaborative
- Specialty Audit – Obstetrics (50 episodes) – Lancashire Coding Collaborative
- Specialty Audit – Trauma and Orthopaedic (50 episodes) – Lancashire Coding Collaborative
- Specialty Audit – Orthopaedic – Foot Osteotomy (50 episodes) – Lancashire Coding Collaborative

In addition to this, the department has one member of staff training as a Clinical Coding Auditor (scheduled to qualify in 2020) and they carried out the following internal coding audits:

- Individual Coder Audits (50 episodes per audit) – All Band 2-4 coding staff
- Audit of wards coded electronically (BUIU / UROC / CLAB / ECIS) (100 episodes)

2.5 Complaints Management

Feedback is a powerful and useful mechanism for improving the quality of care and the patient experience, individually and for the wider NHS, as well as contributing to a culture of learning from experience. Patients, relatives and carers are encouraged to communicate any concerns to staff with the aim of addressing those concerns immediately. The Trust has adopted the principles of good complaints handling, as set out by the Parliamentary and Health Service Ombudsman and which reflect the Trust's own vision and values as follows:

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

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

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

The Customer Relations Team deals with concerns raised formally and informally, ensuring that individual concerns are addressed effectively and lessons are learnt from the issues raised. During 2019-20, 1596 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 405 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 2019-2020, 7 complaints were referred to the Ombudsman, 1 was partly upheld, 2 were not accepted for investigation and 4 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	87.5%
KF26 (Q13c)	In the past 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	16.2%

For Q14, ELHT has seen a significant improvement on the previous year's percentage (85.2%). This places ELHT in the top 20% of Acute and Community Trusts and is significantly better than average when benchmarked nationally.

For Q13c, ELHT has seen a significant improvement on the previous year's percentage (17.5%). This places ELHT in the top 20% of Acute and Community Trusts and is significantly better than average when benchmarked nationally.

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

3.1 Achievements against Trust Quality Priorities

The table below gives an overview of progress in Q1, Q2 and Q3 against the quality improvement priorities identified in last year's Quality Account for implementation this year.

No	Quality Priority Aim	How the quality priority achievement will be measured	How the quality priority achievement will be monitored
1	**Deteriorating Patient** Continuing work form last year – implementation of a trust-wide approach to improve the recognition of and response to the deteriorating patient	Use of mortality/cardiac asses/deteriorating patient score card; HSMR/SHMI; monthly ward audits; care bundle audit data; national audit.	Monthly Deteriorating Patients Steering Group reports to Patient Safety and Risk Assurance Committee
Progress and achievement to date			
	Sepsis • Sepsis collaborative was re-established with a new aim and clinical lead • Final versions of revised Sepsis bundles have been agreed – adult, maternal and paediatric - with monitoring of compliance in place SHMI data indicates that the Trust is now back within 'expected levels' for sepsis mortality, which is a significant achievement. **EWS** • E-EWS planned as part of the Cerner project • Paediatric and maternity electronic audit tool being developed • New PCH Escalation SOP agreed and approved • NEWS2 App developed and now widely available **AKI** • SHMI data indicates that the Trust is now within expected levels for mortality, which is a significant achievement • AKI bundle data collection has been 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 • E-learning package available to all staff • Management of AKI project underway in Intensive Home Support Service to identify patients that can be managed from home to prevent admission to secondary care **Fluid balance** • The fluid balance change package is available on the Learning Hub (communicated to all Matrons) • IV Fluids - Work cntiuning to review use of ward based pharmacists to educate and continually improve IV fluid management. • Fluid Balance Audit SOP063 and Measure Adult Fluid Status SOP017 reviewed and approved		
2	**Falls** Continuing work form last year – 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

• Implementation of monthly electronic falls audit enables wards to input data in a more timely and efficient manner • Bi-monthly Strategy Falls Group Meeting continuing to meet, scrutinise the data and provide challenge/support to areas • Falls Lead Nurse continues to support the embedding of learning and good practice • Compliance results from the 2019 Falls Change Package audit distributed to all wards, along with action plans for the wards to complete as a QI project • A 'Falls Awareness Week' was held in September 2019 across all hospital sites with good engagement with the public and nursing staff.			
3.	**Maternity and Neonatal Safety Improvement Programme (MatNeoSIP):** To reduce the rates of stillbirths, neonatal death and brain injury occurring during or soon after birth by 20% by 2020	Data from Athena Post Delivery System	Harm Reduction Report to Patient Safety and Risk Assurance Committee
• Implementation of Placenta Clinic which saw a 22% reduction in stillbirths in its first year of opertion. • Rainbow Clinic has commenced • Two new midwife sonographers being trained to increase capacity for Placenta Clinic • ELHT Maternity Services Clinical Guideline 68: Detection and Management of Fetal Growth Restriction has been reviewed and revised • ELHT Maternity Services Clinical Guideline 74: Reduced or Changed Fetal Movements has been developed as standalone guideline for clarity. • ELHT Maternity Services Clinical Guideline 5: Antenatal auscultation and electronic fetal monitoring (2017) updated for clarity • Staff training in FCTG Training (E-Learning), and growth restriction identification & referral			
4.	**Safer Surgery:** To improve safety culture within theatres through compliance with '5 steps to safer surgery' by March 2021	Incident reporting through Datix; analysis of brief-debrief forms; culture survey; e-learning compliance	Reporting through Mortality Steering Group and Harm Reduction Report to Patient Safety and Risk Assurance Committee
• 'Culture Club' a training programme devised with Organisational Development lead to develop and strengthen Band 7 Leadership. • Bi-monthly Scenario-Based Learning sessions on audit days help embed the safety culture into everyday practice/situations. • 5 steps of safer surgery online training programme has been developed for all staff within theatres • Standardised Brief/Debrief forms rolled out across sites and the information collated to identify common themes. • 10,000 Feet continues to be used in practice with patient input agreed from the Trust's Patient Participation Panel			

3.2 Harm Reduction Programme

ELHT's Harm Reduction Programmes encompass a number of different improvement initiatives designed to improve patient care and reduce harm. Each element of this programme has its own steering group, supported by the Quality Improvement Team, and updates are reported through to Patient Safety and Risk Assurance Committee on a bi-monthly basis. The table below provides an overview of the aims and key achievements of each individual project.

Achievements

Aim	Key Achievements to 31 March 2020
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	**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 **AKI** • AKI bundle revised and in use across the Trust • AKI bundle data collection has reviewed and supported by the

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	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 **<u>Fluid balance</u>** • 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, learning from incidents and other safety related information
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.
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
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 2019 for East Lancashire Hospitals NHS Trust is set out in the following table:

SHMI Outcomes	**Rolling 12 months to Sep-19**
East Lancashire NHS Trust SHMI Value	1.024
East Lancashire NHS Trust % of deaths with palliative care coding	33
East Lancashire NHS Trust SHMI banding	2 (as expected)
National SHMI	1.00
Best performing Trust SHMI	0.698
Worst performing Trust SHMI	1.188
Trust with highest % of deaths with palliative care coding	59
Trust with lowest % of deaths with palliative care coding	12

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.

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	33%
National percentage of deaths with palliative care coding	36%
Trust with highest percentage of deaths with palliative care coding	59%
Trust with lowest percentage of deaths with palliative care coding	12%

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 (PROMs)

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

- Hip Replacement
- Knee Replacement

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

The following tables set out the percentage of ELHT patients identified as achieving an 'improved post-operative adjusted average health gain' in comparison with the national figures for both of the PROMs procedures using the EQ-5D measure of health gain. The

'EQ-5D Index' scores are a combination of five key criteria concerning patients' self-reported general health: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

3.3.3.1 Hip Replacement Surgery

Hip Replacement Surgery	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20*
ELHT	94.0%	92.0%	91.5%	92.4%	93.4%	No Data
National Average	89.5%	89.6%	89.1%	90%	90.1%	91.4%

3.3.3.2 Knee Replacement Surgery

Knee Replacement Surgery	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20*
ELHT	84.5%	85.3%	83.4%	82.9%	89.5%	No Data
National Average	81.0%	81.6%	81.1%	82.6%	82.6%	84.1%

**PROMs outcome data for 2019-20 is not currently available on NHS Digital by Hospital/Provider. The national average displayed for 2019-20 is provisional data covering April to September 2019.*

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 2019-20 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 19 Aug 20.

All ages	2013/14	2014/15	2015/16	2016-17	2017-18	2018-19	2019-20 (Apr - Dec 19)
Readmission Rate	8.40%	8.74%	8.79%	8.44%	8.30%	8.62%	9.14%
Age Band	2013/14	2014/15	2015/16	2016-17	2017-18	2018-19	2019-20 (Apr - Dec 19)
0-15	11.15%	11.22%	12.06%	12.21%	11.75%	12.51%	12.04%
16+	7.80%	8.19%	8.05%	7.64%	7.54%	7.81%	8.59%

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 9.14% which is below the Dr. Foster risk adjusted expected rate of 9.30% Compared to local acute hospitals, the Trust is middle of the group and slightly higher than the national rate of 9.0%.

- For the 0-15 age group, the rate is 12.04% which is higher than the expected rate of 10.64% and the national rate of 9.7%.

- For the 16+ age group the rate is 8.59% which is below the expected rate of 9.05% and better than the national rate of 8.8% 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.

10. Establishment of 'Patient Trigger Reviews' so that parents can contact the department directly for an outpatient consultation after admission/last appointment. This allows parents control on required further help and advice and offers a more suitable alternative to readmission - this has been established.

11. Allergy specialist nurse recruited February 2020, so that children and families with severe allergies can be managed safely at home and avoid admission and readmission for acute episodes. Also the development of Allergy MDT with Consultant Paediatricians to manage allergy patients in a more seamless way.

12. Introduced direct ED referrals to our Children's Community Nursing Service and are rolling that out to NWAS to support admission avoidance.

13. Increased our nurse led clinics for respiratory and community nurses and are setting up for epilepsy and allergy.

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 re-admissions.

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 third epilepsy nurse specialist started in June 2020, 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 who joined in February 2020, so that children and families with severe allergies can be managed safely at home and avoid admission and readmission for acute episodes - joint allergy clinics/MDT commencing Sept 2020.

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. Developing an asthma severity score and associated pathway using QI methodology.

8. Developing an allergy pathway using QI methodology.

3.3.5 Responsiveness to Personal Needs of Patients

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

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

National Inpatient Survey 2019

Between August and December 2019 a total of 1250 adults who were an inpatient in our hospitals during July 2019 were sent a questionnaire. 439 patients returned a completed questionnaire, giving a response rate of 36%. The results include patients' perceptions of:

- The quality of communication and information between medical and nursing staff, patients and family/carers.
- Patient involvement in discussions and decisions about their care and treatment.
- The ward environment and the quality and choice of food.
- Care and treatment including pain control.

Overall, feedback is consistent with the findings of the 2018 survey and with other Trusts for most questions. There was an improvement from the previous year on the following question:

- During your hospital stay, were you ever asked to give your views on the quality of your care?

The Trust scored less well however in relation to waiting times for a bed to be available on a ward and information provided when patients were referred to a specialist.

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

- 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:

- Development of a Trust-wide and Divisional action plan to address any issues identified.
- The Trust will continue to actively seek feedback from patients, carers and family members about their experience of care while using our services.
- Clinical Divisions will be encouraged and supported in reviewing and responding to feedback received to improve the experience of patients, families and carers.
- The Trust will continue to drive and embed the NHS Vital Signs National Improvement Project working in partnership across Pennine Lancashire to deliver improvement practice.
- Continue to engage and involve patients and the public in quality improvement projects, working with our Public Participation Panel which supports patient led change throughout the Trust, with a particular emphasis on ensuring that the views of patients and carers are considered and our services meet the needs and perspectives of service users.
- Development of a framework for the establishment of a Children and Young People's Participation Group.
- The Trust continues to have a strong relationship with Healthwatch which is demonstrated by their involvement and support in quality improvement projects and the ongoing support and commitment of Healthwatch Blackburn with Darwen in the development of our Public Participation Panel.
- Strengthening of links with local groups and organisations within the community to further engage with patients and the public.
- The ongoing development of "Always Events" within the Trust based on feedback from patients about "what matters" to them.
- The development of a new single Acute Medical Unit system of care which will aid effective patient flow and improve the patient experience.

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 83% 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 77% of staff respondents would recommend the Trust as a place to work during the reporting period.

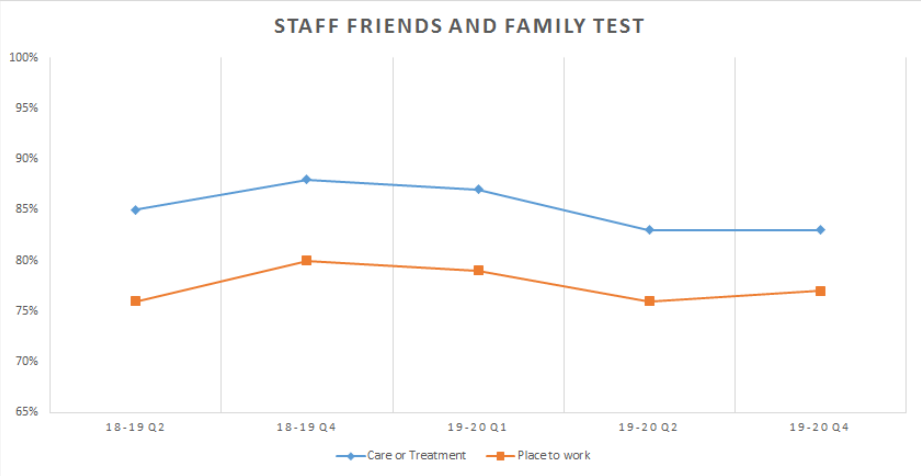
The Trust scored 7.3 for the overall staff engagement score on the 2019 national staff survey which is significantly above the national average of 7.1 for Combined Acute and Community Trusts in 2019. The national staff survey also highlighted that ELHT remains in the best 20% for staff satisfaction with 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.
- 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.
- To promote, gather, analyse and action staff suggestions, involvement and feedback from employees within the organisation.
- To progress 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.
- 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)

Many patients are now familiar with the Friends and Family Test (FFT), which offers those that have recently received care within acute hospital Trusts, the chance to rate whether they would recommend for their friends or relatives to receive similar care within the same environment. Patients are invited to respond to the question by choosing one of six options ranging from extremely likely to extremely unlikely. Due to the Covid-19 pandemic the Trust has had to make some temporary changes in how we provide FFT; currently inpatients, including surgical day case attenders, accident and emergency attenders, maternity, outpatient attenders and community service users are asked this question.

We are really pleased that so many of our patients take the time to offer their views, our response rates are some of the highest nationally for an acute trust. Table 1 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 (the national average) for the period April 2019 to March 2020.

	April 2019	May 2019	June 2019	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
Inpatient % patient response rate												
ELHT	49	53	52	52	55	52	49	55	53	60	71	36
Nat Ave	24	24.8	25.1	26.1	25.6	25	25	24.8	22.6	24	24.4	Not available
A&E % patient response rate												
ELHT	15	16	23	22	24	19	20	20	19	17	18	19
Nat Ave	11.5	12.1	12.1	12.4	13.2	12.2	12.6	12	11.6	11.7	12.1	Not available
Combined inpatient and A&E patient response rate												
ELHT	26	28	32	32	33	30	29	32	29	30	33	25
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 the national average for the period April 2019 to March 2020. As you will note, our A&E recommend rate varies around the national average, whilst our inpatient experience consistently surpasses the national average.

	April 2019	May 2019	June 2019	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
Inpatient % recommend												
ELHT	99	99	98	99	99	98	99	99	99	99	99	99
Nat Ave	96	96	96	96	96	96	96	96	96	96	96	Not available
A&E % recommend												
ELHT	81	81	85	84	86	86	84	81	84	85	85	88
Nat Ave	85	86	86	85	86	85	85	84	84	85	85	Not available
Combined inpatient and A&E recommend												
ELHT	92	93	92	92	93	93	92	91	92	93	94	94
Nat Ave	Not available											

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:

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

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 (2019-20) Data submitted from Trust to NHS UNIFY system. Data available at NHSEI site : https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/		**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Year to Date**
East Lancashire NHS Trust	Number of VTE assessed admissions*	34280	34611	35285	The VTE data collection and publication is currently suspended by NHSEI to release capacity in providers and commissioners to manage the COVID-19 pandemic. This was communicated via letter on 28th March 2020	
	Total admissions	34895	35195	35863		
	% of admitted patients risk assessed for VTE(rounded to nearest decimal)	98.24%	98.34%	98.39%		**98.33%**
National	Number of VTE assessed admissions	3652237	3800582	3793465		
	Total admissions	3819176	3980834	3979503		
	% of admitted patients risk assessed for VTE (rounded to nearest decimal)	95.63%	95.47%	95.36%		**95.44%**
Best perform-ing Trust	(The Trusts reporting 100% all have small numbers of admissions and come under independent sector)	ELHT ranked 15th among acute NHS Trusts	ELHT ranked 15th among acute NHS Trusts	ELHT ranked 16th among acute NHS Trusts		
Worst perform-ing Trust		69.76%	71.72%	74.07%		

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 97% since July 2013, above 97.5% since July 2014 and above 98% since July 2016.

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

- Support is requested from Trust Board to continue the VTE committee with adequate and appropriate operational support from Quality and Safety team to ensure that high standards achieved as one of the top ten Acute NHS Trusts in the country for year ending 2018/19 is restored and sustained long term.
- A drop in VTE risk assessment figures from 99% in 2018/19 to 98.3% in 2019/20 is noted. This is due to impact of transition phase from change in VTE risk assessment documentation from historical paper version to the electronic risk assessment in Extramed Hospedia system. A transition period was allowed when documentation was still accepted in paper version but organizational figures were calculated from electronic system. Currently full transition to electronic system is completed and therefore figures are expected to improve with ongoing support through VTE Committee.
- 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). Operational support in ongoing manner is requested from Quality and Safety team to continue the effective functioning of VTE committee.
- Trust is currently participating in the National VTE GIRFT audit (Getting it right first time) which will further enable to benchmark Trust position nationally. Once GIRFT VTE audit report is received from the national audit forum, a Trust wide Action plan will be developed through the Trust VTE committee and implemented to incorporate shared learning from GIRFT audit cross organisationally.
- Each of the Trusts divisions participates in VTE clinical audits to ensure effective compliance with VTE risk assessment on admission.
- VTE committee and its Quality Improvement group leads on focused quality improvement projects to enhance the robustness of the VTE risk assessment.
- 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 in three languages namely English, Polish and Urdu.
- A short educational video for patients on how to self-administer Low dose heparin injections was developed through Family Care Division to benefit pregnant women. VTE committee is now exploring to develop an educational video for all patients needing to use this medication for VTE prevention in the Trust.
- A new pathway for VTE diagnosis and management was recently approved as a pilot incorporating Age adjusted D-Dimer testing in those aged over 50 years before the NICE guidance was published. Trust wide implementation of this pathway was delayed due to Covid pandemic. This will soon be resumed now during the restoration phase2 as Age adjusted D-Dimer testing is recommended in updated NICE guidance 2020. This will help reduce anxiety among patients over age 50 and reduce the need for unnecessary imaging such as CT pulmonary Angiography and VQ scan with financial and efficiency gains besides enhancing patient experience.

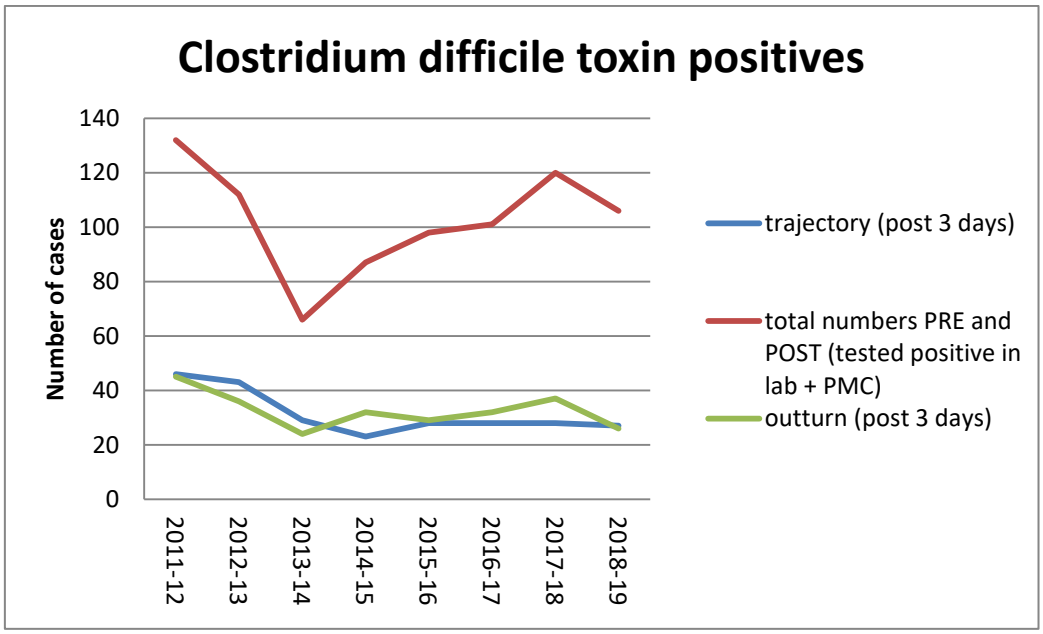
  NICE VTE guidance update was delayed in its publication nationally by more than a year and published only recently in April 2020 after National lockdown during Covid19 pandemic. Trust VTE policies are currently updated based on this national guidance and awaiting approval at the next VTE committee.

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 70 clostridium difficile positive which is over the trajectory set at 51.

In 2019/20 changes were made to the reporting algorithm whereby the number of days to identify hospital onset healthcare associated cases reduced from ≥ 3 to ≥ 2 days following admission and also the addition of a prior healthcare exposure element for community onset cases.

Clostridium difficile toxin positive results from April 2019 – March 2020:



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

Assertive action on management of hospital acquired infections has been undertaken for a number of years to reduce the rate to the present level. Each case of HOHA & COHA are discussed at the C. difficile multidisciplinary CCG meeting to determine lapses in care. (These have not taken place over the past 5 months due to COVID)

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 bi-annually 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.

Patient safety incidents per 1000 bed days	**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**	**Oct 2018 to March 2019**	**April 2019 to Sept 2019**
ELHT number reported	8190	7563	6732	6579	7010	7122	7032	7401	6426	6398	8128
ELHT reporting rate	55.7	48.2	44.18	42.05	44.9	44.8	45.5	46.4	42.0	40.9	52.0
Cluster average number	4196	5458	4647	4818	4995	5122	5226	5449	5583	5841	6276
Cluster average reporting rate	35.9	31.2	39	39.6	40.7	41.1	43	43	44.5	46	50
Minimum value for cluster	35	443	1559	1499	1485	1301	1133	1311	566	1278	1392
Maximum value for cluster	12020	12784	12080	11998	13485	14506	15228	19897	23692	22048	21685
Patient safety incidents resulting in severe harm	**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**	**Oct 2018 to March 2019**	**April 2019 to Sept 2019**
ELHT number reported	29	28	18	16	13	8	14	9	6	9	5
ELHT % of incidents	0.4	0.4	0.3	0.2	0.2	0.1	0.2	0.1	0.1	0.1	0.1
Cluster average number	15.5	17.3	15	13.7	13.4	13.8	13	13.5	13.5	14	15
Cluster average reporting rate	0.9	0.4	0.4	0.3	0.3	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	0	0
Maximum value for cluster	74	128	89	85	75	67	92	78	74	62	76
Total incidents across cluster	2168	2373	2052	1862	1826	1872	1821	1810	1771	1780	1896
Cluster % of incidents	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.2	0.2		0.2
Patient safety incidents resulting in death	**April 2014**	**Oct 2014**	**April 2015**	**Oct 2015**	**April 2016**	**Oct 2016**	**April 2017**	**Oct 2017**	**April 2018**	**Oct 2018**	**April 2019**

	to Sept 2014	to Mar 2015	to Sept 2015	to March 2016	to Sept 2016	to March 2017	to Sept 2017	to March 2018	to Sept 2018	to March 2019	to Sept 2019
ELHT number reported	3	6	8	8	6	8	2	2	1	6	4
ELHT % of incidents	0	0.1	0.1	0.1	0.1	0.1	0	0	0	0.1	0
Cluster average number	4.9	5.2	5	5.7	5	5.5	5	5.3	5.1	5.2	4.8
Cluster average reporting rate	0.2	0.1	0.1	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	0	0
Maximum value for cluster	27	24	22	37	36	31	29	24	22	23	24
Total incidents across cluster	683	716	665	780	690	751	661	712	706	678	628
Cluster % of incidents	0.1	0.1	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 in the last reporting period has increased from the previous 3 years. Staff are encouraged and understand the importance of reporting all levels of incidents across the Trust so that learning can be shared. The Trust does however consistently report higher numbers of incidents compared with similar Trusts in the cluster, which demonstrates an open and honest culture within the Trust. 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 has a comprehensive harms reduction programme supported by Quality Improvement Team and Quality and Safety Unit which provides assurance of the reduction in harms to the Trusts Quality Committee. The Trust is not an outlier in terms of severe harms and deaths due to patient safety incident and have seen a decrease in the number of these severity of incidents year on year.

In early 2020 the Trust was approached by NHS England and NHE Improvement to be an early adopter for the draft NHS Patient Safety Incident Response Framework which is replacing the Serious Incident Framework (SIF). In 2020 – 2021 the Trust will be focusing on the implementation of the PSIRF which will include:

- Enhancing capabilities in being open when things go wrong
- Further developing robust support mechanisms for patients, staff and investigators affected by or involved in patient safety incidents
- Developing the Trusts Patient Safety Incident Response Plan (PSIRP) in consultation with stakeholders and getting agreement for the plan from our commissioners and NHS England
- Enhancing Knowledge, understanding, application and monitoring of patient safety improvement as the key output in response to patient safety incidents that will lead to quality improvement programmes.
- Providing feedback on the PSIRF to NHS England and NHS Improvement to support the development of the final version of the framework.

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 2019/20 the Trust has reported 5 incidents that meet the criteria of the NHS Never Event Framework:

Type of Never Event	Number
Wrong site surgery	1
Retained foreign object post procedure	4

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 have been developed, updated and assurance provided to Executive Management Team on a monthly basis.

Learning from Never Event Incidents

On five occasions within 2019-20 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:

- Multi professional shared learning from incidents, based around the five steps to safer surgery, Local Standards for Invasive Procedures (LocSSIPs) with scenario based training for all clinical staff
- A more robust processes has been developed and being implemented across the Trust (including updating Trust Policy) to ensure that the National Patient Safety Alert NHS/PSA/RE/2015/008: Supporting the introduction of the National Safety Standards for Invasive procedures is actioned in full and assurance provided to the Trusts Quality Committee and our Commissioners. Improvements include:
    - Development of a clear document structure and pathway for approval and reviews of LocSSIPs
    - Ensuring the trust has a library of LocSSIPs which is up to date and easy to access by all staff
    - Development of e-learning package on LocSSIPs to raise awareness
    - All local inductions for new staff identify any LocSSIPs that service use, how to access and the standards for completion
    - Audit programme to monitor the compliance of LocSSIPs and identify any further areas of improvement

3.3.12 Learning from Deaths

Throughout 2019/20 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 identification of cases to be reviewed follows the processes identified within 'Learning from Deaths' and in line with National Guidance.

Not every death is subjected to an SJR; the primary reasons for triggering an SJR are listed in the trusts learning from deaths policy. The triggers for SJR are reviewed and amended in line with alerting groups.

Breakdown of deaths in 2019-20 and number of completed SJR's for this time period.

Total number of inpatient deaths 2019 - 2020	**Completed**	**2019-2020**		
	Q1	453		
	Q2	440		
	Q3	564		
	Q4	522		
Total		1979		
Number of Stage 1 & 2 SJR's completed 2019 - 2020		**SJR 1**	**SJR 2**	
	Q1	50	6	
	Q2	67	9	
	Q3	52	6	
	Q4	82	4	
Total		251	25	
Number of Stage 2 SJR cases completed and number of which were sent for Concise Review or Route Cause Analysis 2019 – 2020 Cases which scored 1 - Very Poor or 2 – Poor and where deficiencies in care may have contributed to death		**SJR 2**	**Sent for Concise Review**	**Sent for RCA**
	Q1	4	0	4
	Q2	2	0	2
	Q3	4	2	2
	Q4	1	0	1
Total		11	2	9

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

Areas of good practice the Trust has highlighted include:

- Timely intervention and management by the trusts acute care team
- Management of extremely unwell patients on critical care

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

- Management of the deteriorating patient
- Management of end of life care
- Recognising and acting on delays in inpatient treatment or investigation pathways
- Communication with families.
- Consideration of nutrition in unwell patients

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.

Paediatric Mortality

At East Lancashire Hospitals NHS trust, all Paediatric deaths including out of hospital deaths are reviewed through a mortality process. In 2019 a strengthened review process more akin to the structured judgement review process used in adults was implemented. All paediatric deaths are subject to a multidisciplinary primary review with a paediatric consultant and senior nurse reviewing the case in a structured way. Following this all deaths are reviewed at the paediatric mortality group consisting of consultant's senior nurses and doctors in training. Actions for improvements are noted and implementation is monitored through this group.

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

		In Hospital	At Home	Another Trust	Out of Area
Total number of Paediatric Deaths by Location and quarter the Death occurred 2019/2020	**Q1**	1	4	1	1
	Q2	3	3	1	1
	Q3	2	1	2	2
	Q4	1	6	2	0
Total		**7**	**14**	**6**	**4**
Number of Stage 1 & 2 PMR's completed during by quarter 2019/2020 And the number which required an RCA	**Completed**	**PMR 1**	**PMR 2**	**Sent for RCA**	
	Q1	3	0	0	
	Q2	5	5	0	
	Q3	11	5	0	
	Q4	5	9	0	
Total		**24**	**19**	**0**	

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

- Timely medical reviews undertaken when concerns were raised
- Timely investigations when clinical picture frequently changing
- Close working with specialist centre
- HDU trained staff on duty
- Good consultant continuity and review
- Good multiple management approaches

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

- Importance of effective and structured handover, especially in complex/HDU patients
- Importance of following Standard operating policy PEWS policy to prompt consideration of sepsis in a deteriorating patient
- Identify scribe during resuscitation for retrospective prescribing of drugs given
- A redesign of the prescription chart to allow timings to be bespoke
- Blood pressure compliance is poor therefore criteria and compliance to be audited
- Further education for all Doctors in the use of PEWS stickers and considering sepsis
- Introduction of ward round check list to ensure that PEWS compliance, observations and fluid balance are reviewed on a daily basis followed by monitoring and auditing of same
- Requesting consultant to allocate prescribing of medication and document in notes

Learning Disability Mortality Reviews (LeDeR)

Learning Disability Mortality Reviews (LeDeR) are routinely completed following the death of inpatients who had a known Learning Disability. These reviews are reported through the Mortality Steering Group and actions from learning monitored.

The reviews outline key areas such as Contributory Factors, Problems with Service Delivery, Good Practice. Any inpatient with a known Learning Disability will receive a Mortality Review as defined by National guidelines and Trust process.

If a LeDeR review identifies any concern that care has been directly affected as a result of the person having a Learning Disability either an SJR or an RCA can be requested to enable a thorough review of the care provided.

All deaths of patients who had a Learning Disability are routinely uploaded to the National LeDeR data system and an external review completed. The process is monitored through East Lancs CCG and the Trust has remained an active partner in the regional LeDeR steering group.

Breakdown of Learning Disability deaths in 2019/20 and number of completed LeDeR's for this time period by financial quarter:

		2019/20
Total number of Learning Disability deaths 2019 - 2020	**Q1**	2
	Q2	2
	Q3	6
	Q4	3
Total		13
Number of LeDeR's completed 2019 - 2020	**Q1**	12
	Q2	2
	Q3	0
	Q4	1
Total		15
		RCA
Number of LeDeR which required an RCA	**Q1**	0
	Q2	0
	Q3	0
	Q4	0
Total		0

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

In November 2019 within Medicine 75% of acutely admitted patients are seen by a consultant within 14 hours of admission on both weekdays and weekends. The target is particularly challenged for patients admitted after midday. Successful consultant recruitment in acute medicine will enable more inreach to the emergency department in the future, therefore increasing early review.

In Surgery between July and November 2019 on average 65.5% of patients had consultant review within 14 hours of admission on weekdays and 75% during weekend. Considerable redesign of acute surgery has been undertaken including a new extended consultant rota from January 2020.

In Paediatrics between July and November 2019 72% of children had consultant review with 14 hours during week days and 47% at weekends. Consultant staffing in paediatrics focuses on children who can be discharged within 14 hours, and we are not able to provide the same level of consultant staffing at weekend.

The standard of 90% is fully met for vascular surgery.

For Stroke patients 86% had a Stroke Consultant review within 14 hours of admission to the Stroke Unit, 44% had review before admission for the quarter until November 2019.

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 95% of patients have daily consultant review. This falls to 75% at weekends
- For patients requiring twice daily review that meet level 2 or 3 criteria, this is achieved 84% of the time on weekdays and 55% of the time at weekends.

3.3.14 Staff can speak up (Freedom to speak up)

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

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

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

- Though the Staff Guardian - identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with direct access to anyone in the organisation, including the chief executive, or if necessary, outside the organization.

- If a concern remains then they can be brought to the attention of our Executive Director or Non-Executive Director with responsibility for whistleblowing or one of the external bodies as listed in the Trust Policy.

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

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

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

3.4 Other Quality Achievements

3.4.1 Hospital experts demonstrate state-of-the-art eye testing to opticians

Optometrists from across East Lancashire attended a lecture hosted by the Ophthalmology Service at East Lancashire Hospitals NHS Trust, to learn more about Ocular Coherence Tomography (OCT).

A lecture was held at the Royal Blackburn Hospital site open to optometrists from the area to explain OCT scanning. Specialist Optometrists presented cases where OCT had proved invaluable to patient care.

An Optical Coherence Tomography scan creates a cross-section view of the eye, allowing an optometrist to see the structure inside. More advanced than traditional imaging methods, OCT scanning is useful for detecting sight-threatening conditions, like macular degeneration or glaucoma, that don't tend to have any symptoms until they start to have an impact on a person's vision. The non-invasive imaging test is not only more advanced, but is also a safer way for ophthalmologists to access the detailed images of the eye that they need.

As OCT scans become more widely available in the area, in community optical practices and high street opticians the Ophthalmology Service invited staff to the lecture to explain how to interpret the images. Attendees were asked to pay a fee to attend, which has been donated to ELHT&Me, the hospital's charity. The money will be spent improving patient experience within the Ophthalmology Department, beyond standard NHS funding.

3.4.2 Digital health pioneers awarded by NHS Innovation Agency

Clinical coding specialists at East Lancashire Hospitals NHS Trust (ELHT) have been rewarded for their outstanding performance by winning a prestigious award presented by the Innovation Agency.

East Lancashire Hospitals was among the winners at the North West Skills Development Network's Informatics Awards, part of the Connect 2019 conference showcasing pioneering work in digital health.

Clinical coders are health information professionals whose main duties are to analyse clinical activity and assign codes using a classification system. In simple terms, every clinical service provided by NHS Trusts such as East Lancashire Hospitals generates clinical codes, without the correct clinical code, the local NHS might not assign the correct costs to patients or generate the correct statistical data.

East Lancashire Hospitals' clinical coding team were named team of the year in recognition of a number of achievements, including five members of the team achieving their National Clinical Coding Qualification, with one coder achieving a double distinction.

3.4.3 First patients welcomed into new Fairhurst Building

Burnley General Teaching Hospital's brand new £15.6 million Fairhurst Building will welcomed its first patients on Monday 14 October 2019.

Patients with an appointment for the Orthodontic, Maxillofacial Surgery and General Outpatient clinics at Burnley General will be seen in the state-of-the-art Fairhurst Building. Previously these clinic appointments were carried out in a much older part of the hospital.

Completion of the Fairhurst Building is the latest milestone of a £60 million development programme at Burnley General which began in 2003 and demonstrates East Lancashire Hospitals' long term commitment to delivering truly integrated, high quality treatment and care across East Lancashire.

In the last three years alone, East Lancashire Hospitals has opened the Lancashire Elective Centre, Primrose Chemotherapy and Breast Care Unit, new children's outpatients and upgraded the hospital's theatres.

3.4.4 Greater collaboration for two North West Trusts

East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT) have agreed to work in closer collaboration, with Kevin McGee as the Chief Executive and Accountable Officer of both Trusts.

Mr McGee has been undertaking this role since May 2019, with both Trust Boards, NHS England and NHS Improvement (NHSE/I) supporting the appointment. This strategy of collaboration follows extensive discussions with Board members of both organisations, the Governors at Blackpool FT, governance advisors and regulators and will see both Trusts benefit form sharing good practice and experience.

The arrangement brings with it many benefits for the patients, staff and stakeholders of both organisations, including:

- Enhancing quality of care
- Drive towards financial sustainability
- Improving performance
- A strengthened leadership team across both Trusts
- A strong career offer to all staff which will lead to more effective recruitment and retention, attracting the best staff and keeping them
- Enhanced education and training, research and development with enhanced links to our local Universities
- Quality improvement with scalability to ensure a move towards a consistent delivery of services
- The ability to undertake a strategic review of services.

The move to greater collaboration is in line with the national NHS strategy and the NHS Long Term Plan and reflects a paradigm shift in how providers in Lancashire and South Cumbria will work together in future to meet the significant health and care needs of the population. The Trusts will continue to work with partners in their local ICPs, (Integrated Care Partnerships) as well as the wider Lancashire and South Cumbria (ICS) Integrated Care System (Healthier Lancashire and South Cumbria).

An ongoing assurance process has been agreed with NHSE/I to pave the way for a future where the Trusts continue to work effectively together to deliver quality outcomes and improved patient experience and play an active role in supporting the ICS strategic objectives.

The Trusts will continue to work collaboratively with the ICS to ensure that we see a step change in delivery via closer collaboration and attain the system's goal of delivering the agreed health and care outcomes for the people in Lancashire and South Cumbria.

3.4.5 Rainbow Pregnancy Clinic launched for expectant mums in East Lancashire, to coincide with Baby Loss Awareness Week

East Lancashire Hospitals NHS Trust has launched its Rainbow Pregnancy Clinic, in line with Baby Loss Awareness Week. The clinic provides specialist clinical and holistic care for women who fall pregnant following late miscarriage, stillbirth and early neonatal death – a 'rainbow' pregnancy.

The Rainbow Pregnancy Clinic is based on continuity of care for parents expecting a rainbow baby, in a specialist multi-disciplinary team. This bespoke antenatal clinic is led by consultants, with additional midwifery support and shared care with other relevant services. Expectant parents are able to use a separate waiting area when visiting the clinic, and can attend more regular 'reassurance scans' to ensure the health of the unborn baby.

The Clinic also works closely with the Reassurance Early Pregnancy Clinic, where women expecting a rainbow baby can be referred as early as five weeks, much earlier than the standard of 16 weeks, and can access emotional support as well as early scans. These mums are then seamlessly transitioned to the Rainbow Pregnancy Clinic as their pregnancy continues. This care is offered during subsequent pregnancies too, providing specialist care for every new baby a mother may have following a loss.

Baby Loss Awareness Week 2019 took place between the 9-15 October, and is a collaboration between charities and organisations working together to raise awareness about the issues surrounding pregnancy and baby loss in the UK. It is an opportunity for bereaved parents, and their families and friends, to unite with others across the world to commemorate their babies' lives.

3.4.6 National accreditation for ELHT specialist endometriosis service

ELHT has been accredited by the British Society for Gynaecological Endoscopy (BGSE) as a national centre for Endometriosis.

The Trust's Lancashire Women and Newborn Centre at Burnley General Teaching Hospital is one of only three in the region providing a specialised service for patients with endometriosis and the BSGE accreditation cements the position of ELHT as a leading centre in this area of gynaecological care.

Endometriosis is a chronic disease where tissue which behaves like the lining of the womb is found in other areas of the body. These cells react to a woman's menstrual cycle each month and also bleed. As there is no way for this blood to leave the body, the condition causes inflammation, severe pain and the formation of scar tissue. The condition affects around one in ten women in the UK and other symptoms include heavy periods, pelvic pain and chronic fatigue.

To become an accredited centre, a hospital must meet stringent criteria regarding the service it provides to patients. Requirements include a dedicated, consultant-led endometriosis service run within a specialist outpatient clinic and access to a multidisciplinary team including two colorectal surgeons, urologist, pain management specialists and two Endometriosis Nurse Specialists.

The ELHT team are of one of only three specialist services north of Manchester, and referrals are made to them from across the region, covering a wide area from Blackpool in the west,

Manchester in the south, up to the Lake District and West Yorkshire in the East. Women can also search a national database of endometriosis centres and request referrals to a centre of their choosing. Increasingly, ELHT are being selected as the provider of choice by women from across the country.

In addition to leading the way in clinical excellence, the team at ELHT is also building on the hospital's strong reputation for excellence in training. The next generation of expert endometriosis surgeons are now being trained here in East Lancashire.

3.4.7 Patient safety magazine wins GOLD award

The Communications and Quality and Safety teams at East Lancashire Hospitals NHS Trust celebrated winning GOLD at the Chartered Institute of Public Relations (CIPR) North West Pride awards this weekend.

The team was one of only three to be shortlisted and were recognised in the 'Best Publication' category for their 'Share2Care – Human Factors' magazine which centres around patient safety.

The judges' comments stated: "This publication deals with a very tricky subject but reminds us of the critical human impact one can have. The design was clean and engaging, but it was the critical core content that the judges felt made this publication stand out. It's easy for an organisation to say it will learn from its mistakes – this publication makes that a reality."

Organised by the Chartered Institute for Public Relations, the PRide awards is an annual ceremony that showcases the very best of public relations and communications within each region.

3.4.8 East Lancashire Young Person's Mental Health Service Achieves Extra Accreditation

The Burnley-based East Lancashire Child and Adolescent Service (ELCAS) has become just the second service in the UK to receive a national accreditation for quality. The service has been accredited by the Royal College of Psychiatry's Quality Network for Community CAMHS (QNCC).

The accreditation is valid for three years (March 2022), subject to continued evidence of compliance and a yearly review to ensure ELCAS upholds standards.

QNCC is a network hosted by the Royal College of Psychiatrists which works with professionals from health, social services, education and the voluntary sector to improve the quality of young people's mental health services.

ELCAS is also the only young person's mental health service in England to achieve both QNCC accreditation and an 'Outstanding' from the Care Quality Commission which was announced in February 2019.

3.4.9 Patients PLACE hospitals highly for cleanliness, food and overall environment

Top marks for food, cleanliness, and overall condition of the environment have been awarded to East Lancashire Hospitals NHS Trust (ELHT) in the Patient-Led Assessment of the Care Environment (PLACE) report for 2019.

Compiled from reports by 58 independent inspectors during Autumn 2019, the Trust's rating for cleanliness rose to 97.78% compared with 94.40% the previous year.

ELHT also once again achieved high scores for food (85.07%) and overall condition, appearance and maintenance (92.95%).

PLACE assessments take place across the country and patient assessors (local people) go into hospitals to assess how well NHS organisations are meeting the needs of patients, and identify where improvements can be made.

3.4.10 East Lancashire mums have 100% confidence and trust in maternity staff, survey says

East Lancashire Hospitals NHS Trust (ELHT)'s maternity staff have been praised in the Care Quality Commission (CQC) Maternity Survey 2019. 100% of women who responded to the survey said that they had "confidence and trust" in the staff caring for them during labour and birth.

The Trust's scores for the survey, which asks women about their experience before, during and after birth, have remained consistent with their 2019 scores, their highest ever.

Examples of the positive feedback from the East Lancashire mums that responded include:

- 99% felt listened to by their midwife at antenatal check-ups
- 99% felt involved in decisions about their antenatal care
- 98% were asked about their mental health at antenatal check-ups, and 95% were asked at follow-up visits at home, following the birth of their baby
- 98% felt that they were treated with respect and dignity during labour
- 98% felt they were treated with kindness and understanding following the birth of their baby
- 94% had skin-to-skin contact shortly after birth

The results also demonstrate the positive impact of the Trust's 'Breastfeeding Friendly' status, with 79% of respondents having breastfed their baby, either solely or alongside bottle milk, and 98% feeling respected by midwives for their decisions about how they wanted to feed their baby.

Compared to the 128 other hospital trusts in England, ELHT performed significantly higher than the national average in questions relating to mental health support, giving birth in a comfortable atmosphere, advice and support during labour and involvement in care decisions.

The complete CQC Maternity Survey 2019 report for East Lancashire Hospitals is published by the CQC on their website: cqc.org.uk/maternitysurvey

3.4.11 National Emergency Laparotomy Audit (NELA)

NELA gathers a wealth of information about one of the most risky types of emergency operation with the aim to saves lives and quality of life for survivors enhanced by measuring and improving the care delivered.

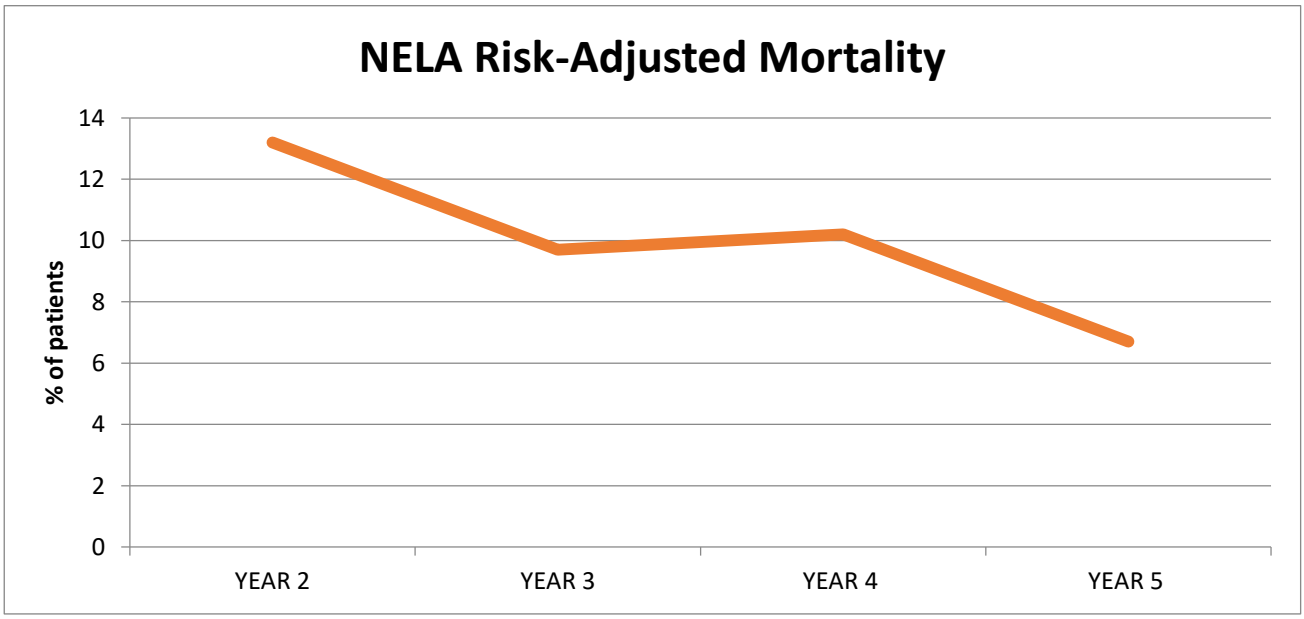
The Year 5 Nela report published in 2019 highlighted that ELHT are now within the top 20% of the country for emergency laparotomy mortality which has been reduced from 13.2% to 6.7% in the last 4 years. The national average has remained static for the last two years at 9.6%.

For the second consecutive year we have achieved 100% case ascertainment which indicates that our clinicians are identifying patients promptly and these patients are being initiated on the pathway of care aligned with standards set by NELA. These standards include our high risk patients having both consultant surgeon and anaesthetist leading care and being present in

theatre, we achieve this is in 90% of patients, with 92% also going directly to critical care post-operatively.

This year we have successfully improved the consent process with the introduction of a standarised consent form detailing possible risks clearly, in addition it requires the assessment and documentation of a formal NELA risk prediction score. The risk an operation poses to a patient is used as part of the pre-operative discussion with patients and their loved ones to ensure that they are involved in their care planning and decisions being made about them. The year 5 NELA report 2019 showed that our compliance with risk prediction assessment was 89% well above the national average of 77% and a standard that we have improved on annually from our initial compliance of 61% in year two.

Our enhanced recovery programme is now established in emergency laparotomies with focus on a partnership in care, supporting patients to regain independence and getting them back to what is normal for them. We have a reported reduction in median hospital length of stay from 12.3 to 10.6 days for the last year.



We carry out around 200 emergency laparotomies per year, this reduction in mortality equates to 13 more people

3.4.12 Top Flu Fighters, the best in the country

East Lancashire Hospitals NHS Trust (ELHT) believes that the flu vaccination programme is one of the most important ways of maintaining **Safe**, **Personal** and **Effective** Care across the organisation.

In 2019 East Lancashire Hospitals was the highest performing trust in the country for the uptake of flu vaccinations for frontline health care workers and this is the second time in three years that we have been the Trust with the highest uptake.

East Lancashire Hospitals (ELHT) Frontline Health Care Workers (HCW) Flu Vaccination Uptake 2017-2019	
Year	**Final Overall Frontline HCW Flu Vaccination Uptake (%)**
2019	**94.8***
2018	93.6
2017	**92.3***

**ELHT were the highest performing Acute trust in the country*

During the 2019/20 Flu season the uptake of the Flu vaccine in healthcare workers nationally was 74.3%. The final uptake of flu vaccinations at ELHT for the 2019/2020 campaign was **94.8%** and has exceeded last year's very successful campaign of 93.6%.

This is a truly impressive achievement which shows the high level of commitment our staff, particularly the frontline workers; have for the flu fighter campaign.

ELHT has been identified as one of the stand out Trusts in the UK and we have supported other organisation in their planning an implementation of their Flu campaigns. Planning is already under way for the 2020 Flu campaign as we aim to improve on last year's uptake.

3.4.13 Change to discharge planning meetings

Discharge planning meetings (DPM) are held where there is an identified need for additional support for parents and their babies. This usually (but not exclusively) relates to babies who are subject to child protection plans prior to birth. DPMs are meetings held with parents, social workers and other involved professionals to ensure safety plans and support is in place

Historically, DPMs have always been held in the hospital setting, prior to a mother and baby being discharged; all mums who were deemed to require a DPM were expected to deliver at Lancashire Woman's and New Born Centre in order for this to be facilitated. Previously, woman who delivered outside of this unit (either at home or at Blackburn for example) had to be transferred to LWNC.

The pilot proposal was as follows:

- Woman were to be given a choice on where to have their babies (Blackburn, Burnley, Rossendale birth centres, homebirth and birth suite).
- Woman and babies could be discharged once medically fit – midwives MUST inform social worker of delivery and discharge.
- The social worker would arrange the DPM in the family home, the next working day.
- Pilot was to last 3 months and parent's view and experiences would be sought to inform the 'patient story'.

The pilot evaluated well and the following themes were identified:

- No increased risk in relation to the babies was noted or reported

- Women, already distressed re child protection procedures, felt more in control of their birth experience. This will impact positively on attachment and bonding between mum and baby.
- DPMs held in the home were reported to be more positive experiences. This is important because building positive relationships between families and professionals has been shown to improve outcomes for children who are involved in child protection procedures.
- The post-natal ward reported a reduction in delayed discharges which positively impacted on capacity and work load.
- Colleagues in CSC reported that the pilot had demonstrated a more time effective way of completing DPMs.

In agreement with CSC, the pilot was adopted and is now standard practice in Lancashire CSC (East division).

3.4.14 Improvement Practice Team helps deliver sustainable improvements

As part of the NHS Vital Signs National Improvement Programme, East Lancashire Hospitals NHS Trust is working in partnership, across Pennine Lancashire, delivering Improvement Practice.

The work of the Improvement Practice Team at ELHT supports continuous improvement, which is aligned to key organisational and team objectives, in order to deliver reliable **Safe**, **Personal** and **Effective** Care.

The approach taken is to engage and empower staff in identifying and participating in improvement activity that will deliver sustainable improvement in their area of work, with measureable outcomes in the domains of Delivery; Quality; Cost; Morale (staff and patients).

Since its establishment in working with front line teams a number of measurable improvements have been achieved, for example:

- Theatres: 10% reduction in patient cancellations on the day
- Electronic referral from ward to District Nursing: releasing 1.23 whole time equivalent nursing time back into care
- Laundry: 70% of wards/ areas at RBH have implemented a standard replenishment system
- Endoscopy: reduction in cancellations on the day by 40%
- Respiratory ward: reduction in the average length of stay from 6.09 days to 4.47 days

3.4.15 Reduction in in-patient length of Stay

The Long Length of Stay Team was established in January 2020 as an NHS England funded Initiative to work cross divisionally with MEC, SAS and Complex case management for a focused MDT approach to systematically reduce LLOS to our trajectory set by NHS England of 123.

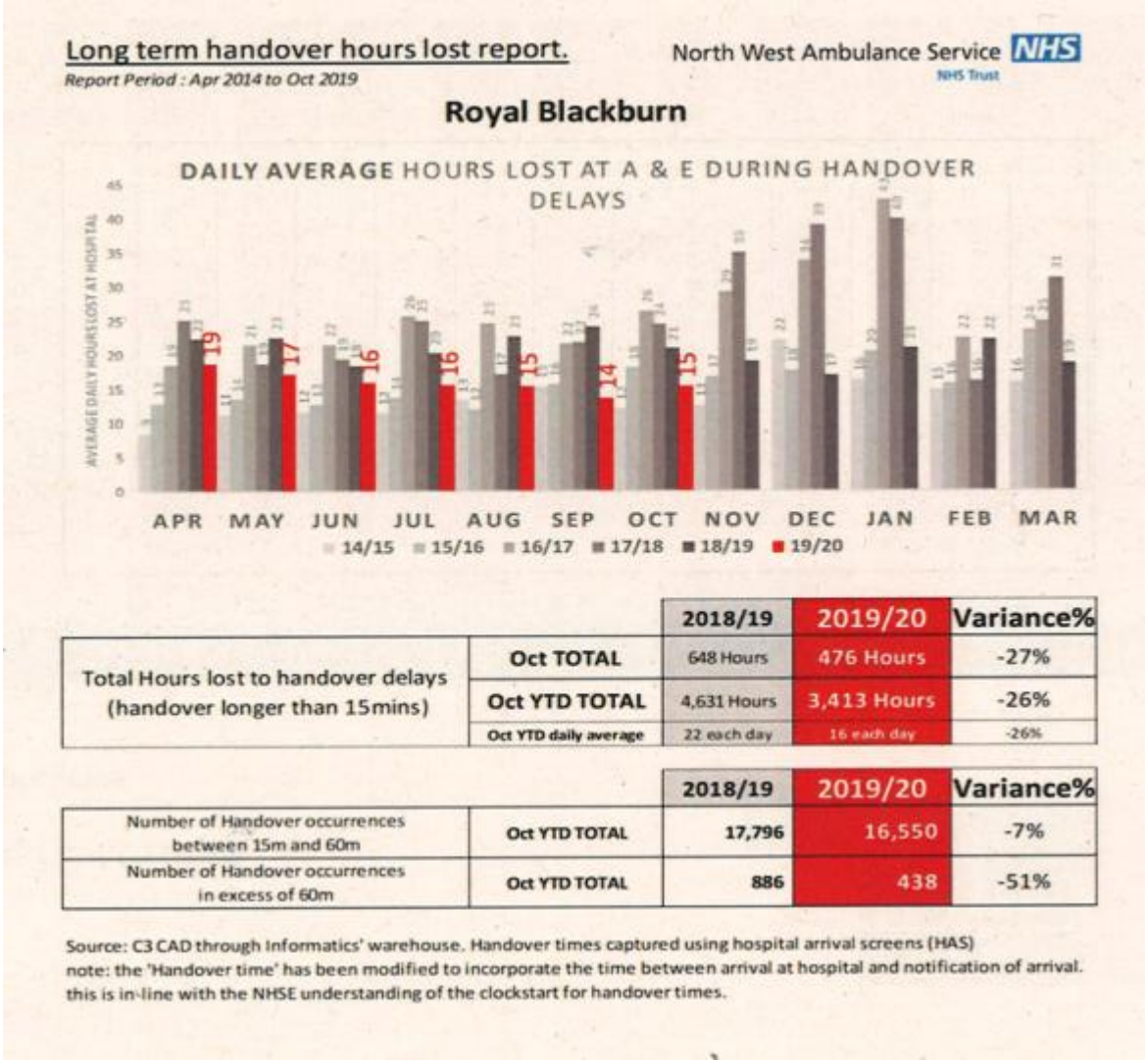
The RLLOS team embedded SAFER principles through cross divisional working with Divisional Leadership teams to create a culture of continuous improvements in service delivery. This was achieved by empowering, educating and instilling strong leadership and culture. The focus was on three wards that we recognised had higher length of stay compared to other wards and would benefit from coaching/ Quality Improvement in order to embed the SAFER principles,/ Red to Green approach and incorporating the 'Where's Best Next' questions. Also working with a recognised Quality Improvement focused ward to learn from their experiences of how they engaged staff and embedded these principles and reduced their LOS by 26%.

3.4.16 Emergency Department NWAS improvement work

The Emergency Department at Royal Blackburn hospital have taken part in phase 1, 2018 and phase 2, 2019, of the NWAS super 6 improvement programme. The aim of this programme was to make significant and sustained improvements to the ambulance handover and turnaround times.

The department created a champion group and worked collaboratively with our NWAS colleagues and have implemented several new processes and have sustained our improvements.

The data below shows the impact our work has had on reducing the number of lost ambulance hours.



		2018/19	2019/20	Variance%
Total Hours lost to handover delays (handover longer than 15mins)	Oct TOTAL	648 Hours	476 Hours	-27%
	Oct YTD TOTAL	4,631 Hours	3,413 Hours	-26%
	Oct YTD daily average	22 each day	16 each day	-26%

		2018/19	2019/20	Variance%
Number of Handover occurrences between 15m and 60m	Oct YTD TOTAL	17,796	16,550	-7%
Number of Handover occurrences in excess of 60m	Oct YTD TOTAL	886	438	-51%

Source: C3 CAD through Informatics' warehouse. Handover times captured using hospital arrival screens (HAS)
note: the 'Handover time' has been modified to incorporate the time between arrival at hospital and notification of arrival. this is in-line with the NHSE understanding of the clockstart for handover times.

The trust has successfully recruited 3 ambulance liaison officers from our own team, who have an important role to play in maintaining and achieving the 29 minute turnaround time. They are dedicated to making these improvements for our patients.

The Trust has been asked to take part in phase 3 to provide learning and examples to other trusts just joining the collaborative.

3.4.17 Refer-to-Pharmacy

ELHT innovated the world's first hospital to community pharmacy electronic referral system in 2015. This allows pharmacy staff to inform community pharmacists that their regular patients are in hospital (so they can stop dispensing for them; saving time and preventing medicine waste e.g. blister pack patients), and then at discharge the system sends a 'discharge notification' with a copy of the patient's Transfer of Care discharge letter, so the community pharmacist can see what has changed and ensure changes are actioned by GPs. The system is also used to refer patients into evidence-based medicines adherence improvement consultations (e.g. New Medicine Service) with community pharmacists; these have been shown to help patients get the best from their medicines and to stay healthy at home.

Refer-to-Pharmacy was designed by the ELHT Pharmacy team in co-production with several community pharmacists and software supplier Cegedim Rx. It is very quick and intuitive to use at both ends – referrals can take as a little as 10 seconds to make. Refer-to-Pharmacy received the 2016 Patient Safety award for Best Emerging Technology.

Outcome measures show hundreds of patients a month are referred, and of these some dozens will have errors intercepted by the community pharmacist on the patient's first post-discharge prescription from their GP. Also hundreds of hours are being saved by community pharmacists, and thousands of pounds in dispensed medicines waste is being prevented each year.

3.4.18 Dedicated Ward Pharmacy

This is ELHT's paradigm-shifting workforce transformation scheme, which started in 2016 and has revolutionised the way our pharmacy service is delivered; positively influencing patient flow, medicine safety, and patient and staff experience. The pilot revealed that patients had shorter lengths of stay, reduced readmissions (possibly related to using Refer-to-Pharmacy), went home earlier in the day, there was improved transfer of care into and out of the Trust, drug acquisition costs reduced, and recorded interventions revealed the nature and number of the thousands of interventions the pharmacy team delivered and which explained the reasons for these virtuous outcomes.

Dedicated Ward Pharmacy is where the same pharmacist spends their working day on just one ward (traditionally they'd cover 2 or more wards in a day). They actively participate in consultant-led multi-disciplinary ward rounds, advising on all aspects of medicines optimisation, preventing prescribing errors from occurring at source, and picking up intelligence relating to discharge plans so that Transfer of Care discharge letters are typically created the day *before* a planned discharge. Pharmacy Technicians and Pharmacy Assistants are also involved in supporting the scheme.

Pharmacy Technicians focus on medicines reconciliation of new patients i.e. acquiring the best possible medicines histories then identifying anomalies to be resolved on the next ward round. They support the discharge process by creating the medicines sections of Transfer of Care discharge letters for pharmacists to authorise. This is a role traditionally carried out by doctors, so it saves doctors' time. Pharmacy Assistants (now locally referred to as Dedicated Ward Dispensers) are carrying out more dispensing activity closer to patients (rather than remotely in the dispensary), which improves the turnaround time of dispensed medicines for discharge.

Word has spread about the Dedicated Ward Pharmacy service, and the Trust has hosted numerous visits from other hospital pharmacy teams who have come to learn how we innovated, delivered and spread the service. Several Trusts have started their versions of Dedicated Ward Pharmacy. As part of our spread strategy, the University of Manchester carried out a service evaluation during the second of the three phased deployment in 2018; some of their findings have been included in the final parts of the slide set.

3.4.19 SAFER / Effective Flow

The SAFER Patient Flow Bundle is a practical tool to reduce patient delays in hospital. When the five elements of SAFER are used consistently length of stay is reduced and patient flow and safety improves.

S - Senior Review. All patients will have a senior review before midday.

A – All patients will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD)

F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (> 7 days – also known as 'stranded patients') with a clear 'home first' mind set.

Using a 'plan, embed and sustain' methodology the SAFER Patient Flow Bundle has been introduced across adult inpatient and community wards, with implementation and sustainability driven through early engagement with key individuals. Real improvements in standardising ward and board round processes have been made to ensure effective care co-ordination and discharge decisions.

Sustainability of SAFER as "business as usual" relies on successful implementation of clinical leadership, communication, executive support, measurement and social movement. The sustainability plan involves measurement of ward based dashboards, planned progression for Long/Longer stay patients to include additional board round peer reviews and support, roll out of virtual board rounds to ensure compliance to social distancing, and review and implementation of Internal Professional Standards.

3.4.20 Supporting Mental Health Patients

The quality improvement project was developed out of research conducted by one of our chaplains and counsellors, and published in Nursing Times in 2018. The project seeks to improve the experience of mental health patients through staff training based on patient experience. It was initially founded on research conducted in conjunction with the University of Cumbria and this year the Health Research Authority approved further research with this patient group, which has now been completed.

Almost 2,000 members of staff have now completed the training with ELHT around working with suicide and self-harm risk, including all staff on Critical Care and the AMU's. The training is now also part of the ELHT's HCA induction programme and has been delivered within a number of other NHS Acute Trusts.

Feedback from the training, continues to be excellent, with currently 98% of staff attending stating that it should be required training for all staff.

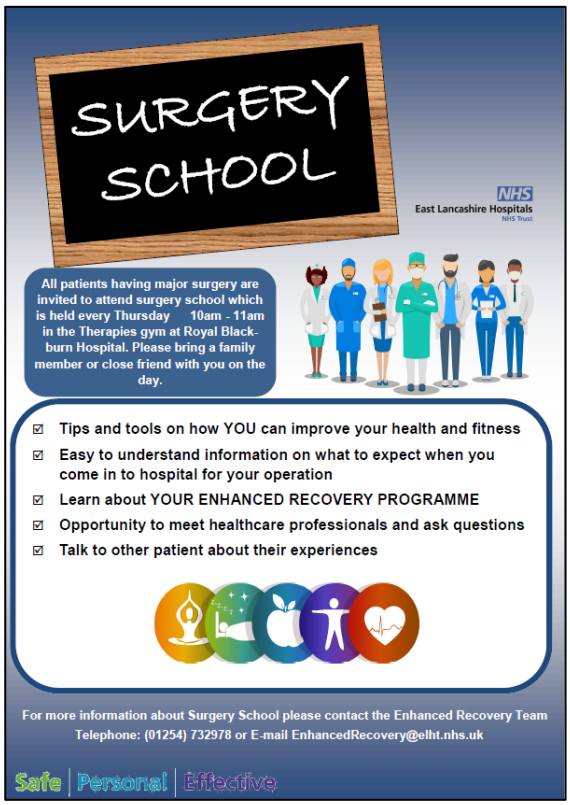
3.4.21 Surgery School

This year saw the launch of our Surgery School, an education session offered to all patients who are having major elective surgery within colorectal, urology and HPB. The school is led by the enhanced recovery nurse with a physiotherapist, acute pain specialist nurse and pharmacist all delivering information that is tailored to needs of this patient group.

We want our patients to feel empowered to take some responsibility to prepare for surgery, there is so much that can be achieved even within a short time, we focus on physical activity and chest training using incentive spirometry but also take time to discuss psychological wellbeing of our patients at an often worrying time. Our aim is to try to manage the expectations of patients and their families before they are admitted for surgery with the aim of reducing anxiety whilst giving them confidence that their active role in our partnership is essential and can actually improve their experience.

For the members of our multidisciplinary team surgery school is a fantastic opportunity to meet our patients and their families. Having familiar faces in the team caring for you when admitted to hospital has proven really positive for both patients and staff. At surgery school we aim to create an environment that encourages discussion with staff but also other patients. This communication has allowed us to identify some problems or concerns patients have had and we have been able to deal with these promptly with the aim of reducing any potential delay or anxiety in the run up to the surgery date.

Feedback from the patients who have attended is excellent and over the next year we hope to see many more patients benefit from going back to school!



3.5 Statements from Stakeholders

3.5.1 Healthwatch Blackburn with Darwen

Healthwatch Blackburn with Darwen is pleased to be able to submit the following considered response to East Lancashire Hospitals NHS Trust's Quality Accounts Report for 2019-20.

Part 1 including Statement on Quality from the Chief Executive:

This section of the Quality Account provides a clear 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 both the Pennine Integrated Care Partnership and the Lancashire and South Cumbria Integrated Care System. We have evidenced first-hand how the Trust has worked closely with partners in the Pennine ICP during the pandemic.

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 patient safety and to improve and transform services with partners to become a clinically and financially sustainable organisation as well as a learning organisation that is committed to the continuous improvement of care provided, an aspiration we fully support.

Part 2: Quality Improvement:

We are pleased to see the implementation of the Quality Strategy in 2019 and the recognition of this achievement by being requested to become an early adopter of the Patient Safety Incident Response Framework.

There are clear measures being taken to develop a robust quality improvement programme to not only improve CQC outcomes but also patient experience. We have been very happy to support the establishment of a Public Participation Panel in the last year and have been impressed by the Trust's involvement of the Panel in several new initiatives. We very much appreciate the continuous open working relationship with ourselves as a 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 2020-21

We note the initiatives listed in 2.3 which will receive specific focus during 2020-21 and would agree with the priorities as described.

Mandated Statements

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

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

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

Part 3 Quality Achievements and Statutory Statements

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

We also note the continued focus on improving care for the 0-15 age group and the work being carried out to deliver a seven day service meeting the clinical standards.

Summary

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

3.5.2 Healthwatch Lancashire

Healthwatch Lancashire is pleased to be able to submit the following considered response to East Lancashire Hospitals NHS Trust's Quality Accounts Report for 2019-20.

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 partners and the closer integration with other providers of health and care services within the Lancashire and South Cumbria Integrated Care System. We are particularly pleased that this work has been carried out through the NHS Vital Signs National Improvement Programme enabling a standardised approach to a range of pathways.

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 welcome the introduction of more frequent smaller-scale sampling and rapid feedback to provide real-time data collection and the implementation of subsequent improvement via the Clinical Effectiveness Committee as described.

We also note the comprehensive range of methods and routes to enable and encourage patient feedback to help services ensure that the views of patients and carers are considered.

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 2020-21

We note the initiatives listed in 2.3 which will receive specific focus during 2020-21 and would agree with the priorities as described.

We commend East Lancashire Hospitals for their success in becoming a member of the NHS Vital Signs Programme.

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.

We like the inclusion of keys to Audit abbreviations which accompanied the participation charts.

Part 3 Quality Achievements and Statutory Statements

The clear format of the achievements against priorities (3.1, 3.2) is very helpful to the reader.
From the section 3.3.5. Responsiveness to the needs of patients, we would single out the development of a framework for the establishment of a Children and Young People Participation Group as being a very positive step and from our own experience we can attest to the value of their involvement.

We are gratified to read of the continuing commitment to the principles of the Freedom to Speak Up review in line with the report by Sir Robert Francis QC including the provision of feedback to the person who raised the concern.

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.

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 remain committed to finding ways of supporting the Trust to achieve its aims.

3.5.3 East Lancashire Clinical Commissioning Group (EL CCG) and Blackburn with Darwen Clinical Commissioning Group (BwD CCG)

East Lancashire Clinical Commissioning Group (EL CCG) and Blackburn with Darwen Clinical Commissioning Group (BwD CCG) welcome the opportunity to comment on the 2019/20 Quality Account for East Lancashire Hospitals Trust (ELHT).

Throughout 2019/20, the Trust has continued to demonstrate their commitment to providing safe, personal and effective care for patients with a clear focus on closer integration with health and care providers across Pennine Lancashire.

The CCGs are pleased that the Trust and CCG were invited to be an early adopter of the Patient Safety Incident Response Framework (PSIRF). This work will support a culture of learning across the Trust and lead the way for wider implementation across health care. The CCG is committed to working alongside the Trust in its implementation throughout 2020/21 and beyond.

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 and learn from deaths. The Trust continue to develop the Mortality Reduction Programme and the CCGs have been happy with the progress made in integrating the Structured Judgement Review (SJR) process with patient safety risk management. The recruitment into Medical Examiner roles is positive and allow additional scrutiny and understanding of the Trusts mortality position and improvement. Learning Disability Mortality Reviews (LeDeR) are being routinely completed with actions and lessons monitored through the Mortality Steering Group.

Progress has been made against the quality improvement priorities identified in the 2018/19 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. The CCGs support the Trusts Quality Priorities for 2020/21 as key areas to further improve patient safety.

The Trust has participated in 95% of national clinical audits, 100% of national enquiries and completed 244 local clinical audits, demonstrating their continued commitment to the delivery of evidence based safe care.

ELHT has performed well against their Commissioning for Quality and Innovation (CQUIN) scheme achieving the payment threshold in each indicator at Q1-Q3. Monitoring of the scheme was suspended in Q4 due to the Covid-19 response and CQUIN has been suspended for 2020/21.

Readmissions within 28 days of discharge has increased on the previous year to 9.14% and remain above the national average of 9.0%. The CCG welcome the actions to improve the ratio, especially for the 0-15 age group where rates are 12.04%. The introduction of 'common childhood illness' guides, a joined up approach with partner agencies and the development of a mobile application are all positive actions which are anticipated to improve the position and more importantly the experience for patients/families.

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 and involvement with external organisations such as Healthwatch.

Friends and Family response and recommendation rates remain high and the CCG commend the Trust that response rates are some of the highest nationally, demonstrating the importance that the Trust place on patient/family feedback.

The Trust reported 5 Never Events in 2019/20. Root cause analysis investigations have identified lessons learned and actions which the Trust has implemented. The CCG are satisfied that there is a robust action plan in place relating to Local Safety Standards for Invasive Procedures (LocSSIPs), with excellent levels of engagement with staff across the organisation to share the learning.

The CCG were pleased with the annual NHS Staff Survey results for the Trust which demonstrated a positive staff culture. The Trust has shared an action plan with the CCG of areas of work to further improve performance and engagement with staff. The Trusts commitment to the principles of Freedom to Speak Up are positive and indicative of an organisation that placed a high value on an open and honest culture within the NHS.

ELHT were the highest performing Trust in the country for the uptake of flu vaccinations for frontline health care workers for the second time in three years which is an impressive

achievement and highlights the importance to staff and the organisation for the flu fighter campaign.

Inpatient survey results remain consistent and the CCG recognise the challenge around increasing numbers of patients attending the Emergency Department requiring admission, which has reflected a decline in the position for the question relating to waiting times for a bed on a ward. The CCG are encouraged by the range of activities in place to actively seek feedback and work with patients and other external agencies in order to learn and improve services. Progress against these activities will be monitored and discussed throughout the year as part of regular Quality Review Meetings.

The CCGs support ELHT approach to quality improvement and look forward to continuing to work with the Trust and wider health and social care economy throughout 2020/2021 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:

3.7 GLOSSARY

Term	Explanation
Acute Kidney Injury (AKI)	Acute kidney injury is a sudden episode of kidney failure or kidney damage that happens within a few hours or few days.
Advancing Quality (AQ)	A process to standardise and improve the quality of healthcare provided in NHS hospitals
Advancing Quality Alliance	The Advancing Quality Alliance was established to support health and care organisations in the North West to deliver the best health, wellbeing and quality of care for all by being a trusted source of quality improvement expertise for the NHS and wider health and social care systems.
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	Acts as a single point of contact for the relevant person, patient, next of

(FLO)	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 across ELHT to reduce the noise level and increase concentration if staff feel safety is potentially being compromised.